Assessment of training capacity in New Zealand general practices: a stocktake in the lower North Island and South Island

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ABSTRACT

AIM: General practices are providing clinically-based training for rapidly increasing numbers of medical (and other health professional) trainees. This study investigated capacity and intention of general practices to additionally teach junior doctors (now required to undertake community-based attachments by the New Zealand Medical Council) alongside current trainees in their service.

METHODS: A web-based/telephone survey of all general practices was developed and administered November 2015–April 2016.

RESULTS: In the Otago study region (lower North Island, South Island), 463 currently operating practices were identified. (A companion Auckland-based study concurrently investigated the upper North Island.) Of the 280/463 (60%) responding practices, 93% (261/280) were currently taking health professional trainees, with 86% (241/280) taking at least one type of medical trainee. Practices indicate that 14% fewer of them will take undergraduate medical students than previously (199 practices down to 162), but more would take junior doctors (42 up to 79) and GP registrars (129 practices up to 142).

CONCLUSIONS: Most practices in these regions already contribute to teaching. Practices indicated limitations in accommodating continued increases in numbers of trainees in the current poorly coordinated system. Improved support and training for practices is needed to enable practices to take more trainees of multiple types per practice, both concurrently and sequentially.

New Zealand has a primary care-led health system, with increasing emphasis on effective care in the community, yet there is a declining proportion of doctors working in primary care and an overall shortage of vocationally trained general practitioners (GPs). In line with experience internationally,[1,2] creating opportunities for clinically-based learning in primary care settings at junior doctor level, alongside existing undergraduate (and registrar) learning, is one of a number of measures recently introduced to try and address medical workforce shortages and maldistributions.

Primary care practices (mostly general practices) across New Zealand are being asked to take rapidly increasing numbers of medical (and other health professional) trainees for clinically-based training. General practices are widely recognised as effective and relevant learning environments for health professionals, with excellent potential for clinically-based, integrated inter-professional learning.[3] General practices currently receive requests from multiple sources: from the Royal New Zealand College of General Practitioners (RNZCGP) for GP registrars, district health boards (DHBs) (junior doctors–PGY 1 and 2s), universities (Yr2–Yr6 medical students), nursing education providers (20+ nursing training programmes), other health education programmes and internationally from elective students requesting placement.

Since the introduction of New Zealand's Primary Health Care Strategy in 2001,[4] reiterated in the 2016 Health Strategy,[5] there has been an increasing emphasis on the importance of a primary care-led health system, with a corresponding need for an appropriately skilled primary care workforce that can meet the needs of an ever-increasing and increasingly diverse population, including a growing health burden of chronic condition management.

Vocationally trained, experienced general practitioners are essential to primary care health teams, and although many more nurses, midwives and other health professionals are now working effectively in important primary care roles,[6] this does not obviate the need to train sufficient numbers of medical graduates for careers in general practice and other primary care settings, with the target proportion of medical graduates going into primary care in comparable health systems being between 45–50%.[7] Paradoxically, since 2000, although the total medical workforce increased from 9,779 in 2000 to 15,366 in 2014, the proportion of those working in general practice and primary care categories decreased from 39% to 31% over the same period.[8,9] It is important to note that in the UK, there is an explicit aim to recruit 50% of new graduates into general practice training posts,[10] although this is still considerably higher than the only 19% of new graduates, and the 35% of postgraduate Year 3s, whose first preference is to go into general practice in the UK.[7,11] In contrast in New Zealand, in the decade or so from the mid-1990s to mid-2000s, only 50 first-year New Zealand GP registrar training places a year were funded by the then Clinical Training Agency (CTA); far off approaching 50% of postgraduate training places and well below replacement and with no allowance for population growth.[12] However, since 2004, gradually increasing numbers of training places for medical students and GP registrars have been progressively created to reach current numbers to belatedly help fill the gap. Medical student intake across both medical schools has gradually increased from 365 in 2009 to 565 in 2014 (and due to reach approx. 600 by 2020) as government-funded domestic places have been progressively increased. GP registrar numbers have increased from 50 funded places per annum in 2000 to 187/565 (33% of postgraduate training places) in 2016.

From 2014, new community-based attachments (CBAs)—three-month attachments for junior doctors—also aim to give medical trainees further valuable clinical experience in a community-focused service (most often but not exclusively a general practice). Mandated by the New Zealand Medical Council (MCNZ), CBAs are being progressively implemented across the country with an expectation that all junior doctors be able to complete such an attachment from 2020.[13,14] Although these are much needed and welcome changes in policy to address a significant training and distribution shortfall, the consequence is unprecedented pressure on general practices to take many more medical trainees at multiple levels, a problem predicted for some time.[15,16] When capacity is at a premium, there is not only a risk of displacing some learners by others but also stretching goodwill at practices over time, such that they withdraw from teaching altogether. Coordination and support is key to avoid compromising general practices and their ability to accommodate all trainees, including nursing and other health professional students.

This study therefore aimed to establish the capacity and future intentions of general practices to take on an increasing number of health professional students at all training levels in the all-of-Otago study region. It was conducted in collaboration with the University of Auckland, who investigated DHB areas in the northern part of the North Island. Their results will be reported separately. This national stocktake project was proposed by the universities and endorsed by RNZCGP, Health Workforce New Zealand (HWNZ), General Practice New Zealand (GPNZ), NZ Rural General Practice Network and DHB representatives in November 2015 (working party meeting, RNZCGP offices).

This paper provides a snapshot of general practices across the Otago study area by DHB region in relation to each of the main Otago campuses and considers nationwide implications.

Methods

Training context

There are approximately 1,000 primary care practices nationally, ranging from those with 1–2 consulting rooms to those with over 15 consulting rooms. At pre-registration (undergraduate) level, the two medical schools at University of Auckland and University of Otago request undergraduate students' placements in practices in a coordinated way across the country. Auckland generally requests placement for students in practices in the upper the North Island, and Otago requests placements in the more lightly populated lower North Island and South Island. At Otago, undergraduate trainees spend varying time in practices based on the year they are in and the campus they belong to (see Table 1). Practices do not necessarily take a student every attachment, and most often only have one trainee at a time for a variety of reasons (eg, holidays, room availability and supervisory capacity).

All attachments commence in November each year and rotations run successively (12 month training year) for final (6th) year medical students, junior doctors and GP registrars. Attachments vary in length but all of these students require a consulting room most of the time in practice. Practices are usually contacted separately by each agency placing trainees so there is little knowledge, apart from at practice level, of how many and what type of trainees each practice takes.

Stocktake

For the purpose of this stocktake of general practice training capacity across the Otago study region, the Wellington campus area was deemed to cover the Tairāwhiti, Hawkes Bay, Midcentral, Whanganui, Wairarapa, Hutt and Capital & Coast District Health Board (DHB) geographical areas. The wider Christchurch campus area covered Nelson-Marlborough, Canterbury and South Canterbury DHB areas, and the Dunedin campus area covered the Southern and West Coast DHB areas.

Practices were identified via several means—primary health organisations of various types (including GPNZ and RNZCGP), university department lists as well as publically available web-based information. Practices and PHOs were contacted to ensure accuracy of practice names, phone numbers and other contact details. Practices were initially informed of the training capacity survey and the intent of the stocktake exercise via general information channels (websites, PHOs etc.), and open letters were circulated as widely as possible. Endorsement was provided from GPNZ, HWNZ, DHBs and RNZCGP.

The stocktake was undertaken via a web-based/telephone/faxed survey directed to practice managers and/or senior clinicians if a practice manager was unavailable. A structured questionnaire was developed by University of Otago and University of Auckland researchers, asking about practice demographics, recent experience of having

Table 1: Clinical placements and primary care modules at the three University of Otago campuses during 2016.

Weeks in clinical placement	4th year Feb–Oct		5th year Feb–Oct		6th year (trainee interns) Nov–Nov		Total curricular weeks	Total (clinical placement) weeks
Campus area	Curricular weeks#	Clinical half days*	Curricular weeks	Clinical half days*	Curricular weeks	Clinical whole weeks*		
Wellington	5 weeks	12 half days	2 weeks	0 half days	7 weeks	7 weeks (70 half-days)	14	7+1.2=8.2
Christchurch	8	24	0	0	4	4 weeks (40 half- days)	12	4+2.4=6.4
Dunedin	5	10	7	40	3	3 weeks (30 half-days)	15	3+5=8.2

*contracted time in general practices, seeing patients with clinicians.
#weeks dedicated to primary care in curriculum, designed, taught, assessed by experienced primary care health professionals.

trainees (undergraduate medical students, junior doctors, GP registrars and other health professional students) in the practice, as well as future intentions and capability for each of these groups. Other questions covered size and nature of the practice, current staffing levels and other services/clinics that were available to the practice, and limitations to taking more trainees in practices. Partway through the data collection, some questions were omitted, as they proved difficult for practice staff to answer, eg, year group of undergraduate medical student was changed to 'any undergraduate medical student'. The final shortened survey is attached (Appendix).

Invitations to participate with an electronic survey link were sent to all Otago study area practices followed by a reminder phone call and, if required, subsequent email. A further final phone call to the non-responding practices was undertaken in April 2015 with shortened survey faxed as a word document.

Data were cleaned and checked for accuracy. Where practices completed the online survey several times the most recent survey was used. Some practices did not fully complete the survey but any data they had completed was included. Responses were more likely to be incomplete with regard to questions about different types and levels of trainees. Response denominators are therefore given for each question. Percentages were calculated depending on the response denominator for each question. All responses regarding undergraduate medical students were amalgamated, as practice responders were often not able to reliably distinguish between different levels of medical students.

The responses regarding limitations to and incentives for expanding teaching were grouped (0–1: no limitation/importance, 2–3: some limitation/importance, 4–5: significant limitation/importance.

No further statistical analyses were considered appropriate in view of the self-reported nature of the data, the variable nature of responses and the apparent lack of reliable information at practices about past involvement in training.

Results

Participation

In the Otago study region, 463 currently operating primary care practices were identified, including small rural hospitals. For consistency, satellite clinics (a peripheral site where patients are seen intermittently) were considered part of their parent practice if they would not be able to consistently fully host a trainee themselves.

During the process of identifying practices, several clinics were found to be amalgamating with other practices, building rooms or closing. Between regions, similar types of clinic varied in their ability to take health professional trainees due to differences in availability of supervisors, for example after-hours clinics. There were several 'specialised' clinics identified, eg, men's health clinic, skin clinics. These were not included unless it was clear that they could fully host a trainee for a clinical attachment.

Non-responding practices

Despite all practices being contacted by letter, fax, email and at least once by phone, 183 failed to answer the survey in the six-month study time frame despite stated intention to do so. Of the 183 non-responding practices, 82 (45%) are nevertheless known to one or other of the university departments, as they currently take, or have recently taken, medical students. The other 101 may or may not take trainees, but are unlikely to do so.

Responding practices

Responses were received from 60% (280/463) of practices. The response rate was highest from practices in the Dunedin campus area. Overall survey response rates were: Wellington campus area 57% (105/185), Christchurch campus area 60% (107/179) and Dunedin campus area 69% (68/99), respectively. One hundred and ninety self-identified as urban, 66 rural and 24 regional. Consistent with the population demographics and spread in the lower South Island, the highest proportion of rural practices was in the Dunedin campus area; 41%. Of the 280 responses, 139 practices returned electronic surveys, 75 returned phone surveys and 66 returned hand-written faxed surveys.

Table 2: Characteristics of responding general practices across in the Otago study region by campus area in the study period.

General practices in the Otago study region (includes rural hospitals (11) in Otago study region)	Otago study region	Wellington campus area	Christchurch campus area	Dunedin campus area
Responding practices	280/463 (60%)	105/185 (57%)	107/179 (60%)	68/99 (69%)
Size of practice • 1–2 rooms • 3–4 rooms • 5–7 rooms • 8–10 rooms • >10 rooms	n=276 24 (9%) 78 (28%) 100 (36%) 31 (11%) 43 (16%)	n=102 7 (7%) 27 (26%) 31 (30%) 10 (10%) 27 (26%)	n=107 14 (13%) 35 (33%) 41 (38%) 8 (7%) 9 (8%)	n=67 3 (4%) 16 (24%) 28 (42%) 13 (19%) 7 (10%)
Practices identifying as rural	66 (24%)	10/105 (9%)	28/107 (26%)	28/68 (41%)
No. practices with satellite clinics	23 (8%)	11 (10%)	4 (4%)	8 (12%)
Satellite clinics and other available clinics*	102 (279)	49 (104)	29 (107)	24 (68)
Total number of consulting rooms available at any one time	1,837	806	571	460
No. FTE doctors	852	359	267	226
No. FTE nurses	860	387	255	218

*includes Marae, rest home, school clinics, prison and other.

Number of consulting rooms at practices was used as a proxy for practice size, as trainees in practices affect consulting room use. The most common type of practice by size has 5–7 consulting rooms. Nearly three-quarters (201/280; 72%) of all responding practices have seven or fewer consulting rooms. The Christchurch campus area had more very small practices (1–2 consulting rooms) and the Wellington campus area more very large practices (>10 room practices) than the other regions. Other characteristics of responding practices are shown in Table 2.

Teaching and learning—health professional trainees in practices

Of all the responding practices, 93% (261/280) were involved in taking health professional trainees in the last five years, with 86% (241/280) taking at least one type of medical trainee; only 14% (39/280) indicated otherwise. When the known teaching practices from the non-responding group (82/183) are added it is reasonable to assume that 323/463 (70%) of Otago study region practices are involved in medical trainee teaching. As shown in Table 3, undergraduate medical trainees and nursing trainees were the commonest type of student. Overall, 199/280 took an undergraduate medical trainee, with 158/275 taking nursing trainees. Of the 14% of responding practices who have not had any type of medical trainee, half (20/39; 51%) nevertheless take other trainees (nursing, social work, pharmacy, dietitian, etc.).

Table 3: Current and previous health professional trainee teaching by responding practices across the Otago study region, by campus area, reporting current/previous teaching.

Responding general practices	Otago study region n=280	Wellington campus area n=105	Canterbury campus area n=107	Dunedin campus area n=68
Practices which have a health professional trainee of any sort	261 (93%)	98 (93%)	102 (95%)	64 (94%)
Have/had undergraduates	199 (71%)	68 (65%)	72 (67%)	59 (87%)
Have/had PGY	42 (15%)	16 (15%)	10 (9%)	16 (24%)
Have/had GPEP registrars	129 (46%)	48 (46%)	45 (42%)	36 (53%)
Have/had nursing students	158 (56%)	70 (67%)	54 (50%)	34 (50%)
Have/had other health professional trainees*	35 (13%)	17 (16%)	10 (9%)	8 (11%)
Take no medical trainees+	39 (14%)	17 (16%)	17 (16%)	5 (7%)

Responses to the question 'Over the last year (2015) or previous five years (2010–2014) does your practice take any of the following trainees?'
*other health professional trainees include dietitian, pharmacy, counselling, psychology, social work trainees.
+some of these practices take other health professionals.

Future intentions

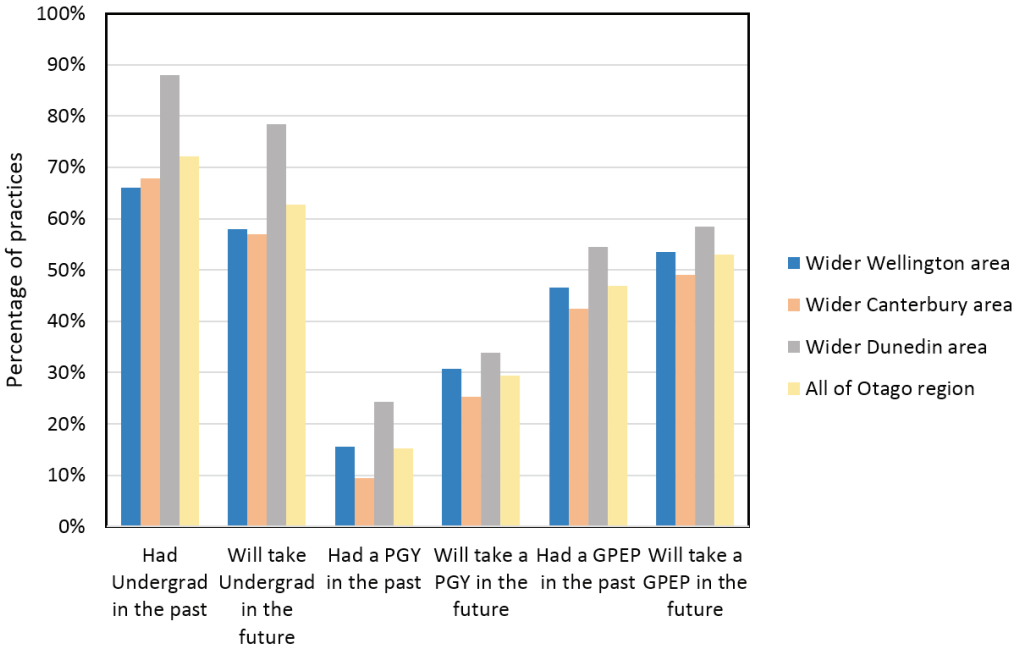
Overall, practices indicate they will continue to teach medical trainees. A small number of practices (17/280) had taken medical trainees in the past (12/17; 70%, undergraduate trainee only) but indicated they were not intending to take them in the future. A few of these (5/17) indicated they could possibly take a trainee part-time if other options were available during the week.

Across the Otago study region, 59% (162/276) of practices indicated that they would take undergraduate medical students in future. Nearly a third (79/275; 29%), indicate willingness to take future junior doctor trainees and 52% (142/275) would take GP registrars. Over half of all practices indicated willingness to take nurse trainees (155/277; 56%) and 16% (45/277) indicated willingness to take other health professional trainees in future. A majority of responding practices (67%; 175/262) reported they would consider accommodating a trainee (who required a room) part of the week if there were options for the other days.

Differences between current practice and future intentions

Overall, responding practices across the Otago study region report an intention to slightly increase total numbers of trainees, as compared in Figure 1. However, responding practices indicate that overall, less of them will take undergraduate medical students than they have in the past (199 practices down to 162 practices), but more will take junior doctors (42 up to 79) and GP registrars (129 practices up to 142) in future. Across the Otago study region those figures represent a 14% drop in the number who say they will take undergraduate medical trainees.

Figure 1: Comparison of previous and future teaching—number of responding practices in the Otago study region, by campus area, reporting previous teaching and intention to take trainees in future.



Practice limitations and incentives

The majority of practices responded to questions about limitations on the practice in taking students and to questions about incentives to increase teaching capacity. Interest in teaching was high, with less than 3% (8/265) of responding practices considering 'lack of interest' to be a significant limitation. Practices reported that lack of supervising staff (69%, 184/265 [75 said a 'significant limitation']) was the most limiting factor. Christchurch campus area practices tended on average to have fewer consulting rooms, and also reported physical infrastructure as being a significant limitation more so than the other two regions. Other reported limitations are shown in Table 4.

Practices responded to questions on incentives to develop teaching capacity, as shown in Table 5. Assistance with converting, building or equipping teaching room(s) was recorded as a key incentive by 70/262 (27%).

The overall impression from the survey across the Otago study region (lower North Island and all the South Island) is that practices are willing but stretched, as a respondent concluded:

"Our patients are very tolerant and positive about our teaching role but I would not want to saturate this, or exhaust our enthusiasm as teachers." (GP respondent)

Table 4: Factors reported as limiting practices in Otago study region, by campus area, in their ability to take more trainees.

	Otago study region n=265			Wellington campus area n=102	Christchurch campus area n=99	Dunedin campus area n=64
Limitation#	Total*	Some limitation	Significant limitation	Significant	Significant	Significant
Infrastructure (rooms)	157 (59%)	71 (27%)	86 (32%)	26 (25%)	44 (44%)	16 (25%)
Supervising staff	184 (69%)	109 (41%)	75 (28%)	23 (23%)	28 (28%)	24 (38%)
Money	124 (47%)	87 (33%)	38 (14%)	16 (16%)	12 (12%)	10 (16%)
Lack of Interest	54 (20%)	46 (18%)	8 (3%)	1 (1%)	6 (6%)	1 (2%)

Responses to the question 'How would you rate the following as a limitation for your practice to taking medical students?'
#responses shown in order questions were asked.
*total of some and significant limitation.

Table 5: Factors reported that would incentivise practices in the Otago study region, by campus area, to increase their training capacity.

	Otago study region n=255			Wellington campus area n=99	Christchurch campus area n=95	Dunedin campus area n=61
Incentive#	Total^	Somewhat important	Very important	Very important	Very important	Very important
Wall plaque	81 (32%)	65 (26%)	16 (6%)	7 (7%)	3 (3%)	6 (10%)
Additional status	126 (49%)	98 (38%)	29 (11%)	12 (12%)	9 (9%)	8 (13%)
Combined accreditation	152 (60%)	102 (40%)	51 (20%)	21 (21%)	14 (15%)	15 (25%)
Access to investigations	114 (45%)	64 (26%)	51 (20%)	20 (20%)	19 (20%)	11 (18%)
Assistance with teaching rooms*	155 (61%)	85 (33%)	72 (28%)	32 (32%)	26 (27%)	12 (20%)

Responses to 'How important are these factors in incentivising your practice to develop its teaching capacity?'
#responses shown in order questions were asked.
^total of somewhat and very important incentive.
*Assistance with converting, building or equipping teaching room(s).

Discussion

This is the most comprehensive survey of general practices in the Otago study region (lower North Island and South Island) undertaken with respect to clinical teaching capability and capacity in primary care to date. When considered together with the Auckland-based survey concurrently undertaken in the upper North Island it provides a nationwide 2016 snapshot of current and intended clinical teaching capability for health professionals in the community at practice level.

Survey results in this study indicate that most general practices in the study region are already involved in medical, nursing training and other health professional teaching, and most are willing to continue their overall involvement in training at current levels. This is an impressive commitment compared to the results from a limited number of other studies,[11] even if all non-responding practices were considered not to teach. Overall, practices consider they are limited in taking more trainees per practice by: too few supervisors at the practice, inadequate physical space and infrastructure (especially smaller practices) and currently fragmented accreditation processes. Present levels of remuneration will limit expansion of teaching. Critically, although practices report intention to continue taking about the same number of nursing placements, over time practices consider they will take fewer undergraduate medical students in favour of more GP registrars and junior doctor placements.

Strengths and limitations

Although the response rate (60% overall) could have been higher, this rate compares favourably with other online, postal and telephone surveys in general practice. Nevertheless, available information about non-responding practices shows that at least 40% of these practices in the Otago study region are taking medical trainees of some sort, and although we have no information about their future intentions, it seems reasonable to assume that at least 70% of the region's practices are involved in some teaching of health professional trainees.

The survey was directed initially at practice managers, but a number reported having to check information with others (eg, GPs, practice nurses) at the practice before they felt able to complete the questionnaire. Many found it difficult to distinguish between different types of medical trainees, and some questions about types of medical student were subsequently

dropped from the survey to make it easier for practices to participate.

While a few practices had previously had junior doctors in their practices, in the now discontinued postgraduate general practice placement (PGGP) scheme administered by the RNZCGP, very few CBA placements had occurred in the study region at the time the data was collected.

Comparison with the upper North Island area study, and other studies

Unlike the findings reported in this current paper, the upper North Island study conducted by our Auckland colleagues has identified around half of practices in their study region as currently not involved in any type of health professional training.[17] There are not many nation- or region-wide studies of general practice training capability and capacity anywhere, but a broadly comparable UK study showed a similar result—less than half of all British general practices being involved in undergraduate teaching, with investment in extra support and training being required to increase capacity further.[18]

Why there is such a large difference in this respect between the two New Zealand study areas is not entirely clear, but we do know that there are far more corporate and/or larger practices in the Auckland metropolitan area than elsewhere, and this may have influenced the upper North Island results overall. In contrast, both surveys identified very similar responses about practice factors that would limit more teaching. Concerns about physical infrastructure and difficulties providing appropriate supervision at multiple training levels within a practice were especially common.

In Australia, with a comparable training system, cost benefit analysis has shown that even with some payment, all trainees represent a cost to practices.[19] Costs to practices in New Zealand are likely to be more, since amounts paid to practices for taking undergraduate students and GP registrars are considerably less than in Australia.[20]

Implications

In future, given present restraints, practices indicate a willingness to only slightly increase overall trainee health professional numbers. Assuming half the national estimates (since approximately half the nation's population live in the lower North Island and South Island), currently there are 259 trainee interns, approximately 30 PGYs and 108 registrars requiring general practice placements in the Otago study region. By 2020 this is set to increase to approximately 300 trainee interns, 300 PGYs and 150 registrars. In addition, more 4th and 5th year medical students, nurses and other allied health professionals will continue to require general practice placements. Results imply that unless total capacity is increased to collectively accommodate all health professional undergraduates, junior doctors and GP registrars, medical students may not gain adequate and essential clinical experience in general practice by the time they graduate. This has critical implications for medical undergraduate placements and the influence on students considering choosing general practice as a career.[21]

It is clear there is limited training 'headroom' with regard to new teaching practices across the entire region. Among the small number of practices not currently teaching, some will not be suitable and others would need substantial investment in creating effective learning environments.

What can best be done to enable existing teaching practices to systematically provide for more trainees? Responses from the study show that practice capability for teaching and learning could be most effectively increased by firstly increasing numbers of supervisors, by instigating additional training and support (as widely advocated by others[22,23]), and secondly providing assistance for physical infrastructure improvements. Other practice support measures include sharing of trainee placements where necessary, a standard combined practice accreditation process and formal recognition of teaching practices as having additional status.

As described in comparable jurisdictions, investment in strategic capacity building is needed. There needs to be prompt attention to a coordinated collaborative placement system,[24] introduction of team teaching and learning models,[25] and the creation of all-of-practice learning environments where all staff can be part of a teaching team. There is also considerable but largely unrealised potential for inter- and intra-professional learning to be fostered at practices, with

students from different health professions and at multiple levels often being present at practices concurrently.[26] Students can learn with and from each other if safely facilitated to do so, taking some pressure off teaching time for senior staff.

As key health system providers, general practices are changing—evolving work roles, workloads, skill mix, premises, business models, system and consumer expectation all make for a dynamic, fluid primary care environment. Our study revealed that there are many practices which have amalgamated, built new premises, closed, opened or changed. Having a view of practices as much as practitioners is essential to knowing how and where to place trainees. For this to happen, agencies requiring trainees to spend time within the general practice setting need to work together to support these practices to build capability and capacity.

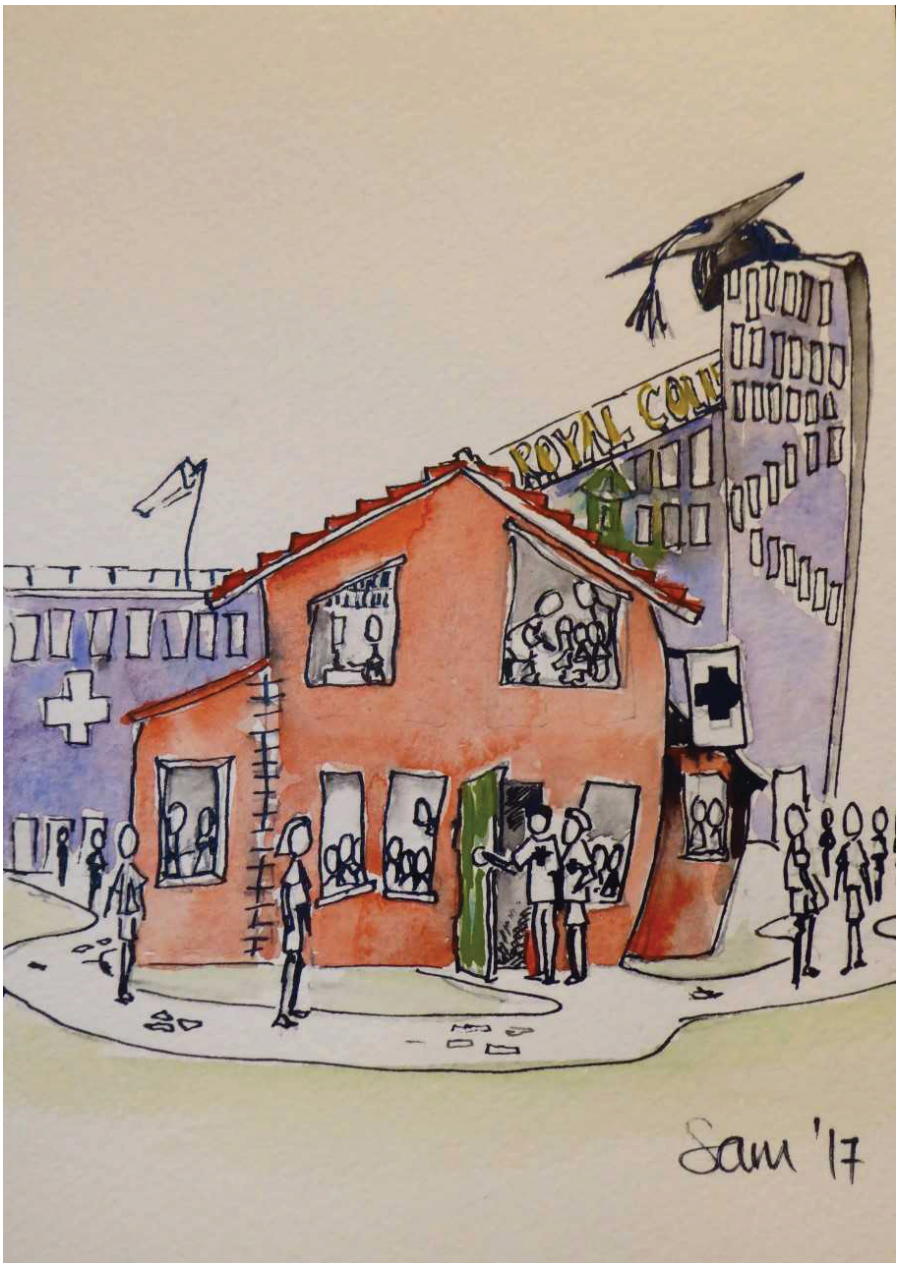


Illustration by Samantha Murton.

Appendix

Welcome to the Department of General Practice & Primary Health Care primary care training practice capacity survey

This survey is led by the University of Auckland, and is also being conducted on behalf of the University of Otago, the RNZCGP and Health Workforce NZ, with the support of GPNZ, the NZ Rural GP Network and the NZMA.

We appreciate your participation. This will enable us to accurately map the current general practice and primary care training landscape, and conduct modelling of possible scenarios which might increase capacity.

Today we will be gaining your thoughts and opinions in order to better serve you in the future. Be assured that all answers you provide will be kept in the strictest confidence.

1. Please fill in the following details.

Practice Name	
Your Name	
Email address	

2. How many General Practitioners (full time & part time) are employed by the practice?

   - How many **full time equivalent GPs** are employed by the practice?

3. How many Practice Nurses are employed by the practice?

   - How many **full time equivalent Practice Nurses** are employed by the practice?

4. How many Consulting Rooms are available at one time for the practice in total? ☐

5. Are there other clinics available to your practice for teaching purposes? (That you are currently using or can make use of in future eg. satellite, school, marae, rest-home, prison)

   Yes ☐ No ☐

6. Last year (2015), did your practice take any of the following trainees and if so, how many?

	Jan - Dec 2015 Yes	No	How many
Undergraduate medical students (Years 2 – 6)	☐	☐	
PGY (house surgeon / junior doctor)	☐	☐	
Selective medical students	☐	☐	
Elective medical students - Domestic	☐	☐	
Elective medical students - International	☐	☐	
GPEP (GP registrar)	☐	☐	
Nursing students	☐	☐	
Other (eg, pharmacy and social work)	☐	☐	

7. In the previous years, from 2010 to 2014, did your practice take any of the following trainees?

	2010 - 2014 Yes	No
Undergraduate medical students (Years 2 – 6)	☐	☐
PGY (house surgeon / junior doctor)	☐	☐
Selective medical students	☐	☐
Elective medical students - Domestic	☐	☐
Elective medical students - International	☐	☐
GPEP (GP registrar)	☐	☐
Nursing students	☐	☐
Other (eg, pharmacy and social work)	☐	☐

8. For this year (2016), with your current circumstances, could your practice take any of the following trainees and how many?
(This is purely for practice scoping and not a recruiting exercise).

	2016		How many
	Yes	No	(approx.)
Undergraduate medical students (Years 2 – 6)	☐	☐	
PGY (house surgeon / junior doctor)	☐	☐	
Selective medical students	☐	☐	
Elective medical students - Domestic	☐	☐	
Elective medical students - International	☐	☐	
GPEP (GP registrar)	☐	☐	
Nursing students	☐	☐	
Other (eg, pharmacy and social work)	☐	☐	

9. For how many months of the year (0-12) would your practice prefer to have the following types of trainees?

	Preferred Number of months
Undergraduate medical students (Years 2 – 6)	
PGY (house surgeon / junior doctor)	
GPEP (GP registrar)	
Nursing students	
Other (eg, pharmacy and social work)	

10. Would your practice be able to take a trainee for part of a week if there were other options for the remaining days of the week?

Yes ☐ No ☐

11. Are there any restrictions for your practice accepting trainees depending on the time of year? [eg seasonal variations / school holidays]

Yes ☐ No ☐

12. How would you rate the following factor(s) as a limitation for your practice in taking medical trainees? (**Undergraduate/PGY/GP registrars**)

	Not a limitation		Some limitation			Significant limitation
	0	1	2	3	4	5
Infrastructure (no available rooms)	☐	☐	☐	☐	☐	☐
Supervising staff	☐	☐	☐	☐	☐	☐
Money	☐	☐	☐	☐	☐	☐
Lack of interest	☐	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐	☐

13. How important are these factors in incentivising your practice to develop its teaching capacity?

	Not Important		Somewhat Important			Very Important
	0	1	2	3	4	5
University, College & DHB endorsed wall plaque	☐	☐	☐	☐	☐	☐
Additional status awarded to a teaching practice	☐	☐	☐	☐	☐	☐
Combined accreditation as a teaching practice	☐	☐	☐	☐	☐	☐
Ability to access additional investigations for patients	☐	☐	☐	☐	☐	☐
Assistance with converting, building, or equipping teaching room(s)	☐	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐	☐

Do you have any other comments, questions or concerns?

We thank you for your time spent taking this survey, this is very much appreciated.
Please scan and e-mail the completed survey to **GPClinicalplacements@otago.ac.nz**
or you can fax to **04 385 5539**

Competing interests:
Both authors work for University of Otago, Wellington.

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