Excellence in Training and the future GP workforce

Professor Nicholas Glasgow

The Future of General Practice GPRA Meeting
Parliament House, 27th – 28th Feb 2007

Overview

- Medical education
  - International pressures
  - National context
- Excellence in training
- Some challenges going forward

International pressures on medical education

- Workforce shortages
  - The Toyota production line metaphor
- Changing burden of disease
  - E.g. Chronic diseases and co-morbidities
- Technology
  - Does it work?
  - What is the cost-effectiveness?
  - What is the best option for this person in this context at this point in time? (Sound judgements in the face of uncertainty)
- Consumerism
  - The business metaphor
- Quality and safety

Australian context

- Share the international issues
- Particular issues
  - Aboriginal and Torres Strait Islander health
  - Rural, remote health
  - Outer-metropolitan health
  - Public/private mix
  - Division of responsibilities for various aspects of health across jurisdictions – the Commonwealth / State and Territory divide

Link between training and workforce shortage

- Increase Supply
  - Increase numbers
  - Shorten training times
  - Change the skill mix of the existing workforce
  - Substitute health professionals
  - Strengthen generalism
  - Create new kinds of workers
  - Address uneven distribution
  - Increase productivity
- Reduce Demand
  - Health promotion and disease prevention
  - Enhance community capacity for self care
  - Point of Care Testing
  - The gatekeeper role

Excellence in Training

Outcomes orientated education

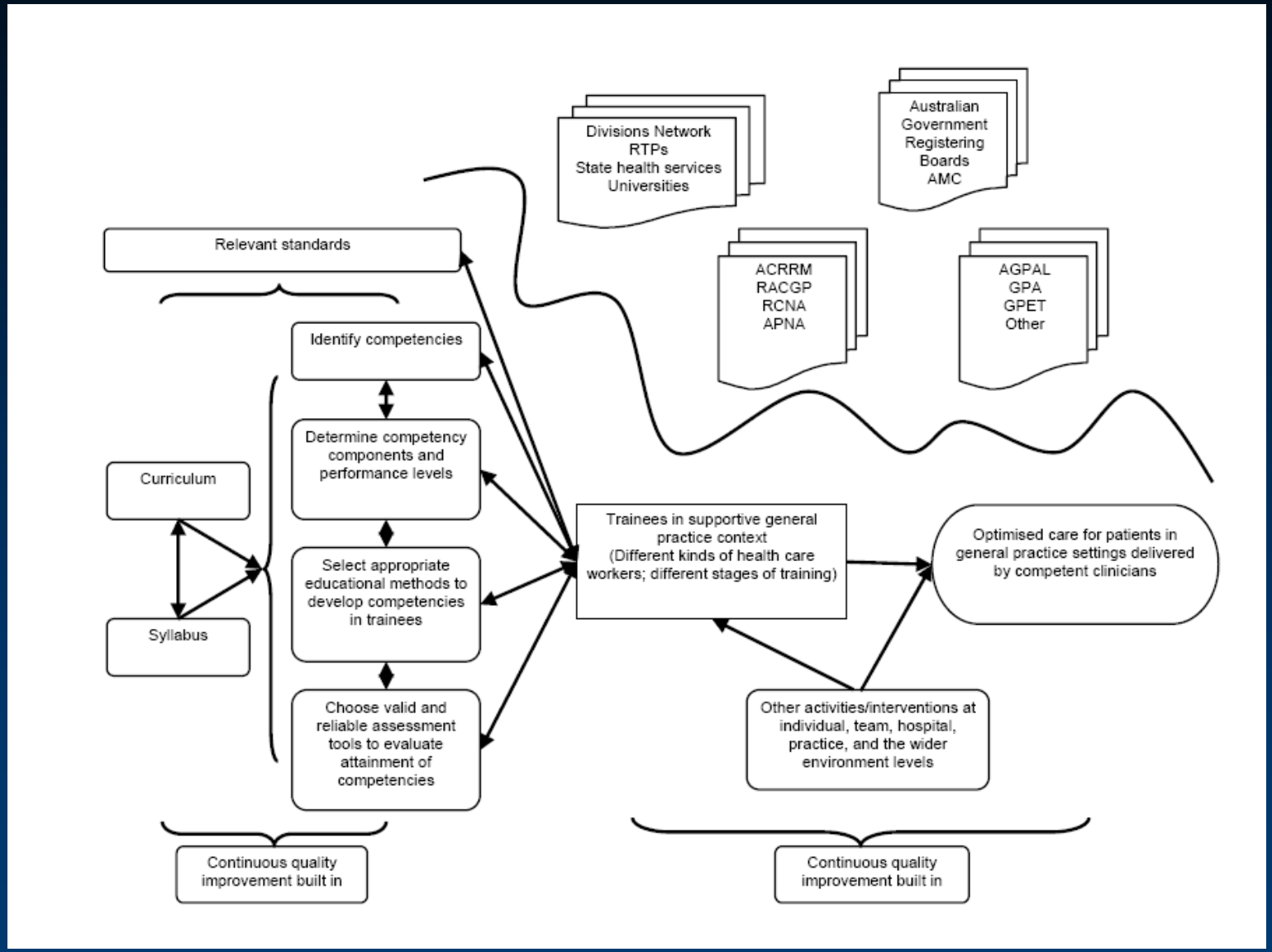
A Comparison of the Elements of Structure-and Process-Based Versus Competency-based Educational Programs		
	Educational program	
Variable	**Structure and process-based**	**Competency based**
Driving force for curriculum	Content-knowledge acquisition	Outcome - knowledge application
Driving force for process	Teacher	Learner
Path of learning	Hierarchical (teacher → student)	Non hierarchical (teacher ↔ student)
Responsibility for content	Teacher	Student and teacher
Goal of educational encounter	Knowledge acquisition	Knowledge application
Typical assessment tool	Single subjective measure	Multiple objective measures ("evaluation portfolio")
Assessment tool	Proxy	Authentic (mimics real tasks of profession)
Setting for evaluation	Removed (gestalt)	"in the trenches" (direct observation)
Evaluation	Norm-reference	Criterion-referenced
Timing of assessment	Emphasis on summative	Emphasis on formative
Program completion	Fixed time	Variable time

Carraccio C, Wolfsthal SD, Englander R, Ferentz K, Martin C. Shifting paradigms: from Flexner to Competencies. Academic Medicine 2002;77(5):361-367.

Five considerations in educational program design

- Clearly align the objectives of the educational activities with the outcomes of interest (e.g. appropriate chronic disease management outcomes);
- Design sound educational programs;
- Identify educational programs across the system targeting the same outcomes and seek to maximise synergies between programs;
- Be fully aware of and work within the existing complexity of the training environment; and
- Actively manage the process of change

Complex educational environment



Alignment with outcomes of interest

- Explicit curriculum
  - E.g. An educational program is designed to equip members of the general practice team to use a computer based recall and reminder system in order that people with asthma receive a full cycle of care, including proactive anticipatory care. GPs and practice nurses complete the program and are assessed as being competent in its use. They apply the knowledge and skills in practice. Access to proactive and anticipatory care is increased for people with asthma

- Don’t underestimate the effects of the “hidden curriculum”

Elements of sound educational programs

- Standards for trainees / training programs explicitly related to curricular philosophy and objectives;
- High level competency statements directly and explicitly related to competency components and performance levels at different stages of training;
- Appropriate educational approaches selected to develop specified competencies in the trainees;
- Assessment instruments valid and reliable, used for both formative and summative purposes, aligned with learning objectives and chosen according to the type of competency being assessed;
- Trainers are trained to deliver the program; and
- The whole educational program has inbuilt continuous quality improvement with feedback actively used for enhancements

And its not just doctors who have a view

- The Pew Commission (an impartial advisory body composed of leaders from health professions education, state and federal government, professional associations, business, the care delivery system and the public and supported by the Pew Charitable Trusts)
- Commonwealth and State/Territory Governments
- Consumers

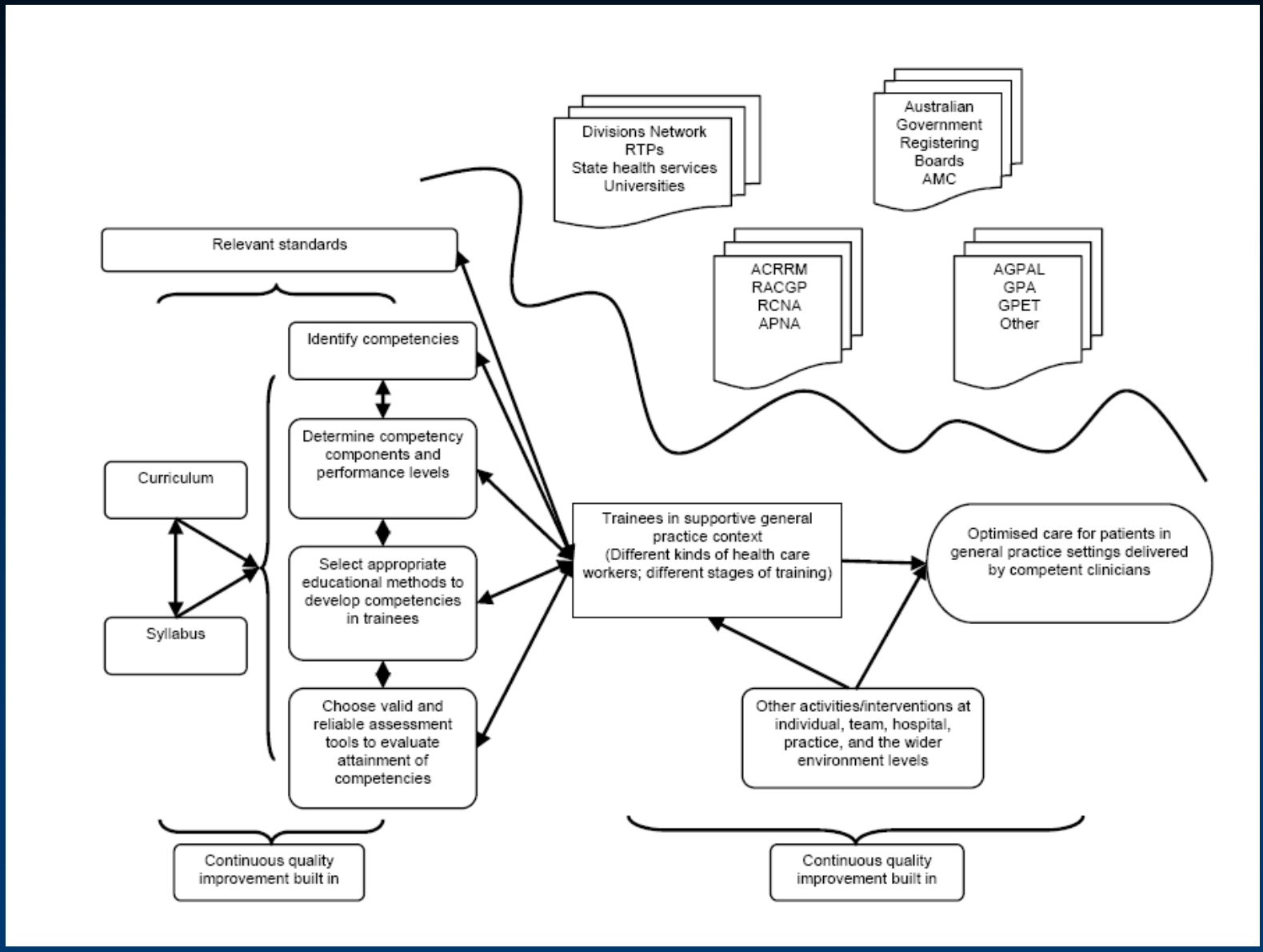
Pew Commission competencies for the 21st century

1. Embrace a personal ethic of social responsibility and service.
2. Exhibit ethical behavior in all professional activities.
3. Provide evidence-based, clinically competent care.
4. Incorporate the multiple determinants of health in clinical care.
5. Apply knowledge of the new sciences.
6. Demonstrate critical thinking, reflection and problem-solving skills.
7. Understand the role of primary care.
8. Rigorously practice preventive health care.
9. Integrate population-based care and services into practice.
10. Improve access to health care for those with unmet health needs.
11. Practice relationship-centered care with individuals and families.
12. Provide culturally sensitive care to a diverse society.
13. Partner with communities in health care decisions.
14. Use communication and information technology effectively and appropriately.
15. Work in interdisciplinary teams.
16. Ensure care that balances individual, professional, system and societal needs.
17. Practice leadership.
18. Take responsibility for quality of care and health outcomes at all levels.
19. Contribute to continuous improvement of the health care system.
20. Advocate for public policy that promotes and protects the health of the public.

Seek to maximise synergies with relevant programs

- Across the vertical continuum of education
- Across the “horizontal” continuum of educational activities including doctors in different training programs and doctors training with other health professionals
- Between colleges and organisations tasked with particular but not exclusive roles within the environment

Keeping coherence in mind



Actively manage the process of change (GroI)

Different Strategies Needed at Different Stages in the Process of Change	
Stage	**Strategies**
Orientation	
• Being aware of change proposal	Speeding change proposal through variety of media, personal approach of target group, opinion leaders
Interest, commitment	
Insight	
• Knowledge, understanding • Insight into own performance	Good instructions, CME, self-assessment, peer review, feedback
Acceptance	
• Positive attitude to change • Decision to change	Local consensus, presenting evidence, using opinion leaders, modelling new performance by peers, analysing barriers to change and finding solutions
Change	
• Adoption, try out in practice • Confirmation of feasibility and benefit	Skills training, extra resources, redesigning practice processes, extra staff, support and facilitation
Maintenance	
• Integration into routines • Embedding into organisation	Monitoring, feedback and reminder systems, integration into care pathways, leadership and management support, incentive

Some challenges for general practice

- Is the art of good general practice under threat?
  - Outcomes obsessed
  - Time poor
  - Rewarded for through put

- Is the science of good general practice under threat?
  - Explosion of knowledge
  - Rapidity of technological advances
  - Relative paucity of evidence derived from general practice settings
  - Time poor

Some challenges for general practice

- Can we state and demonstrate what general practice offers the health system in ways that are positively received by non-general practitioners? Or do we just bleat?

- How do we balance different ways of defining our profession?
  - the ethos of general practice
  - what GPs do
  - what primary care in Australia needs

- Infrastructure – who will invest?

- “Gatekeeping”

Not this kind of gatekeeper … rather

- Transparent discussion of benefits and harms
- Joint decision making
- Sound therapeutic relationship
- Sound judgements in the face of uncertainty
- Always the option to return

Image: http://www.markzug.com/Gatekeeper.htm

What is a GP?
(General Medical Service Committee Annual Report 1995)

- “The irreducible essence of general practice is the care of people who are or believe themselves to be ill. Sensing unease within themselves which is not resolved using their own perceptions or the resources of those around them, people seek a consultation to secure an understanding of what is happening to them, what it means and what might be done with what effect. This aspect of human behaviour transcends history, geography and culture and will survive the ephemeral health policies of transient governments. Providing a response to these concerns is what most GPs feel they are best at and happiest doing. By identifying the heart of our craft as the response to this timeless human need, we at a stroke restate our raison d’Ùetre and define our sovereign professional territory at a time of doubt and demoralisation.”

The way forward

- Consolidate
- “Preserve our best and be malleable about the rest” (Leach D, Stevens D)
- Celebrate history and achievements
- Strive to write new pages in that history through continued innovation, reflection and growth
- Who among you will write those pages?

THE AUSTRALIAN NATIONAL UNIVERSITY

- End

http://www.anu.edu.au/aphcri/Domain/Workforce/index.php