PGY2 attachments in general practice—a New Zealand experience

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The New Zealand Curriculum Framework (NZCF) for Prevocational Training[1] was implemented by the Medical Council of New Zealand (MCNZ) in 2014, requiring all interns to complete one clinical attachment in a community-based setting over the course of the intern training programme, with 100% compliance by 2020. The Medical Education Training Unit (METU) at the Canterbury District Health Board (CDHB) undertook a pilot with RMOs (Post Graduate Year 2/3) doctors a year prior to the implementation to enable all parties to develop systems and processes to support community rotations in general practice.

An emergent evaluation framework developed by Haji et al[2] guided the design, implementation and evaluation. More importantly, it facilitated a partnership approach to placement development with the community practices and RMOs. The aim of the pilot was to determine what worked for everyone, what was reproducible and what could inform the development of future placements.

Haji's[2] framework guided the mixed method data collection, which included site visits, interviews with practice managers and general practitioners (GPs), pre and post face-to-face interviews with RMOs and an electronic end-of-attachment evaluation survey completed at the end of all hospital placements.

Overall the experience of RMOs and GPs in this pilot programme has been very positive and is consistent with findings from international studies.[3–6] A study locally undertaken in Canterbury in 2005[7] to determine the drivers and barriers to providing clinical attachments in general practice provided background for this initiative.

This letter shares the outcomes of this pilot with a focus on the features of the learning environment that supported learning, the learning outcomes reported by the RMOs and the educators experience and insights. We believe these can be of assistance to others designing and managing placements.

Features of a successful learning environment

Positive features of the learning environment identified included: RMOs having their own clinics, generous consultation times, the presence of an assigned GP who provided immediate supervision, feedback and advice. Any down time was appreciated and appeared well utilised. The practice managers had a key role in orientating the RMO to place, people and the IT system. There was an element of patient triage in assigning workload to the PGY2 doctors that ensured a good range of patients. Patient consent was not an issue having been facilitated by the practice.

Learning gains for RMOs

RMOs stated that they gained insight into the primary-secondary care interface, the experience assisted with career choice and exposure to commonly seen, less serious clinical conditions was beneficial for learning.[3–6] Clinical experience identified as unique included medical screening (eg insurance, drivers medical), preparing Work and Income and Accident Compensation Corporation certificates, examining and managing children, musculo-skeletal assessment, dermatology (particularly rashes), obstetrics and gynaecology (including irregular bleeding, miscarriage) and sexual health. Pre-placement training in these areas was recommended by the RMOs.

In the three larger practices, opportunities to be part of the wider learning environment and community links, including rest homes and other agency placements, were appreciated by RMOs. In a small

practice the addition of an RMO helps build that sense of a peer community.

All felt they had a better understanding of the general practice context, the challenges faced by GPs and the interface with the hospital. They learned about the importance of the discharge summary providing clear information and instructions to the GP. The complexity of referral processes was noted. There was increased understanding of nursing and allied health roles.

The educators experience

Evaluating the pilot within this model has ensured documentation of expectations, with co-planning through the collection of feedback on the experience and learning. Key learning points follow:

1. Expectations of both the host practices and the RMOs were identified, aligned and met as part of the evaluation process. This process of collecting information before assigning RMOs to attachments aided planning for each specific RMO and guided placement decisions. As each practice has its own culture offering a unique set of experiences and competencies, there is value in matching RMOs to placements in terms of their interests and career pathways. This is likely to be increasingly important as numbers increase toward 100% placement by 2020
2. One practice developed a response to pressure for space and rooms that worked very well for the RMOs: a half to full day community rotation where one RMO went to a physiotherapy practice, another to a child health agency. The development of sessional visits outside the practice to gain experience with other agencies, in the community and other practices (eg physiotherapy) has merit for the future
3. A set of experiences and skills that are gained in general practice and less seen in the hospital has been identified by the RMOs (and included above). This is helpful for mapping the CDHB curriculum to the NZCF and could be incorporated into a learning module to support orientation to a GP attachment
4. Guidelines for covering periods of absence by either RMO or supervising GP are being prepared
5. The findings of the 2005 study[7] regarding Post Graduate Year (PGY) 2 RMOs being more suitable than PGY1 to undertake these placements was upheld and reflects the level of experience, clinical knowledge and prescribing status of PGY1 doctors.

Finally the issue of space, numbers and capacity is an ongoing one. It arose in both the 2005 study[7] and this project. The issue will be compounded in the future by the growing number of learners in general practices with medical students, GP registrars and increasingly nursing and allied health students seeking placement opportunities. Overall the experience for RMOs and GPs in this pilot programme has been very positive and is meeting the goals and expectations of the MCNZ. The critical question for district health boards is what financial support and resources will be required to ensure full implementation of community placements by 2020 and to ensure sustainability of the programme?

Competing interests:
Nil.

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