



Vertical and Horizontal Learning Integration in General Practice

About this guide

Pressures on training practices are increasing. Red tape and paperwork is rising and general practices are becoming more involved in undergraduate medical teaching. There are increasing numbers of aspiring GPs who need to be trained to the excellent standard required to provide frontline primary care.

To meet these obligations, some practices are looking for ways to maximise existing skills, knowledge and resources to deliver quality learner-centred training, while still running an effective business.

The vertical and horizontal integration of medical education and clinical teaching can go some way to meeting these needs.

This guide will help outline to GP Supervisors, GPs and practice managers the benefits, risks and challenges associated with using this training approach, as well as practical examples of integrated learning.

General Practice Supervision Australia (GPSA) is supported by funding from the Australian Government under the Australian General Practice Training (AGPT) program.

GPSA produce a number of relevant guides for GP supervisors and practices, visit www.gpsupervisorsaustralia.org.au/guides to view additional guides.

“We are not re-inventing the wheel. We are trying to consolidate on the back of each other’s expertise and learning.”

– Dr Duncan MacKinnon, Principal at Bega Valley Medical Centre, NSW.

© 2021 GPSA.

All rights are reserved. All material contained in this publication is protected by Australian copyright laws and may not be reproduced, distributed, transmitted, displayed, published or broadcast without the prior permission of GPSA, or in the case of third-party material, the owner of that content. No part of this publication may be reproduced without prior permission and full acknowledgement of the source: GP Supervisors Guide: Vertical and Horizontal Learning Integration in General Practice.

GPSA has made all efforts to ensure that material presented in this publication was correct at the time of printing and has been published in good faith. GPSA does not accept liability for use of information within this publication. Due to the rapidly changing nature of the industry, GPSA does not make any warranty or guarantee concerning the accuracy or reliability of this content.

Please note that all references to general practice in this resource are intended to apply equally to both the urban and rural context of the GP medical specialty such that use of the term “GP” is taken to mean “RG” throughout.

This material has been reproduced and communicated to you by or on behalf of GPTA Ltd in accordance with section 113P of the Copyright Act 1968 (the Act). The material in this communication may be subject to copyright under the Act. Any further reproduction or communication of this material by you may be the subject of copyright protection under the Act.
Do not remove this notice.

Contents

| | | |
|----|-------------------------------------------------------------------------------|----|
| 1 | Vertical and horizontal learning integration | 4 |
| | A choice and a necessity | 5 |
| | Nine perspectives of vertical integration | 6 |
| | Facilitators and barriers | 7 |
| | Guiding principles | 8 |
| | Case study 1: From necessity to the “ideal” | 9 |
| 2. | Making it work in your practice – including small practices | |
| | Basic practicalities | 10 |
| | Identify and maximise your resources | 10 |
| | Case study 2: A team within the community | 12 |
| | Practical examples | 13 |
| | Prepare your team, practice and patients | 14 |
| | Incorporating learning into patient consults | 15 |
| | Determine expectations and standards | 16 |
| | Case study 3: Medical students on integrated learning | 17 |
| 3. | Keeping the learner in focus | |
| | Learning placement cycles | 18 |
| | Maximise group discussion | 18 |
| | One-to-one time with GP supervisors | 18 |
| | Case study 4: ‘Horizontal’ integration of GPs and mental health professionals | 19 |
| 4. | Benefits | |
| | Learner benefits – increased exposure | 20 |
| | GP supervisor benefits – fresh perspectives | 20 |
| | Practice benefits – cohesive learning | 20 |
| | Patient benefits – access to doctors | 20 |
| | Case study 5: A team effort with benefits for everyone | 21 |
| 5. | Challenges and risks | |
| | Continuity of care | 22 |
| | Tracking the learner | 22 |
| | Inadequate curriculum | 22 |
| | Teaching standards | 22 |
| | Good luck | 23 |
| | References | 24 |
| | Acknowledgements | 24 |

1. Vertical and horizontal learning integration

Although an integrated training approach has been used to varying degrees and has been a familiar concept on the general practice landscape for well over a decade, it is difficult to offer a single definition of the vertical and horizontal integration of general practice education and training.

For the purpose of this guide, the term vertical and horizontal integration relate to qualified GPs and GPs in training learning from and teaching each other and other health professionals in either one-to-one situations or in shared sessions.

‘Vertical’

The ‘vertical’ component of integration relates to shared learning and teaching within the four stages of GP training and learning:

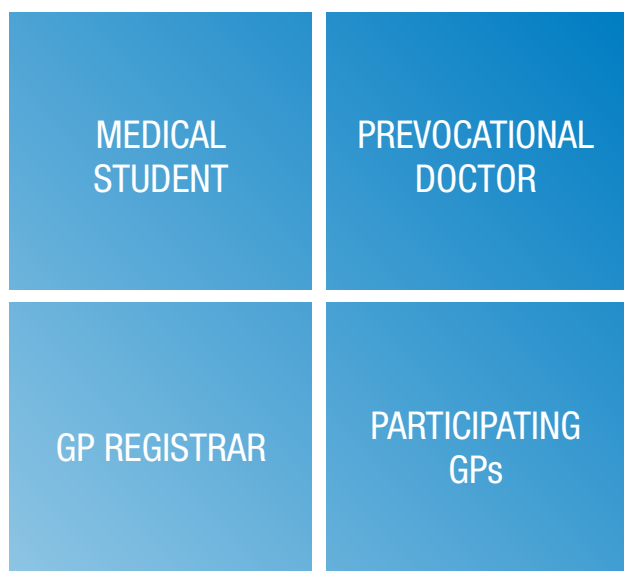
- medical student;
- prevocational doctor;
- GP registrar; and
- GPs participating in continued professional development.

Within GP training circles ‘vertical integration’ is commonly referred to as “the coordinated, purposeful, planned system of linkages and activities in the delivery of education and training throughout the continuum of the learner’s stages of medical education”.¹

‘Horizontal’

The ‘horizontal’ component relates to the inclusion of other health professionals within and external to the practice into the learning and teaching mix. This includes practice nurses and practice managers, and allied health and primary care professionals.

It’s important to note that other organisations – GP Colleges, Primary Health Networks, Universities, Regional Training Organisations and GP representative bodies – may also play a role to help facilitate, advise and oversee integrated learning.



“Implicitly, vertical learning means having different levels of learners learning together.”

– Dr Tuck Meng Soo, GP Supervisor at Interchange General Practice, Canberra.

A choice and a necessity

Training practices and GP supervisors are essential to meet the increasing demand to train the next generation of family doctors, while maintaining quality. The placement for a GP registrar usually runs for between six and 12 months. Prevocational doctors completing a community rotation in some jurisdictions, may be at a practice for up to 12 or 13 weeks. While medical students may be placed at a practice for a period of time ranging from 10 days to typically up to six or eight weeks.

While training placements vary in length and intensity, all require a solid commitment from the practice and its team members.

Some practices adopt an integrated learning approach to meet training demands and because they see it as a dynamic and stimulating learning option. They may also see it as an opportunity to retain learners in their later stages of training and again when they are qualified (see case study on page 7).

For some practices, this approach has become the desired way to deliver training with benefits fully realised. However, there are also significant challenges associated with vertical and horizontal learning integration (see Chapter 5).

“Some practices adopt an integrated learning approach to meet training demands and because they see it as a dynamic and stimulating learning option. They may also see it as an opportunity to retain learners in their later stages of training and again when they are qualified”



Nine perspectives of vertical integration

Successful vertical integration is reliant on understanding and recognising the different perspectives that it encompasses. Glasgow and Trumble's² report on case studies of vertical integration outlined nine differing perspectives of vertical integration, as shown in Table 1.

TABLE 1: NINE PERSPECTIVES OF VERTICAL INTEGRATION (GLASGOW AND TRUMBLE)

| | |
|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Conceptual perspective | <ul style="list-style-type: none"> • complexity of the educational system is acknowledged. • allowance is made for such things as multiple entry and exit points, non-linearity in terms of the movements between stages, non-uniformity of prior learning experiences, diversity of cultural and linguistic backgrounds, generational movement in career goals and aspirations (those in later stages may have firm convictions about the nature of general practice which those at earlier stages do not and will not share) and the dynamic nature of the discipline itself. |
| 2. Educational perspective | in which activities, learners, resources and curricular objectives are integrated in order to achieve enhanced educational outcomes. |
| 3. Funding perspective | in which the focus of vertical integration activity is to realise efficiencies in the monetary costs associated with training general practitioners in each of the four stages. |
| 4. Learner perspective | in which vertical integration activities are defined by learners from the four stages participating together in educational activities. |
| 5. Organisational perspective | in which the focus of the organisation is the major locus of vertical integration activities emphasising one of the four stages. |
| 6. Physical perspective | in which vertical integration activity is manifested in the physical collocation of staff and resources active in the four stages. |
| 7. Pragmatic perspective | in which vertical integration is the coming together of like minded motivated individuals and organisations where time and resources permit to undertake some specific activities in the four stages rather than implement a grand plan. |
| 8. Teacher perspective | in which vertical integration activities are defined by one teacher operating in a number of the four stages. |
| 9. Theoretical perspective | in which a conceptual framework for a model of vertical integration of general practice training across the four stages is constructed. |

Facilitators and barriers

Each practice will face its own enablers and barriers to delivering effective integrated learning. These factors will help you determine if this approach is the best fit for your team, patients and practice.

For example, does the potential to provide a more team-based and stimulating environment for both GP supervisors and learners outweigh a potentially reduced capacity to see patients? Is the time taken to plan shared sessions off set by better succession planning.

A qualitative study from regional training organisation GP Synergy examined responses from GP supervisors at 12 training practices in its region³. Of these practices, 25 per cent had medical students, prevocational doctors and GP registrars. The remaining 75 per cent had at least two placements from these three stages of learning.

The facilitators and barriers listed by GP supervisor respondents are shown in tables 2 and 3.

**TABLE 2:
FACILITATORS TO INTEGRATED LEARNING**

| Facilitators | Percentage of practices* |
|------------------------------------------------------------------|--------------------------|
| Contribute to workforce/succession planning | 75 |
| Enjoyable/stimulating | 66.7 |
| Keep self up to date with knowledge | 66.7 |
| Mutual learning/sharing of ideas | 58.3 |
| Rewarding – giving something back to the profession | 41.7 |
| Influence career path/provide different view on general practice | 33.3 |
| Get paid for teaching | 25 |
| Reduces isolation | 25 |
| Increases self-awareness during consultations | 8.3 |
| Nurture growth of trainee | 8.3 |

*Percentages total more than 100% as each GP supervisor gave more than one response

Source: R Canalese, S Ramoo., *Vertical Integration of Education and Training in General Practice – A qualitative study, GP Synergy*

**TABLE 3:
BARRIERS TO INTEGRATED LEARNING**

| Barriers | Percentage of practices* |
|------------------------------------------------------------|--------------------------|
| Time | 91.7 |
| See fewer patients | 58.3 |
| Level of competence of trainee | 50 |
| Inadequate remuneration | 41.7 |
| Requires planning | 33.3 |
| Tiring | 25 |
| Lack of space | 25 |
| Attitude of GP registrar | 25 |
| Being a solo practitioner | 16.7 |
| Difference in perception between GP supervisor and learner | 16.7 |
| Patient's resistance to having learners | 16.7 |
| Bureaucracy | 8.3 |
| Length of training time of medical students | 8.3 |
| GP supervisor feels inadequate as teacher | 8.3 |


Guiding principles

When considering vertical and horizontal integration, it can help to develop some guiding principles that underpin your practice's integrated learning and teaching activities.

What teaching and learning principles are important in your practice? What does your team need to commit to in order for this approach to work? Get together with your team and find out. For starters, here are a few examples.

- Learning is centred on the learner: The learner's needs – both in terms of curriculum and personal development – must be a focus of training, regardless of the stage of learner. The practice needs to establish the common ground for the teaching/learning schedule for the length of each particular placement and take into consideration and meet learners' needs.
- Create a level playing field: Although experience should be recognised as extremely important, existing hierarchy among the team should generally be levelled out in an integrated learning environment. Equal respect for every team member's position – as teachers and learners – is paramount.
- Establish a learning and teaching ethos: Set a clean intentional state – determine the highest intentions for the group so that the group operates from a robust state of intentionality. This will simultaneously tap into the highest values, meanings and behaviours that will underpin shared learning. Consider the values and behaviours that you want in your shared learning environments. Do values allow for open questioning? Do they encourage two-way feedback? Do they promote respect for differing opinions? Are they based on an acceptance of trust of colleagues? Do they facilitate personal reflection and development? What meaning does each person give to being involved in the group?

Work with your team to find their optimum teaching and learning environment.



“Every practitioner, including nursing and allied health, is a teacher in his or her own right and that role is well respected and acknowledged.”

– Bega Valley Medical Practice's Practice Teaching Plan.



From necessity to the “ideal”

Bega Valley Medical Practice, NSW

Dr Duncan MacKinnon, Principal at Bega Valley Medical Practice, first considered adopting integrated learning out of “sheer desperation” to attract and retain GP registrars to his practice on the NSW southeast coast.

His idea was to turn his practice into a “hub” for multiple levels of learners. He wanted to provide “a valuable and memorable experience” by offering learners an inspiring team-based environment and inclusion in the local community and town life.

The practice endured a “hard slog” for the first three years as it struggled to gain traction in getting a constant stream of GP registrars, before finally taking off and going from “strength to strength”.

It now has a regular cycle of medical practitioners working at the practice. These include medical students who have returned as GP registrars, GP registrars who have qualified and stayed, ex-GP registrars now qualified GPs returning, and PGPPPs who have returned as GP registrars.

Dr MacKinnon says vertical integration has done much more for the practice than boosting its workforce. It has become the “ideal” training model and has created an unprecedented level of “collegiality” and commitment to teaching that now underpins the ethos of the practice and its team of 10 doctors.

At any given time, the practice may have four GP registrars, a prevocational doctor and a medical student placement. The majority of its doctors work part-time due to family commitments or other medical interests. This includes Dr MacKinnon, who is a GP anaesthetist and VMO at the local hospital, and has a score of other educational and training obligations.

Every team member, including the three practice nurses, has a commitment to teaching and part of the GP registrars’ responsibilities is to help teach the PGPPP doctor, which is a “great way” for them to learn.

Dr MacKinnon knows that his part-time team and cycle of GP registrars is challenging patients’ “ideal of seeing the same doctor for every visit”. But he says his practice is working hard to manage these expectations and risks to continuity of care.

“The way we manage the risk of people falling between the cracks is by working as a team,” he says.

Every day at 8:30am before the practice opens, the entire team of doctors and nurses, meets for half an hour. “In that team meeting we look at the patient list and we talk about the people we saw yesterday who we were worried or unsure about. We network and share information and use the insights and collective knowledge to manage the problems we see. ”

“We bolt out of that room at 9am ready to go! We’ve all had a coffee, all had a laugh and all had a cry. It helps me to remain humble and respectful of each other’s expertise.”

To complement the daily meetings, a weekly all-clinical staff, one-hour teaching session is held. The involvement of health professionals from outside the practice as guest presenters or attendees is encouraged to boost cross-working relationships.

These sessions provide a sense of collegiality and allow Dr MacKinnon and his senior colleagues to pick up on chance “gems” of knowledge from the learners.

“I learn so much from those meetings because the GP registrars may have just done a term with an infectious diseases group...or there is a postgraduate medical student with a degree in another field of medicine...they all have areas of expertise I don’t.”

The teaching from meetings and shared sessions are documented, summarised and put on the practice’s intranet. “We are not re-inventing the wheel. We are trying to consolidate on the back of each other’s expertise and learning.”

Dr MacKinnon’s team is extending vertical integration to taking years 11 and 12 high school students interested in a medical career. “We absolutely go the extra mile because I’m recruiting people for 10-15 years time. We want to role model and inspire the next generation.”

Vertical integration is benefiting and challenging both new learners and senior GPs. “It’s what keeps us on our toes...answering questions and being held accountable. As a teacher, you can’t afford to be threatened by learners. And if you are, you need to seriously look at your ego and what drives you.”

Dr MacKinnon says that practices need to find ways to maximise existing knowledge and learning opportunities.

“I want to inspire supervisors to think outside the square. We need to work smarter. Information is the name of the game. It’s not just about knowing it, but about consolidating it and using it with compassion to change the way we practice.”

2. Making it work in your practice - including small practices

So, you like the idea of vertical and horizontal learning integration, but how do you make it work in your practice? What are the next steps?

As it stands, there are no formal accreditation requirements (apart from being an accredited teaching practice with a sufficient number of qualified GP supervisors) to adopt this training approach. The extent to which a practice integrates learning and teaching will depend on its size, location and local health attachments – and its level of commitment.

For example, smaller practices may have fewer staff and therefore limited opportunities to offer integrated learning. However, if your practice is in this situation, you may need to think outside the box. For example, video conferencing with other practices or sending your learners to conferences or workshops with learners from other practices or local health associations are great ways to provide integrated learning opportunities.

Those practices with enough resources may adopt integrated learning to varying levels. For example, some might require only certain team members to be involved, while for others this style of learning may define their practice and therefore involvement of all team members is expected. Note, that where all GPs in the practice are involved in teaching, it is important to ensure equitable payment of GPs for their teaching sessions.

Note: Regardless of the extent that your practice uses vertically and horizontally integrated learning, it is important that, particularly in the case of GP

registrars, shared learning activities do not replace the one-to-one sessions required by the Colleges, but rather should complement the GP registrar's learning and teaching experience.

Basic practicalities

As well as having enough GP supervisors or qualified GPs to provide adequate supervision of newer learners, some practical resources required might include:

- Conference room, large lunch area or large consulting room for all-team meetings
- Projectors and large screen televisions for group sessions based on PowerPoint presentations and video examples
- IT resources – enough computers and correct access to shared systems
- Consulting rooms, particularly when using 'wave consulting' (see tables 5 and 6).

Identify and maximise your resources

As well as GPs and GPs in training, the expertise of other members of the practice, such as practice nurses and allied health professionals, can be used to maximise opportunities for learning and teaching.

Each person in a practice has a role to play in learning from and teaching another person. The knowledge is there – look for ways to tap into it.

Internal resources

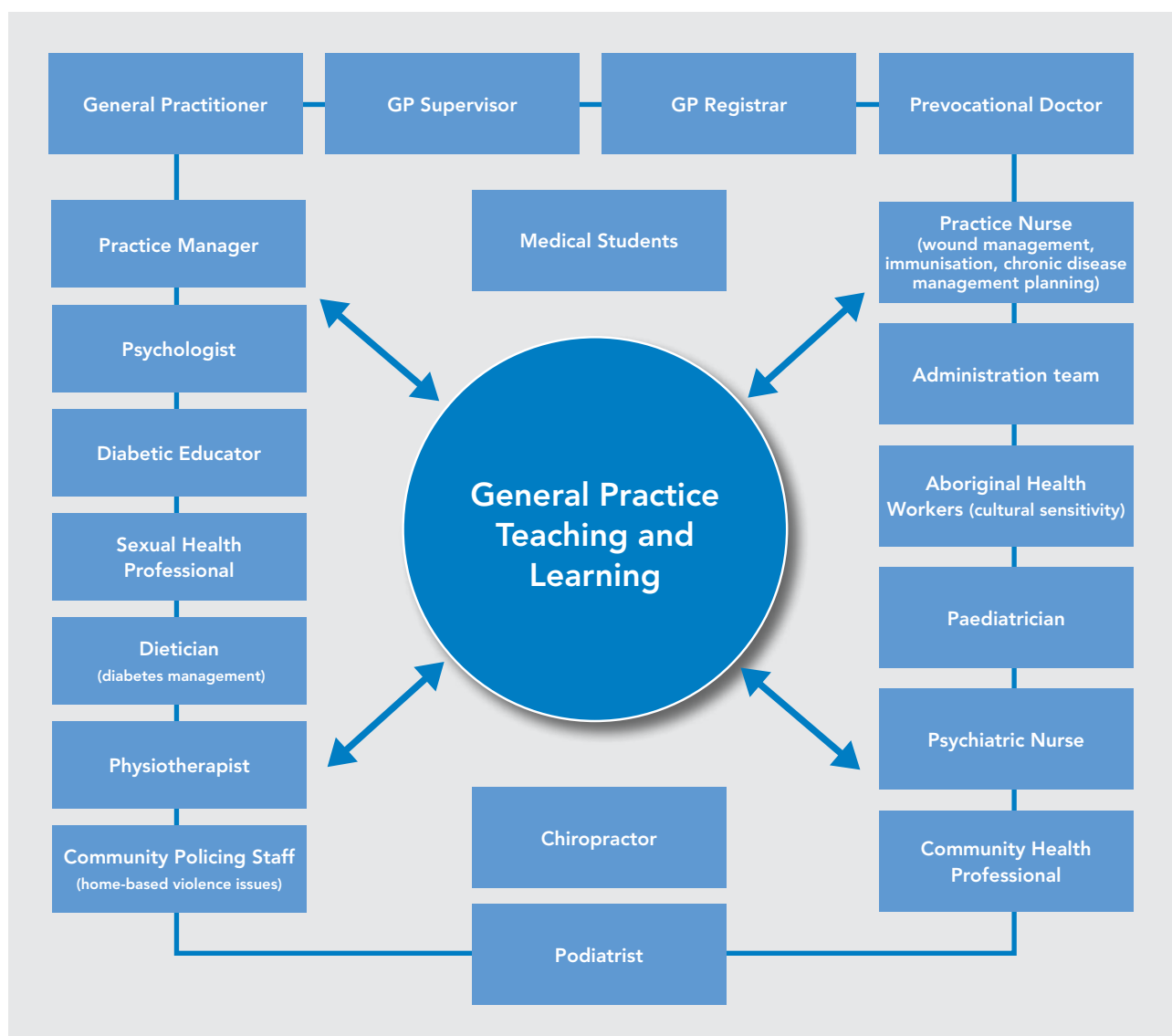
Qualified GPs bring the most practical experience and latest in professional development. Students and post-graduates bring the latest evidence-based treatments and critical appraisal of evidence. Prevocational doctors provide recent insights into the hospital system. GP registrars offer recent student and hospital experience combined with a growing practice experience. Nurses can teach the art of wound dressing, taking blood, immunisation schedules and suturing to all levels of learners. Practice managers can give an insight into running an efficient and effective general practice business.

External resources

Outside the practice setting, there are extensive resources of allied health and other health professionals to draw from. Scheduling a psychiatrist to present at a mental health session or a pharmacist to join a discussion about a new medication can give your team important perspectives and insights into the wider primary care landscape. It may also help improve referral processes and cross-working relationships.

Vertically and horizontally integrated learning gives all the professionals shown in Diagram 1 the chance to be a learner and a teacher in either shared learning and one-to-one sessions.

DIAGRAM 1: POTENTIAL HEALTH PROFESSIONALS TO BE INVOLVED IN GP VERTICAL AND HORIZONTAL LEARNING INTEGRATION





“A team within the community”

Dr Jenni Parsons, Macedon Ranges, Victoria

Dr Jenni Parsons is a GP in the Macedon Ranges shire, central Victoria. She works in a practice that maximises internal and external resources to deliver GP training and professional development.

“We have a small group at my practice that meets once a month and is attended by GPs, GP registrars and medical students, if they are in the practice. We often have local specialists or allied health workers presenting,” Dr Parsons says.

In the last 12 months this has included a local diabetic educator on starting insulin, a gastroenterologist


on assessment and management of Hepatitis C, and local gynaecologist on management of stress incontinence.

The practice looks further than GPs when using its existing skills base. “Medical student teaching at my practice involves sessions for the students with the practice nurse (wound care, immunisations, chronic disease management etc) and on reception (customer service, appointments, privacy, medical records and admin),” Dr Parsons says.

One of the ‘horizontal’ integration influences is through the Local

Mental Health Professionals Network (see page 16), which meets three or five times a year for clinical education/networking meetings. Primary Health Networks educational meetings often invite relevant allied health workers, practice managers and practice nurses to educational meetings.

Dr Parsons adds that she has been to a “very popular” session at a practice in a nearby town that is run by MICA paramedics on the interpretation of ECGs. The session is also attended by medical students, GP registrars, practice nurses and GPs.



“Medical student teaching at my practice involves sessions for the students with the practice nurse (wound care, immunisations, chronic disease management etc) and on reception (customer service, appointments, privacy, medical records and admin.”

Practical examples

There are many ways to incorporate integrated learning into your practice.

TABLE 4: OPPORTUNITIES FOR VERTICAL AND HORIZONTAL INTEGRATION IN SHARED AND ONE-TO-ONE SESSIONS

| Shared sessions | One-to-one sessions |
|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| Lesson taught by GP supervisor attended by GP registrar and/or prevocational and medical student. | GP registrars teaching prevocational doctors or medical students. |
| GP registrars and medical students attending professional development workshop with GP supervisor. | Practice nurses giving GP registrar, prevocational doctors or medical student instruction on wound dressing, ECG or immunisation. |
| Post-graduate students presenting to the team on specialist medical knowledge area or study. | Prevocational doctors presenting to senior GPs on latest hospital processes and information. |
| Weekly clinical teaching session given by senior GP to medical students, prevocational doctor and GP registrar. | Pharmacist describing prescription and effects of medication to GP registrar. |
| Teleconference between rurally-based GP registrar and prevocational doctor at closest practice. | Front desk staff showing medical student patient booking process. |
| Drug and alcohol counsellor presenting to GP learners about common addiction behaviours. | GP registrars or prevocational doctors helping orientation of new medical students. |
| Practice nurse giving medical student and prevocational doctor instruction on diabetes education and management. | Practice manager briefing GP registrar about billing process. |



Prepare your team, practice and patients

If you are considering an integrated learning approach, there are some simple steps you can take to prepare your team and patients for the relevant training changes.

Prepare your teachers

Teaching and mentoring is a natural fit for many GPs who spend most of their time working with other people, educating and guiding them on their health. But even experienced GPs new to supervision might need some teaching tips and guidance. As well as learning from their more experienced colleagues, GPs new to supervision can refer to regional training providers and the colleges for teaching resources.

GPSA's guide Best Practice for Supervision in General Practice provides examples of how to provide learners with a valuable supervision experience. Go to www.gpsupervisorsaustralia.org.au/guides for further information.

GP registrars, particularly those in their later terms might take on significant teaching responsibilities of prevocational doctors and medical students. Teaching can be a key part of a GP registrar's development and it is important to make sure they are ready and confident to take on their teaching role.

If a GP registrar is going to present at a shared learning session for the first time, it is worthwhile for the GP supervisor to go over the session with them first to check the content and assess their teaching style. In turn, prevocational doctors and medical students will also find it reassuring if a GP supervisor or GP registrar checks over their planned presentations.

Prepare your patients

Training practices that accept multiple learners at once, particularly GP registrars who see patients alone, will experience the cycle of doctors joining and then leaving the practice. This can be a challenge for the practice (see Chapter 5) and for patients who may have built a rapport with the departing GP registrar.

Help your patients to understand that your practice is a training practice. Put signs up around the practice waiting room, clearly state your training commitments on your website and have the front desk advise new patients if they are seeing a GP registrar or if a student or prevocational doctor is working with their usual GP.

It's important that your patients consent to a medical student or prevocational doctor sitting in on the consult. Again, appropriate signage is helpful, as well as patients being asked at reception for consent. It can be a challenge to ensure patients feel confident to refuse consent, but also encouraged and reassured to participate.

It is advisable that practices have a system in place to identify patients, such as known drug seekers or patients with mental health issues, not suitable for learners to see without an experienced GP present.⁴

“At the start of the registrar year, I made sure that I spent a session sitting in with each of the new registrars in the practice in the first fortnight to identify some of their strengths and weaknesses. I also plan to do regular medical record audits and to either sit in at least once more in the term and observe a video interview session.”

– Dr Tuck Meng Soo, GP Supervisor at Interchange General Practice, Canberra.

Incorporating learning into patient consults

Having learners take part in patient consults requires a degree of planning – and perhaps a bit of juggling – to ensure that learners get hands-on experience without compromising patient care.

The ‘wave’ teaching method allows GPs to provide one-to-one teaching to different levels of learner while also allowing income to be generated. Table 5 shows a ‘single wave’ that involves one student, two consulting rooms and one GP supervisor. Table 6 shows ‘double wave’ that involves two students, two consulting rooms and one GP supervisor. Read some medical student’s views on integrated learning on the following page.

TABLE 5: SINGLE WAVE (GP BILLS FOUR PATIENTS PER HOUR)

| Time | Consulting room A | Consulting Room B |
|-------|---------------------------------------------|-------------------------|
| 00.00 | Student sees Patient 1 for 15 mins alone | GP sees Patient 2 alone |
| 00.30 | GP sees Patient 1 with Student | |
| 00.45 | Student sees Patient 3 for 15 minutes alone | GP sees Patient 4 alone |
| 01.00 | GP sees Patient 3 with Student | |

TABLE 6: DOUBLE WAVE (GP BILLS FOUR PATIENTS PER HOUR)

| Time | Consulting room A | Consulting Room B |
|-------|-----------------------------------------------|--------------------------------------------|
| 00.00 | Student A sees Patient 1 for 15 mins alone | Student B sees Patient 2 for 15 mins alone |
| 00.30 | GP sees Patient 1 with Student A | GP sees Patient 2 with Student B |
| 00.45 | Student A sees Patient 3 alone for 15 minutes | Student B sees Patient 4 for 15 mins alone |
| 01.00 | GP sees Patient 3 with Student A | GP sees Patient 4 with Student B |

Determine expectations and standards

As well as a commitment to guiding principles mentioned in Chapter 1, everyone involved in shared learning needs to understand the expected commitment and standards for participating in integrated learning activities.

Here are some tips to help keep everyone on track:

- Ensure all learners take part in a thorough orientation of the practice and understand how the practice carries out integrated learning.
- Make it clear that shared and one-to-one sessions start on time and punctuality is expected.
- Invite attendees to indicate their availability before sessions start.
- Mobile phones to be turned off or on silent.
- Any follow up promised by a teacher or required by a learner's session should be delivered on to agreed timelines.

Appoint a session scheduler

There should be one designated administration person in the practice scheduling all the sessions and ensuring appropriate numbers of GP supervisors are available for integrated learning activities. They will need to take the lead on making sure that shared learning sessions are in diaries and that the right mix of learner levels and teaching experience are coupled together.





Medical students on integrated learning

Brook Street Medical Practice, Woodend, Victoria

Brook Street Medical Practice in Woodend, regional Victoria, offers placements to medical students from Monash University. Here's what some of them had to say about their integrated learning experience.

"You get to learn from a range of different people. It has been really good to spend time with different GP's and allied health staff as they all have varied strategies and techniques."

"It has been good to spend time with doctors at different stages of their training. The GP registrars have really good advice to offer us as students as they were recently in our shoes!"

– Bethany

"I like being able to gain specialised knowledge in areas e.g. MSK pathology from a sonographer or motivational interviewing from dieticians and exercise physiologists."

"It is also a good emotional environment...because there are levels of support from many different people."

– Lahorini

"There are numerous things going on at once but we are all learning. Last week a supervisor was teaching a registrar how to implant an Implanon and I was watching. The registrar had never implanted one before and I had never seen one being put in."

"We take part in presenting to other medical students...it improves our understanding of the topics as we may be questioned. It gives us practise at explaining things, we can bring up any issues we have with patients or topics and discuss as a group."

– Angela

"It promotes a safe learning environment "where education is valued, and everyone is more gentle and patient with each other. I think that this is an important ethos to carry into practice because a culture of open accountability and transparency can only improve patient healthcare and the medical culture collectively."

"I feel supported and valued as a student that my learning experience is valued and respected by the GPs. Having friends here makes it easy to debrief and work through new experiences."

– Hui Ling

"Everyone learns differently and you are taught by many different people on different syllabus. Hopefully that will ensure one style delivers the knowledge through."

"You are exposed to a myriad of ideas and opinions which complement each other's knowledge and expand our understanding."

– Sarah

3. Keeping the learner in focus

For vertical and horizontal learning integration to be effective, it's important to make sure that learning meets the individual's needs. While some sessions, for example a professional development workshop, will benefit all levels of learners, others may not.

Some GP registrars have reported the need for more challenging work when learning with a prevocational doctor and others have questioned at what level the "degrees of separation" between learners begin to hinder learning.⁵ Good scheduling and lesson planning will go a long way to ensuring that learning is not too challenging or too limiting.

Learning placement cycles

The cycle and length of training placements is an important consideration when planning for integrated learning. For example, prevocational doctor learning usually peaks at the end of 12-week block before a new prevocational comes in and needs an orientation to the practice. In contrast, a GP registrar learning in parallel with a prevocational doctor continues to build on their knowledge at the practice for a total of six or 12 months.

One way to streamline GP registrar and prevocational doctor learning may be to have the GP registrar expand upon and teach the new prevocational doctor something previously learned, thereby giving the GP registrar teaching experience and also cementing prior knowledge. Weekly topics can also be planned so that the GP registrar does not need to revisit areas already covered.

Maximise group discussion

A major benefit of shared learning sessions is the possibility for group discussion – so make sure you provide an atmosphere that encourages everyone to have their say.

Structure sessions so that there are frequent opportunities for reflection and questions and answers. If necessary, take turns going around the group to provide input. Make it clear – there are no 'silly' questions. Allow teachers to challenge learners and vice-versa to create thought-provoking discussion. Even the most experienced GP has something to learn.

Ideally, shared learning should be face to face. However, webinars, video conferencing, teleconferences and other online options used by smaller, or perhaps rural practices teaming up with other practices still provide ample opportunity for robust discussion.

One-to-one time with GP supervisors

Shared learning should not replace one-to-one time with GP supervisors, particularly the time required by GP registrars through the GP colleges. These sessions are important to build upon shared learning sessions and provide the opportunity to offer clarification or to take a step-up another level from the shared learning session.



'Horizontal' integration of GPs and mental health professionals.

The Mental Health Professionals Network (MHPN) is a federally-funded initiative targeted at improving interdisciplinary practice and collaborative mental health care in the primary health care sector.

It has more than 450 local practitioner networks, which GPs can be part of, across the country. Each network meets between three and four times per year to share information and learn from their mental health colleagues.

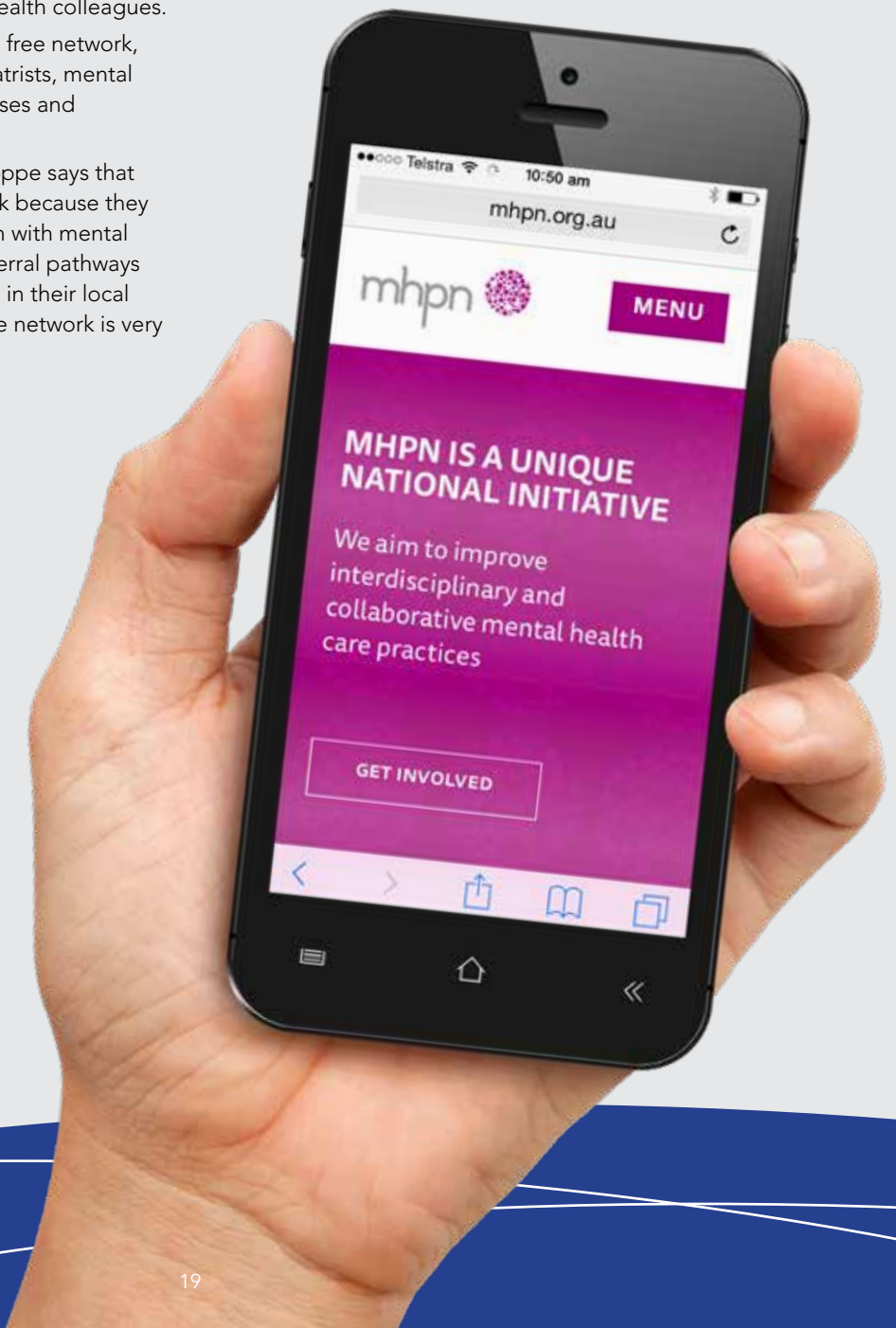
GPs are encouraged to be involved in the free network, which also includes psychologists, psychiatrists, mental health nurses, social workers, practice nurses and occupational therapists.

MHPN National Project Manager Kate Hoppe says that GPs form an important part of the network because they are often the first point of call for a person with mental health illness. "It helps to improve the referral pathways and helps GPs to get to know 'who's who' in their local health professional teams," she says. "The network is very locally-based so people can talk specifically about their 'patch'."

"It helps to improve the referral pathways and helps GPs to get to know 'who's who' in their local health professional teams."

Meetings usually include a guest speaker, discussion on a particular subject and general networking. As well as face-to-face meetings, MHPN also runs a series of free webinars for mental health professionals.

Visit the website to find out more mhpn.org.au



4. Benefits

Shared learning can be an exciting, dynamic and interesting way for learners to get insight and experience into the many facets of general practice. But the benefits don't stop with the learner – there are opportunities for senior GPs to boost their knowledge too.

Learner benefits – increased exposure

By working with different teachers, learners are exposed to a broader knowledge base, experiences and practicing styles than under one-to-one supervision arrangements.

Learning alongside other learners, including those at different stages of GP training, can provide learners with a more supportive environment and improve collegiality between team members.

Early career learners also get the opportunity watch their teachers learn⁷ which helps to cement the concept of lifelong learning.

GP supervisor benefits – fresh perspectives

Learning is a two-way street. While a GP supervisor or senior GP may bring the most clinical experience to a shared learning session, another learner may bring a new knowledge source to tap into. For example prevocational doctors and students can share the latest hospital insights or academic knowledge.

There is also potential for enhanced credibility of teachers – medical students can engage with teachers who are closer and possibly more “connected” to their situation.⁷

Another advantage for the GP supervisor and the practice is the time and cost saved in teaching and reduced demand on GP supervisors because the onus of teaching is shared among the team and shared sessions allow for more learners to take part.

Practice benefits – cohesive learning

If committed to, integrated learning can bring the benefit of an over arching cohesiveness of learning and greater sense of collegiality and camaraderie between team members.

It can also lead to time and cost savings of not having to always train multiple learners separately. It can also aid succession planning with former learners returning to the practice at their next stage of learning or even as qualified GPs.

Patient benefits – access to doctors

More learners, particularly GP registrars, can mean that patients have better access to a doctor in busy practices.

Even though patients and practices will experience turnover of GP registrars, vertically integrated learning can contribute positively to long-term workforce shortages, therefore benefiting patients.

“One advantage [of integration] is the ability of learners to share their learning experiences and ideas. I think this makes for a more lively learning environment and learners don't feel as isolated and unique with their challenges.”

– Dr Tuck Meng Soo, GP Supervisor at Interchange General Practice, Canberra.



“A team effort with benefits for everyone”

Creswick Medical Centre, regional Victoria.

Creswick Medical Centre’s commitment to GP training has spanned more than 20 years and for the past few years it has provided integrated learning for medical students, prevocational doctors and GP registrars.

The regional practice in west-central Victoria has up to five learners (including the occasional years 11 or 12 high school students on work experience) at any one time. Seven accredited GP supervisors, two of whom are also medical educators, oversee training.

“Teaching and supervision are a normal part of your day here — not an ‘extra’,” says Dr Ashley Hayes, GP supervisor and medical educator.

“We provide an integrated learning environment where learners can get on-the-spot expert assistance and advice, learn about the realities of regional GP work and the local conditions and limitations,” Dr Hayes says.

For more senior staff, Dr Hayes says integrated learning acts as a “reminder of why we do things the way we do, as well as engaging in active reflection of the processes that we use.”

Patients benefit from seeing doctors and students at different levels of their training and background, he says. “It is also a chance for them to talk to our learners about how wonderful it is to work and live in a regional community.”

“Our patients in general are very happy to engage with our learners and are often quite chuffed to be informed they have been the best ‘teacher of the day’,” Dr Hayes says.

The practice enjoys workforce and succession-planning benefits that integrated learning can deliver.

“We have a chance to see how medical students and prevocational doctors work in a general practice environment and it is exciting when they apply to return as part of their GP training.”

Dr Hayes says good communication, sharing the load and back-up support from the practice manager and administration team is a must for successful integration. This support is particularly important to ensure the practice’s ideal of having more than one, preferably three, GP supervisors available per session.

“This not only means that the supervisor is able to see some of their own patients without getting

too behind, but it also gives the learners access to more than one way of doing things.”

The practice maintains continuity of care by carefully reading the previous doctor’s notes, making clear written plans in the notes to guide the next appointment or management when results arrive, and also through reviews.

He adds that GP supervisors do audits (for example, review the GP registrar’s notes and results inbox) mainly early in the term. Teaching sessions include random case analysis, to look for “unknown unknowns”.

In turn, GP supervisors build their knowledge and teaching capabilities by attending professional development courses and the practice is refining a peer review process.

“We invite and actively seek feedback from our learners. We also run in-house continuous professional development (CPD) during regular lunchtime sessions, plus a yearly CPD conference, which is organised and presented by our doctors – both supervisors and learners,” Dr Hayes says.



“Our patients in general are very happy to engage with our learners and are often quite chuffed to be informed they have been the best ‘teacher of the day’

5. Challenges and risks

While there are many benefits to providing shared learning and teaching opportunities, there are also some clear challenges and risks that must be considered when adopting a vertical and horizontal learning integration in your practice.

Continuity of care

Training practices often have a change of GP registrars every six or 12 months. This means that some patients may rarely see the same doctor or the same doctor for a long period of time.

This challenge can be addressed through regular team meetings, during which patient cases are discussed, appropriate follow-up is agreed to and notes are detailed and documented. A thorough handover is important and the longer-term GP supervisors should be part of this handover.

Tracking the learner

There is a risk that under shared supervision and teaching arrangements, where a learner is taking direction from more than one person, that learner may receive conflicting information and messages.

GP supervisors should meet regularly to discuss the progress of learners. This will help to ensure each other's clinical teaching and education is consistent and complementary and the learner is being exposed to the right level of information and complexity.

Some practices find that allocating one GP supervisor to a certain group of learners, for example, one GP supervisor for medical students and another for GP registrars, helps to keep track of learner progress.

Those involved in teaching the same learner should keep track with each other about what has been taught and any areas that the learner needs to develop. This is important for all levels of learner, but particularly for those with direct contact with patients, such as GP registrars.

Inadequate curriculum

Learning in shared sessions has to be worthwhile for all participants. To manage the risks of sessions being too challenging or not challenging enough, it helps if one person, perhaps a senior GP, has an overview of the entire curriculum.

Listening to feedback in one-to-one sessions or simply being aware of learner input and engagement in shared sessions can help the teacher assess if curriculum is appropriate. A high level of engagement and participation – questions and answers from within the group – during shared learning sessions will indicate that teaching is hitting its mark. The same goes for one-to-one sessions. Engaged learners will be alert, making eye contact, asking questions and wanting, where appropriate, to try things for themselves.

Teaching standards

Practices that adopt a vertical learning model need to monitor the teaching skills of team members, including practice nurses and registered nurses, who will be taking on teaching roles.

“Continuity of care can be difficult. Doctors need to provide good notes and clear follow-up plans.”

– Dr Liz Ellis, Ballarat Group Practice, Victoria

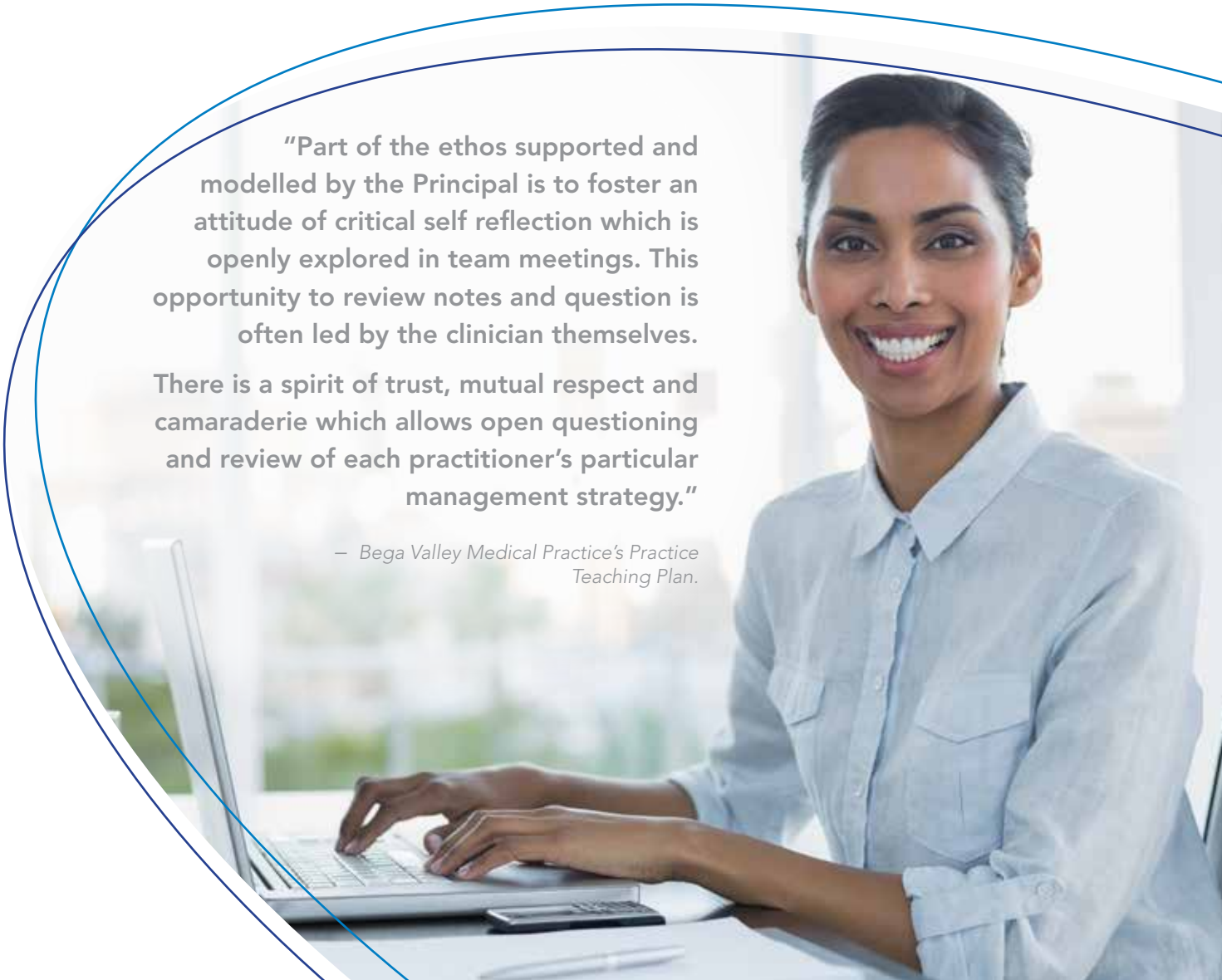
Good Luck

By now you will have a good understanding of the benefits, challenges, barriers and risks to adopting and vertically and horizontally integrated learning. You will have read case studies from GPs and practices that use the approach to train the next generation of general practitioners.

As described in this guide, there are many ways you can incorporate elements of this type of learning into your practice. But there is one key element that is required for successful vertical and horizontal integration – teamwork.

Teamwork and regular team meetings are crucial to keeping the communication channels open so learners and teachers can thrive. It is also essential to ensuring that patient care is not compromised.

Practices considering this training approach would do well to ensure that regular team meetings are planned and attended by all levels of learners to maximise the benefits of integrated learning.



“Part of the ethos supported and modelled by the Principal is to foster an attitude of critical self reflection which is openly explored in team meetings. This opportunity to review notes and question is often led by the clinician themselves.

There is a spirit of trust, mutual respect and camaraderie which allows open questioning and review of each practitioner’s particular management strategy.”

– Bega Valley Medical Practice’s Practice Teaching Plan.

References

1. GPET, 'Literature Review on Vertical Integration', Australian General Practice Training [website], (Feb. 2011),
2. GPET, 'Literature Review on Vertical Integration', Australian General Practice Training [website], (Feb. 2011),
3. Canalese, Rosa and Ramoo, Shamini, Vertical Integration of Education and Training in General Practice –A qualitative study (2013), GP Synergy.
4. Laurence, C. et al., 'Trainees in the practice', Australian Family Physician, volume 41, no.1 (2012), 14-17.
5. Thea van de Mortel, Peter Silberberg and Christine Ahern, 'Shared learning in general practice – Facilitators and barriers, Australian Family Physician, Vol 42 no. 3 (2013), 147-151.
6. Stocks, N. et al. 'Vertical integration of teaching in Australian general practice — a survey of regional training providers', MJA, Vol 194 no. 11 (2011), 75-78.
7. Dick, M. et al., 'Vertical Integration in Teaching And Learning (VITAL): an approach to medical education in general practice', MJA, Vol 187, no. 2 (2007), 134-135.

Acknowledgements

Thank you to the people, especially the busy GP Supervisors and Practice Managers, who provided input into this document.

Dr Liz Ellis; Dr Ashley Hayes; Dr Duncan MacKinnon; Practice Manager Jodie Meaker; Dr Tuck Meng Soo; Dr Jenni Parsons; and Brook Street Medical Practice and its medical students from Monash University



GENERAL PRACTICE SUPERVISION AUSTRALIA

T: 03 9607 8590

E: admin@gpsa.org.au

W: gpsa.org.au

A: PO Box 787 Gisborne, VIC 3437



facebook.com/GPSupervision



twitter.com/gp_supervision