Original Research Paper

To be like any good GP: a qualitative study of GPVTP participants' perceptions of learning general practice

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ABSTRACT

Aim: The purpose of the study was to explore General Practice Vocational Training Programme (GPVTP) participants' perceptions of the learning processes associated with their clinical experiences. Similarities and differences in learning between the two different streams: registrars and seminar attenders were identified.

Method: Focus group interviews with the two GPVTP Auckland groups (nine registrars, seven seminar attenders) on two different occasions were carried out.

An inductive approach was used for data analysis.

Results: In exploring the participants' perceptions of learning processes associated with their clinical experiences, three broad themes were identified from their accounts. Participants constructed the key characteristics of GPs, the content of learning to be a GP and how they learned the role. The key characteristics of the GP role included being very useful and able to manage most problems. It was perceived as being stressful and was also defined in relation to doctor/patient relationships that developed over time. The content of learning to be a GP included clinical competence, doctor/ patient relationships and self-awareness. The participants learned these aspects of the role primarily through experience and reflecting on feedback from experience. Similarities between the two groups far outweighed differences across the three broad themes. Between the two groups, the main difference was in who provided feedback and encouraged reflection on experience. The GP teacher was easily accessible to take these roles for registrars. Colleagues, accessed in different contexts, and patients, provided feedback and encouraged seminar attenders to reflect on their experiences.

Conclusion: The main difference in learning between the two different streams: registrars and seminar attenders was the accessibility of an experienced colleague to provide feedback and encourage reflection on experiences. Maximising learners' experience through structured support and accessing the practical knowledge of experienced GPs are integral parts of learning for general practice. They are fundamental to developing expertise and should continue to be protected and refined as key components of vocational education for general practice.

BACKGROUND

The General Practice Vocational Training Programme (GPVTP) is the only funded provider of formal vocational training for New Zealand GPs. This study involved the 1997 Auckland participants in the GPVTP intensive clinical training year. There were two streams of participants, known as registrars and seminar attenders.

The registrars were state funded and were attached to accredited teaching practices. They received one-on-one practice-based teaching. The seminar attenders worked a minimum of five tenths, in practices that were not teaching practices, as locums or assistants without any one-on-one teaching. They were self-funded to attend the day release seminars and workshops.

The existence of two streams of participants in one training programme is unique in the world. In 1992, government funding for the programme was reduced, leading to a reduction in the numbers of registrars admitted. New RNZCGP policy, introduced in 1992 in response to the continued demand for training (90-100 applicants per annum), allowed doctors new to general practice to attend only the day release seminars, on a self-funded basis.[1]

INTRODUCTION

A greater understanding of participants' perceptions of learning processes may help define quality improvements in general practice vocational training programmes. Some studies of vocational training have been concerned with the clinical experience of trainees.[2,3] For example, one New Zealand study by Tong et al[4] found that GPVTP trainees saw patients with acute and single problems. Another study sought to determine the factors that may influence learning among general practice trainees.[5] Few studies have investigated the learning associated with the clinical experiences of participants in vocational training programmes from a qualitative research perspective. Nor have they compared the learning of two different streams of participants in the same training programme.

General practice and its values have been likened to exploratory qualitative research.[6] Similar inductive techniques are used in both contexts. In general practice, great importance is attached to patients telling their story in order for the clinical data to speak for itself. General practice takes account of the context and individuality of patients. In much the same way, qualitative research is descriptive of a particular situation; it is concerned with processes and how the participants view their situations. This is often underpinned by a broad theoretical orientation that emphasises the social construction of reality.[7]Attempts are made to understand the meaning of experiences and interactions from the participants' own points of view. In this case, the purpose of the research was to explore GPVTP participants' perceptions of learning in a general practice vocational training programme, particularly the processes of learning associated with their clinical experiences. A further aim was to identify if there were any differences in learning processes between the two different streams: registrars and seminar attenders.

METHOD

All Auckland registrars (n = 11) and seminar attenders (n = 12) were informed about the research project and invited to participate in the focus group interviews. The University of Auckland Human Subjects Ethics Committee granted ethical approval for the study. Registrars (n = 9) and seminar attenders (n = 7) were interviewed separately in July. The two groups were interviewed again in October (11 registrars, three seminar attenders). The timing of the interviews was based on practicalities. The day release seminar timetables and participants' availability needed to be taken into account. It proved particularly difficult for seminar attenders to take the extra time needed to participate in the interviews that were

scheduled at the end of the seminar sessions.

Focus group interviews were chosen as the data collection method to explore individuals' perceptions in a cost and time efficient way.[8] Semi-structured interview schedules were developed on the basis of pilot focus group interviews. In the first round of interviews, registrars and seminar attenders were asked to describe their last consulting day. They were asked where their most significant learning came from during their consulting experiences. Probing questions asked them to recall what brought them to particular understandings, what they learned about themselves as GPs and what the personal insights were they had gained.

In the second round of interviews, registrars were asked about their last teacher-learner interaction. They were asked how their consulting experiences had changed over the three months since the last interview and about learning implicit knowledge.[9] Seminar attenders were asked about their last mentor-learner interaction and what they gained from the experience. They were asked how they had developed in their role since the last interview and about accessing implicit knowledge.

The interviews were audiotaped and later transcribed. Copies of the interview transcripts were returned to participants for verification. The changes were included in the finalised transcripts. An inductive approach was used for data analysis. This began with an open coding process; coding each sentence into as many codes as possible to ensure full theoretical coverage.[10] The next step condensed the data attributed to more than 30 codes into three major codes with sub-codes to take the analysis further.[7] The interviewees were sent summaries of the interpretations of the interview transcripts for comment and verification. The covering letter stated that receiving no response would be interpreted as consent to use the summaries as presented. Four responses were received. One registrar said the summary looked "fine" and another it was "a fairly good summary". One seminar attender said that the summary looked "fine from my viewpoint" while another requested her name be removed from the text.

RESULTS

Through their learning, the GPVTP Auckland participants constructed the key characteristics of the role of the GP. They described the content of learning that took place in order for them to take on the role and how this learning came about. Similarities in the accounts between the two groups far outweighed differences across the three broad themes.

Being a GP

GPs were perceived as "useful", "able to manage most problems". In conjunction with dealing with the clinical problems encountered, being a GP was defined in terms of doctor/patient relationships, particularly those that developed over a period of time:

"You actually know their families and know a bit about them. It makes a big difference, I think, enjoyment." (Registrar)

In addition, participants acknowledged that it was not easy:

"Some people think that it is an easy option out... it is not at all because you have to know something about everything and that makes it really hard." (Seminar attender)

Both the registrar and seminar attender groups noted that being a GP was "stressful".

Learning for general practice

Overall three main themes associated with learning to be a GP ran consistently through the interviews with both groups. These were identifiable as clinical competence, doctor/patient relationships and self-awareness.

First, the participants described a wide range of learning associated with developing the necessary clinical competence. They discussed becoming "more confident, especially with the really tricky things" and learning their "limitations as far as medical things go".

Second, participants identified learning about doctor/patient relationships:

"It is like getting a rapport with people to start off with, …picking up sort of signals from someone about whether they may be a little unsure of what you said or is it something else they want to bring up?" (Registrar)

"You can sense the difference in the patients when you do something well. They are content, they are happy all their questions have been answered." (Seminar attender)

The third important aspect of learning was increasing self-awareness in terms of clinical approach and personal insight:

"You figure out what your own path is." (Seminar attender)

"You have to know yourself very well ... Through this year, because [the teacher] keeps pointing it out to me, personally I have been able to see more of what I am, who I am...." (Registrar)

Ways of learning

For both groups, two main themes emerged from analysis of the interview transcripts in relation to ways of learning general practice.

First, they perceived "experience" as the primary source of learning:

"I think that it is general experience, that the more you do and you try different ways ... and you just build up your experience." (Registrar)

"You learn …by your own experience… you get thrown at the situation and you try something out." (Seminar attender)

This experience was not just a matter of "sitting and consulting all day". The experiences perceived as the best learning experiences were those that were new to the training doctor, described as "new challenges" or "first time" experiences:

"Actually being with people and having new challenges, different people from different backgrounds… trying to get a feel for it as you go." (Registrar)

In conjunction with the importance of experience, a distinction was made between having knowledge, either from talking with people or reading books, and "putting it into practice":

"The first time that something like that happens, even though you have the

knowledge, putting into practice you are always a bit uncertain ... The next time ... it's a bit more second nature." (Seminar attender)

"It is all very well talking to your trainer about it and garnering from their experience but also you have to experience some of it yourself." (Registrar)

Second, according to the participants, new experiences led to learning when they were coupled with reflecting on feedback from experience:

"I think that the bottom line is that you have got to be in the situation and if you muck it up then you can reflect on it,` I've mucked it up. What can I change next time?'" (Registrar)

As well as learning from their own
experiences, both groups of participants identified learning from observing other doctors:

"You pick up from watching other doctors in action or... by flicking back in the notes what other doctors have done in the past... and you follow suit." (Seminar attender).

"You often find yourself... becoming a bit like them [the teachers]; not a lot ... some of the ways that they do things you certainly do pick up. Hopefully their good bits." (Registrar)

In summary, both groups of participants perceived that the best way to learn general practice was through new experiences; coupled with feedback and reflection on those experiences. Learning from observing experienced GPs was another way of learning shared by both groups.

Differences in the learning experiences of the registrars and seminar attenders arose from the different clinical contexts in which they worked during the training year. Registrars were supervised by GP teachers in accredited teaching practices. Registrars noted the support provided by their teachers, the "back-up knowledge", encouragement and options:

"It is a lot nicer when the trainer can confirm or support... that you are on the right track... encouragement and another perspective."

On the other hand, seminar attenders worked in practices, which were not teaching practices, as locums or assistants without supervision. They gave examples of seeking advice from colleagues:

"You certainly liaise with your colleagues: You will go and seek advice from them when you know that you really have to."

Therefore, the main difference between the two groups was in who provided feedback and encouraged reflection on experience. In the case of the registrars, the GP teacher was most often described as the person who was "easily accessible" and who provided feedback:

"Your teacher will really be able to reinforce things that you did well, that are not specific things that you can put your finger on."

For the seminar attenders, experienced doctors contacted at CME meetings and the seminar programme provided "general practice experience". Those working at the same practice were sought out for advice. In addition, feedback was sought from patients:

"I learnt a lot from getting feedback from patients; this is one thing that I would like to stress."

DISCUSSION

On the results

The purpose of the study was to explore participants' perceptions of learning processes in the GPVTP and to identify similarities and differences between the two groups: registrars and seminar attenders. Participants perceived experience as the primary source of their learning. Previous research has identified experience as contributing to learning. Bligh and Slade[11] found that "learning from patients" was one of six main factors that may influence learning among general practice trainees.

The other factors were named as "openness to criticism", "negative attitudes", "desire for clear guidelines", "peer support" and "academic approach".

Lovin's[12] qualitative study of a group of paramedics found that learning from experience was the dominant mode of informal learning in that workplace setting. Furthermore, according to Lovin, it was non-routine experiences of the job that were recognised by the paramedics as the primary sources of learning.

The distinction the participants made, between having knowledge and putting it into practice, is a distinction that is
commonly made in the professional and continuing education literature. In the literature, it is discussed as the difference between practical knowledge, developed from experience and abstract knowledge:

"Systems of practical knowledge are distinct from systems of abstract knowledge for each profession. ... professionals actually use practical knowledge systems."[13]

According to Cervero, the goal of professional practice is expertise or wise action. He proposes that knowledge acquired from practice is necessary to achieve this goal; therefore, learning from practice should be central to education for the professions. This is not to say that abstract knowledge has no role to play in learning how to be a GP. Rather it suggests the primary importance of practical knowledge to professional development.

This argument is supported by Ram et al's discussion of changes to the traditional view of gaining clinical competence. The traditional view addresses competence as an accumulation of knowledge, skills and attitudes "relatively stable and distinct from each other".[14] A current alternative view sees the development of professional expertise as building up patterns of signs and symptoms, or knowledge networks, from isolated facts. They state that this process is based on the doctor's individual experience and clinical exposure, and is closely linked to seeing patients and their contexts.

The role of the GP teacher

If practical knowledge is of primary importance in learning to be a GP and this knowledge is best acquired from experience, what role do teachers play in supporting this? Obviously the emphasis is on what the learner does, rather than what the teacher does. Yet the analysis suggests that the role assumed by teachers can enhance learning through experience.

The participants reported that teachers enhanced learning through experience when they provided back-up knowledge, encouragement and options. These findings are

reflected in research conducted into the forms of instruction found to be most meaningful and helpful in learning to understand and deal with ill-defined, complex and risky situations. Interviewees in the Farmer et al[15] study, drawn from a wide range of professions, stated that what helps most is being taught by someone who models how to understand and deal with such situations and who then guides the learners' attempts to do the real thing. Lovin, in her qualitative study of paramedics, found that significant learning occurs as a result of listening to the experiences of others, referred to as "storytelling or trading war stories".[12]

In conclusion, supporting what the learner does requires teachers to play a range of roles. First, to enhance learning through experience they provide back-up knowledge, encouragement and options. Second, they share their own experiences, through modelling and storytelling. In addition, they broaden learning experiences through dialogue, encouraging better insight and understanding.[16] Through all these roles they share the practical knowledge actually used by GPs.

Different learning experiences

The similarities between the two groups of participants, registrars and seminar attenders, were far more striking than the differences. This was true of their descriptions of being a GP, learning for general practice and ways of learning. The difference was explained by the educationally structured nature of the registrars' clinical experiences in contrast to the unstructured nature of the seminar attenders' experiences.

For registrars this meant they had an experienced doctor who provided feedback on their experience, and encouraged reflection. Registrars also had easy access to their teachers' practical knowledge through modelling and storytelling. Their teachers guided registrars' day-to-day practice.

Without easy access to experienced doctors' practical knowledge during their day-to-day practice, seminar attenders looked for practical knowledge in formal educational settings such as CME and the seminar group. Seminar attenders sought feedback from patients. While they were readily able to get advice from colleagues, structured opportunities to reflect on their practice through dialogue with experienced doctors was more limited.

In summary, registrars had structured support for learning through experience, provided by their teacher. Seminar attenders did not have structured support for learning through experience in their day-to-day practice. Their support for learning was fragmented in its provision in different contexts and sought from a wider range of people.

On the method

Qualitative research methods were used for exploring and understanding the participants' perceptions of learning. The participants were interviewed and transcripts were sent out for verification. Summaries of the researcher's interpretations of the interview transcripts were distributed for comment. Having only four responses to the request for comment and verification of the summary interpretations was a matter of concern. In qualitative research, participant involvement in the analysing process increases dependability and confirmation.[17] The lack of participant involvement in this case limited the rigour of the study.[18]

CONCLUSION

From the participants' perspective, learning arose from interactions with patients

and doctors, in some cases backed up with reading. Their experience of learning general practice centred on developing a wide range of practical knowledge. The main difference in learning, between registrars and seminar attenders, was the accessibility of an experienced colleague to support learning through experience and to share practical knowledge.

Maximising learners' experience through structured support and accessing the practical knowledge of experienced GPs are integral parts of learning for general practice. They are fundamental to developing the expertise needed "to be like any good GP". They should continue to be protected and refined as key components of vocational education for general practice.

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