



General practice rotations for post graduate year 1 and 2 house officers—how feasible?

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Abstract

Aims To study the needs and support requirements of general practitioners facilitating general practice rotations for post graduate year (PGY)1/PGY2 house officers at their surgeries.

Method This was a telephone survey of general practitioners (GPs) from different practices in Canterbury Province, New Zealand. A semi-structured interview format was used as this allowed questions and responses to be clarified and provided the opportunity for respondents to make additional comments.

Results Twenty GPs from 20 different practices were interviewed in the study. There was a 100% positive response to the concept of a house officer (HO) rotation in general practice. Perceived benefits included the opportunity for house officers to improve their understanding of primary healthcare and general practice, gain clinical skills less available in the hospital setting, as a way to promote general practice and to enhance communication at the primary—secondary interface. Fifteen (75%) thought that this rotation would be better suited to PGY2 or more experienced PGY1 graduates. Eighteen (90%) of GPs reported that costs to their practice must be covered for HO rotations. Seventeen (85%) of GPs reported that their practices did not currently have adequate consulting space to accommodate a HO.

Conclusions GPs support HO rotations in general practice with perceived benefits for both HOs and general practice. PGY2 house officers were thought more suitable for GP rotations. Potential barriers to GP rotations include possible financial costs and capacity issues at the practice.

In New Zealand, there have been relatively few opportunities for house officers (HOs) in hospitals to gain experience in general practice to date. Internationally, however, there is considerable support for post registration house officers rotating in general practice. Benefits include insight into the primary-secondary care interface and improved relationships between primary and secondary care;¹⁻⁴ assistance with career choice; and increased likelihood that post registration house officers who spend time in general practice are more likely to consider it for a career.^{1,5}

Evidence shows that junior doctors receive a different clinical experience and are exposed to a wider variety of learning situations than in hospital attachments.¹ Rural general practice provides different opportunities in ambulatory and continuity of care,⁶ and exposure to a greater variety of conditions and a different demographic of patients.^{2,7} Williams et al⁵ report greater intraprofessional understanding, wider clinical experience, and better communication skills in their findings.

In their review of 19 studies of general practice rotations for house officers in the United Kingdom, Illing et al¹ found the studies unanimous about the educational benefits of such placements.

The Medical Council of New Zealand (MCNZ) is currently considering the introduction of compulsory general practice runs for house officers as it is thought that they would benefit from this professionally at several levels.⁸

The MCNZ recently consulted widely seeking feedback on possible rotations for junior doctors in general practice, whether there would be any difficulties in implementing them, and how such difficulties could be overcome.

The Medical Education Training Unit (METU) at the Canterbury District Health Board supports this initiative, but recognises that for such a rotation to be successful, the needs and support requirements of GPs would need to be known and addressed. This study therefore investigated the implications of providing such a rotation from a GP's perspective.

This paper outlines the key themes identified from structured telephone interviews of GPs in the Christchurch region of Canterbury Province, New Zealand.

Methods

This was a telephone survey that interviewed general practitioners in the Christchurch metropolitan area. Questions were developed following a literature review of similar rotations in Australia and the United Kingdom to identify key themes and issues and following consultation with staff of the Department of General Practice, Christchurch School of Medicine and Health Sciences, University of Otago, Christchurch.

Survey questions included demographics of the practices and general practitioners, overall perceptions of general practice rotations for house officers, perceived optimal timing and length of rotation, barriers to implementing a general practice rotation, and the possible impact on general practice registrar and undergraduate placement. Questions regarding what preparation, training and support would be required for general practitioners involved in such rotations were included.

The survey used a semi-structured telephone interview, as this allowed questions and responses to be clarified and provided the opportunity for respondents to make additional comments.

Participants were purposefully selected to ensure representation of a range of different sized practices, and to include GPs that were involved with GP registrar/medical student training and those GPs who were not.

One interviewer only was used. Two telephone interviews were held. The initial contact interview explained the study and oral permission was obtained. The questionnaire was emailed or faxed to the respondents and a time for the second telephone interview arranged. The interactive format questionnaire was completed during the interview. Interviewees were invited to review a copy of the completed questionnaire to check the accuracy of the data recorded.

The qualitative data obtained was analysed to identify the key themes using inductive analysis, principles of grounded theory and the constant comparative method. Two researchers independently identified themes.

Results

Demographics—Twenty general practitioners from a variety of different practices were interviewed (10 females and 10 males). Nineteen GPs (95%) were 40 years or older. Sixteen GPs (80%) were in urban practices with 4 (20%) rural. The mean number of GPs in each practice was 3.5 (range 2–8) with a mean of 3 practice nurses per practice. Fourteen (70%) of GPs interviewed were already involved with

supervision and training of undergraduates of which two also supervised GP registrars.

Perceived benefits of a GP rotation—All GPs interviewed supported the concept of a house officer (HO) rotation in general practice. Benefits identified are listed in Table 1, with a sample of comments to illustrate these themes.

Table 1. Benefits identified

Benefits identified	Sample of comments
The opportunity for HOs to fully appreciate the role of the GP (which many felt was poorly understood by hospital staff). It was thought this would enhance primary-secondary care relationships	<p><i>Would be very valuable as would learn about GP as a specialty, which would be useful even for those who stay in hospitals. i.e. learn the different sort of medicine practiced by GPs.</i></p> <p><i>Gives good idea of how 'the other side' works, more understanding of primary- tertiary care interface, experience in working in primary care.</i></p> <p><i>All hospital doctors need/ would benefit from exposure to general practice, as it gives them a much greater appreciation of the challenges faced in primary care. This may help long-term relationships between tertiary and primary sectors</i></p>
Experience in general practice could promote general practice as a career	<p><i>May consider GP as a career possibility</i></p> <p><i>Gives experience in the positives of general practice such as long-term continuity of care.</i></p> <p><i>May consider GP as career option</i></p>
The opportunity for HOs to gain specific skills less available in a hospital setting, e.g. the continuity of care in the community, chronic disease management, dermatological conditions, minor surgery.	<p><i>In hospital medicine, don't learn some simple things, and spending time in GP will help to 'round out' skills, e.g. being able to diagnose simple dermatological problems, etc.</i></p> <p><i>Allows appreciation for the importance of continuity of care</i></p> <p><i>Clinically, general practice would offer a greater understanding of the actual frequency of conditions presenting to general practice, as hospital medicine often gives a skewed perspective of this.</i></p>
Exposure to a wider spectrum of illness seen in general practice compared with hospital-based practice.	<p><i>Greater appreciation of the spectrum of illness that GPs see. Gain experience in making some unsupervised decisions</i></p> <p><i>Opportunity to see conditions that are not seen in hospital medicine as they are already filtered by general practice.</i></p>
Develop communication skills with patient and families	<p><i>Will also gain experience in situations such as consultations for the whole family, rather than just one patient</i></p> <p><i>Will gain better communication skills, and more understanding of a holistic approach to health, not just of the person but also of the family as a whole as well</i></p>

Eighteen GPs (90%) felt that house officers should also be exposed to on-call after hours practice as it was thought that this differed from routine general practice being much more acute and that HOs would benefit from this experience.

Impact on patients—Most GPs interviewed could see both positive and negative outcomes for patients (refer Table 2) with one respondent noting that many of the potential problems for patients also occur in other situations with registrars and locums but could be managed if the rotation was well run.

Only four GPs considered that there were no positive implications for patients and five believed that there were no negative implications, three of these respondents noted that the patients had a choice and that this reduced potential negative impact.

Table 2. Impact on patients

Positive themes	Negative themes
HO may have more time to spend with the patient	Patients may prefer to see their regular GP
The advantage of a second opinion a “fresh set of eyes”	Time of consultation to increase initially due to supervision requirements
Patients enjoy helping young doctors	Potential for lack of continuity of care
Patients may be able to see an HO at shorter notice	Patients not wanting to see someone with less experience or feeling like a “guinea pig”.
Help keep the practice up to date	Patient likely to be shy, and not so forthcoming to HO
Long-term benefits to patients in all settings if the role of general practice is better understood.	

Timing and length of rotation—Fifteen (75%) of respondents thought this rotation would be better suited to PGY2 house officers or to more experienced PGY1 house officers (25%). It was felt that a more experienced house officer would benefit from a GP rotation and their supervisory requirements would be less. Furthermore having a PGY2 house officer registered for a general scope of practice would by-pass many of the issues for pre registration house officers practising in the community including prescribing and medicolegal requirements.

Thirteen (65%) of the respondents supported a 3-month and seven (35%) a 6-week placement.

Reasons supporting 3-month placements varied but generally clustered around the theme of allowing the house officer enough time to be fully involved in the practice environment:

If shorter, may not gain enough skills to be confident by the time they finish the attachment. Longer run may offer incentive for practices, as a second-year house officer would need much less supervision by the end of the attachment and may be able to act in some capacity as a locum...

Comments supporting 6-week placements reflected concerns about the demands a rotation would put on the placement.

Will allow an adequate glimpse of general practice, without being too much of a stress on the practice

Fourteen (70%) of GPs stated that they would be able to accept a HO on placement for only part of the year (e.g. four 6-week placements or two 12-week placements) to minimise disruption to the practice or to fit around undergraduate placements.

Barriers to implementing a GP rotation—Two major factors emerged as potential barriers for general practice rotations.

Consultation space (with resources including computer access) was seen as a major limiting factor. Of the 20 practices where GPs were interviewed 17 (85%) did not have adequate consulting space for a HO although a few practices identified they may be able to rearrange part of their practices to accommodate a HO, e.g. using a treatment room.

Additional financial cost to the practice was overwhelmingly seen as a barrier to having house officer rotations. Estimates of costs for participating practices varied widely. Eighteen GPs (90 %) stated that any extra costs to the practice in terms of overheads or potential loss of revenue must be covered as a minimum requirement. Dollar values ranged up to \$500 per HO per week.

Impact on GP registrar and undergraduate placements—Fifteen (75%) respondents thought that there were a finite number of educational placements available in each practice. Most felt GP registrar training would not be affected, but 18 (90%) thought availability (or timing) of undergraduate placements may suffer.

Preparation/training/support required for HO and GP—With regard to support for HOs, six (30%) respondents thought that many of the skills HOs would need in general practice were best learnt “on the job”. Some areas mentioned in which prior exposure may be helpful included paediatrics, administration, communication, and computer literacy skills.

The support requirements for GPs involved knowledge of the expectations, roles, and responsibilities of all parties, as well as clear learning outcomes, assessment protocol, and medicolegal/registration issues.

All GPs stated they would be comfortable providing clinical assessment for HOs provided clear guidelines were provided.

Discussion

In this study, all general practitioners interviewed supported the concept of general practice rotations for house officers. GP rotations were seen as a positive learning experience for HOs providing an opportunity to gain clinical skills less available in the hospital setting and to gain experience in after hours primary care. GP rotations were also thought beneficial as a way to promote general practice and to enhance communication at the primary-secondary interface. These findings are consistent with other studies reviewing general practice rotations.¹⁻¹² The impact on patients however is less clear. It was noted that patients have choice as to whether to see the HO.

Timing of GP rotations is important with the results of this study favouring rotations for the more experienced PGY2 house officers who were thought more suitable due

to less supervision being required and fewer problems with respect to prescribing and medico-legal requirements.

Prescribing restrictions and the inability of HOs to sign prescriptions and order tests in a general practice environment were found to cause significant disruption in several studies.^{1,2,6} Illing et al¹ found that offering GP rotations to more senior house officers who were able to prescribe and required less supervision would be beneficial. Less supervision for more senior HOs was also seen as beneficial in a further UK study.³ Williams et al¹² looked specifically at the timing of the GP placement and recommended that GP rotations should not be first as pre registration house officers reported feeling unready to assess patients alone and anxiety about assessing the health of patients on the telephone. They believed that the undergraduate training hadn't prepared them for work in general practice, and that trainees preferred that the GP rotation was not their last rotation as they were then worried about starting as a senior house officer after 4 months out of hospital.¹²

From a District Health Board perspective, balancing the timing of rotations to accommodate the more senior house officers could be difficult given hospital service commitments, release time and the supervision needs of these doctors.

Financial cost to the practice was overwhelmingly seen as a barrier to having house officer rotations. Financial issues that arise from supervision, reduced patient load, and lack of clarity around funding arrangements emerge as a significant barrier in several studies.^{2,5,6,10} Illing et al¹ report a 10% increase in the GP working week to supervise HOs in the UK and cites difficulties that have arisen expanding projects due to problems with the financial support not reflecting the degree of supervision required. The supervision time funding issue appears to also occur in Australia.^{6,11}

These funding issues would clearly need to be addressed at a national level through the clinical training agency of the Ministry of Health which currently funds PGY1/2 training and rural general practice placements before GP rotations could be introduced across the country.

Consultation space (with resources including computer access) was also seen as a major limiting factor although several thought they may be able to rearrange part of their practices to accommodate a HO, e.g. using a treatment room. Capacity needs to be further investigated, as it is likely this may be the factor that limits implementation of such rotations. In this study, only 15% of practices currently had sufficient space. Careful consultation must therefore be undertaken to ensure that the capacity of general practice is equal to the task.

While having shorter (6-week) rotations may mean practices are willing to host more placements, some GPs voiced concerns that this would not give HOs sufficient experience in areas such as chronic disease management, which are a major part of the learning objectives. Additionally, it may be difficult to fit a 6-week rotation into the hospital timetable of 3-month rotations. Internationally, 4 to 6 month rotations appear to be the norm, with 4 months favoured.^{1,3,4,9} A community teaching placement with one session/week over 4–6 months is an option described by Smith⁴ and split week in GP and hospital rotations is described by Illing.¹

Taylor and van Zwanenberg T⁵ found that although split week rotations did not seem to cause problems for patients it was sometimes difficult for house officers, as they missed out on some aspects of the practice, e.g. diabetes, asthma clinics.

Although this study is limited by the small geographic area covered, the results and themes identified appeared consistent across the study, and are consistent with the international literature. The results may not necessarily reflect the opinions of GPs in other areas in New Zealand or the availability of placements. The sample size is small (20), however this is thought to be less of a concern as sampling and interviewing was continued until a clear and consistent pattern of responses emerged.

In summary, this study has identified clear support from general practitioners for HO rotations in general practice. Perceived benefits include providing an opportunity for HOs to gain clinical skills less available in the hospital setting, as a way to promote general practice and to enhance communication at the primary-secondary interface.

PGY2 HOs were thought more suitable due to less supervision being required and fewer problems with respect to prescribing and medicolegal requirements in the community.

Potential barriers to GP rotations include possible financial costs and capacity issues at the practice. These barriers should be considered carefully before the MCNZ or the proposed Medical Training Board makes a decision as to whether general practice rotations should be compulsory for all HOs.

Competing interests: None.

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