ECTV Processes for Medical Educators and Visiting Supervisors

1. What is an ECTV?

An ECTV (External Clinical Teaching Visit) is a learning opportunity where the registrar receives direct feedback on their consultation skills. A Medical Educator or an experienced Supervisor from another practice will observe a series of up to five (5) consultations during the visit.

The purpose of the visit is to assess whether the GP registrar's (GPR) knowledge, and clinical skills and attitudes are appropriate for their level of training. The limitations of making firm conclusions as to GPR expected competency based on up to five observed consultations is acknowledged. ECTVs also provide registrars, supervisors and MEs/ECT Visitors with an opportunity to discuss practice related issues.

2. Allocation of an ECT Visitor

Each semester, an ECTV roster is developed by each regional MCCC team. The REAPS (Registrar Education and Practice Support Coordinator) and RHE (Regional Head of Education) will determine appropriate Medical Educators or experienced GP supervisors to undertake the visits.

Relevant Medical Educators and Supervisors (via their practice managers) will be advised via email of the registrars they have been allocated to visit, the level of the registrar and the practice details where the registrar will be working.

If the ME or visiting supervisor believes they will be unable to complete a particular allocated registrar ECTV, they should advise MCCC as soon as possible, so that it can be re allocated.

3. When are ECTVs Required?

Each GPT/PRRT1 registrar requires an ECTV prior to the end of week 6 of the semester. A subsequent ECTV is then undertaken later during the semester (approximately week 20 / must be completed by week 22).
Each GPT/PRRT2 registrar requires an ECTV prior to the end of week 8 of the semester. A subsequent ECTV is then undertaken later during the semester (approximately week 20 / must be completed by week 22).

Each GPT/PRRT3 registrar requires 1 ECTV during the semester.

Additional ECTVs may be undertaken as a teaching or assessment tool. MCCC will communicate with the practice as required to arrange these. These are called Diagnostic ECTVs.

4. Establishing the date

Where a ME (Medical Educator) has been allocated to the registrar, the ME will contact the registrar's practice manager directly to liaise regarding an appropriate date and time for the visit.
Where a GP Supervisor has been allocated, their practice manager will contact the registrar's practice manager to liaise regarding an appropriate date and time for the visit.

The visit should take place on a day when the GP registrar and their Supervisor are both consulting in the clinic.

Once the date is confirmed, the ME or PM of the visiting supervisor must advise MCCC of the date via email. MCCC will confirm the date via email (including the registrar) and set up SWAN for completion of the report as required.

It is advisable for the ECT visitor to contact the practice 24 hours prior to a scheduled visit to confirm the practices is aware of the visit and to ensure that there are appropriate patient numbers.

Changes or absences

If the allocated ME or visiting supervisor is unable to complete a scheduled ECTV, the registrar's practice manager should be advised as soon as possible and the date rescheduled. MCCC should be advised of the amended date.

5. Format of visit

The ECTV should take around 3.5 hours. **The registrar's practice manager is responsible for booking the ECTV in the patient appointment diary.** The format will vary based on the registrar level.

Initial Assessment (first GPT/PRRT1 ECTV)

- 30 minutes before the first consultation. This is time for discussion with the GP Registrar about their term so far.
- At least 4 patients booked for 30-40 minute appointments (note: this is generally ½ hour with patient followed by some discussion time)
- 30 minutes at the end with the registrar's GP Supervisor and the GP Registrar to talk through any issues.

Further Assessment (first GPT/PRRT2 ECTV)

- 30 minutes before the first consultation. This is time for discussion with the GP Registrar about their term so far.
- 3 patients booked for 30 minute appointments
- 1 hour discussing 3-4 cases randomly selected by the ECT Visitor from the last couple of days consulting – (blocked in the diary as "case reviews")
- 30 minutes at the end with the registrar's GP Supervisor and the GP Registrar to talk through any issues.

All other routine ECTVs

- 30 minutes before the first consultation. This is time for discussion with the GP Registrar about their term so far.
- Five (5) patients booked at half hour appointments.
- 30 minutes at the end with the registrar's GP Supervisor and the GP Registrar to talk through any issues.

Diagnostic ECTVs

Will be planned and allocated as required. You will be provided with information on the format at the time.

6. Consent, Privacy and Signage

In order to comply with legislative privacy policies, MCCC requires training facilities to have the following in their facility's privacy statement: 'medical records may be accessed by visiting medical educators and/or general practice supervisors from another practice for the purpose of registrar training'. This forms part of the annual practice agreement with MCCC GP Training. It is also suggested that the training facility display the prepared poster. (GP Training Accreditation/Medical Records Access poster – available on the MCCC website)

Consent is required for each patient. The practice manager will arrange for reception staff to gain written consent for each patient being seen by the registrar during the ECTV.

7. The Visit

Initial meeting

During the first half hour allocated, the visitor will meet with the registrar to discuss the format and purpose of the visit and what the GPR hopes to achieve through the process. Visitors should also discuss the educational progress of the registrar to date and any concerns which require follow up.

The GPR should be advised that the ECT visitor is an observer and cannot participate in the consultation. Any issues which arise during a consultation and on which the GPR needs advice should be referred to the supervisor in the usual way.

The ECT Visitor should also discuss the following –

- Current practice placement eg. Patient profile and range of illnesses, workload and bookings, time management and uncertainty, distressing patient experiences
- Relationships with the supervisor/s and practice staff including ability to obtain assistance with clinical concerns in a timely manner
- In practice teaching – time, process, educational activities, resources for learning
- Review of learning planner
- Exam preparation and intentions

Awareness of patient modesty is important in the observer role and the ECT visitor needs to ensure that where physical examination is required, there is no intrusion on patient privacy. Should a chaperone be required or requested, the GPR should follow usual practice procedure.

Providing feedback following consultations

Following the consultation, feedback is provided on the consultation observed. In discussion, many GPRs tend to focus on those aspects of the consultations that did not progress well and the ECT visitor needs to balance this account by mentioning the more positive features.

ECTVs should have the appropriate balance of support, challenge and vision.

General principles of giving feedback include:

1. Working from the learner's agenda rather than a set framework.
2. Offering feedback based on strengths, weaknesses and areas for improvement.
3. Referring to specific instances observed in the consultation rather than vague generalities and ensuring that feedback offered relate to skills, attitudes and beliefs which can be open to modification
4. Limiting the number of teaching points in a consultation, as the impact may be lost when multiple issues are discussed.
5. Leaving the learner in a positive frame of mind, with a clear understanding of any performance issues and a plan to address any deficiencies observed.

GPRs are encouraged to reflect on the consultation in terms of the RACGP's or ACCRM's domains of general practice.

It is appropriate for ECT visitors to appraise the consultation using the Domains of General Practice (see appendix 1 and 2) and the report is constructed according to this framework. Information on GPR performance pertaining to domains relating to professionalism and ethical practice may need to be obtained from sources other than the consultation, such as from discussion with the GPS.

To assist ECT visitors in this respect, a worksheet has been developed for use during the time of patient observation and is included (see Appendix 3).

Supervisor, registrar, ECT visitor meeting following observed consultations

Where learning needs have been highlighted, the GPR may directly involve the GPS in the ensuing discussion about how these might be addressed and agree on further progress. If not, the ECT visitor might offer some suggestions. Any agreed learning goals should then be documented in the report of the visit.

Finally the GPR and GPS may wish to review other educational and training issues that have arisen during the term. An ECT visitor is also in a privileged position to observe how supervision occurs within the practice and to offer feedback as a peer, to all parties involved in the educational experience. Where significant concerns arise, these should be discussed with the GPR and GPS at the time of the visit with a clear understanding of the agreed course of action which should be documented in the subsequent report.

Random Case Analysis for GPT/PRRT 2 further assessment ECTVs

In Random Case Analysis (RCA), patient records are selected at random by the ECT visitor, who reviews the record and facilitates discussion with the GPR about any issues arising. The strengths of RCA are in the assessment of clinical knowledge and reasoning, and the adequacy of the medical record.

Assessment of expected competency continues to be made on direct observation of the registrar consulting rather than RCA. However formative feedback on cases discussed during RCA can form part of the ECTV report.

The advantages of RCA are that:

1. Clinical knowledge gaps are more readily identified.
2. It allows review of an increased number and diversity of clinical presentations compared to using direct observation alone in the ECTV. (Where the record chosen is a simple problem or repeat of a previous scenario then a new record can be selected)
3. It enables an assessment of the GPR's management of a patient over time
4. It can provide the ECT visitor with an appreciation of the case load of the GPR, (too few or too many patients, or an inadequate mix of patient types)

However, RCA is of limited utility if the GPR's notes are poor, or if the GPR does not recall his or her reasoning during the consultation.

To conduct RCA, the ECT visitor asks the GPR to open the appointment book to a session within the previous week and selects records from that session. The ECT visitor and the GPR discuss what was known of the patient prior to the consultation and the GPR's recall of the how the consultation proceeded. The ECT visitor then uses a range of questions to explore the domains of general practice pertaining to the consultation and to assess clinical reasoning. The ECT visitor selects questions appropriate to the case, taking care to ensure that the process is conducted as a collegiate discussion.
While RCA is considered to be part of the further assessment ECTV, RCA is also encouraged during any ECTV if time allows, for example if patients cancel.

Further reading regarding Random Case Analysis -

https://www.racgp.org.au/afp/2013/januaryfebruary/random-case-analysis/

https://www.racgp.org.au/afp/2016/december/adding-random-case-analysis-to-direct-observation-(arcado)-%E2%80%93-updating-the-external-clinical-teaching-visit-to-improve-general-practice-registrar-assessments/

Issues and concerns

Issues arising during consultations -

If a patient is seriously at risk of inappropriate management by the GPR, the ECT visitor may need to tactfully intervene. The GPR can be asked to leave the consulting room where the issue can be discussed with the visitor and a more appropriate plan of action enacted. This incident should come to the attention of the GPS immediately and again at the end of the session when formal feedback is to be given.

Issues within the practice

The RACGP Standards 2nd edition (3) state: "Clinical teachers who perform external clinical teaching visits are uniquely placed to gather and provide information about the quality of the supervision and training within the training post." (Criterion 1.1.2.3)

At times during ECTVs, ECT visitors may become aware of issues within the practice such as non-compliance with teaching requirements by the GPS or poor relationships between the GPS and GPR. The ECT visitor may attempt to resolve these matters through discussion with the parties involved and agreed

outcomes documented. Otherwise they should be promptly referred to the Regional Head of Education or Accreditation lead medical educator.

GPS unavailability

At times the GPS is unavailable during the ECTV, either for scheduled reasons such as annual leave or unscheduled circumstances such as illness. It may be possible to have a telephone discussion or alternatively to meet with another GPS in the practice. Failing this, a later meeting needs to be promptly arranged either by telephone or a second practice visit. The GPR should participate in all discussions.

Follow-up of underperforming GPRs

During an ECTV, a range of GPR related issues of concern may arise or be observed such as:

1. Poor communication with patients including language deficiencies
2. Significant knowledge gaps.
3. Deficient clinical reasoning/processing skills.
4. Time management
5. Unprofessional behaviour
6. Dealing with demanding patient expectations
7. Personal or health issues that may be impacting on performance.

These concerns should be discussed with both the GPR and the GPS and a plan of action formulated and documented in the ECTV report. Early identification and appropriate action is important in assisting the GPR and GPS to address such concerns.

Where the ECT visitor holds serious concerns, these should also be discussed with the Regional Head of Education (RHE). All issues of concern should be referred promptly, even if just to obtain advice on the most appropriate course of action.

Issues relating to professional behaviour should also be referred to the RHE or DMET.

8. Completion of report

The ECT visitor should document the outcomes of the visit using the designated electronic ECTV report template currently available in SWAN for RACGP registrars and on the MiniCEX Scoring form for ACRRM registrars.

The primary purpose of the report is to assist the GPR to develop further learning goals. Its secondary purpose is to inform the GPS and ECT visitors about the professional development of the GPR. While ECT visitors may adopt a range of styles in writing reports, there must be clear documentation of competencies achieved, those lacking, areas for improvement and suggested actions to achieve learning goals. This is particularly important where the GPR may have displayed professional difficulties. Matters pertaining to the ECTV, which were not discussed at that time, should not be documented. The GPS, who has access to

the GPR portfolio, is subsequently able to view the written feedback. (Note – supervisors do not have access to the practice component (Registrar in Practice Experience information) of the ECTV report.)

The ECT visitor should invite the GPR to make a written response to the subsequent report about the process of the ECTV and the issues discussed.

It is advisable that ECT visitors complete the report within two weeks, when the issues discussed and addressed during the ECTV are still clear in their minds.

9. Invoice to MCCC for time

Visiting Supervisors complete the FNF 002 Supervisors Claim Form – ECTV and submits to MCCC for payment of their time. Casual MEs complete the MCCC Approved additional hours and reimbursements form.
In addition to the 3.5 hours of the visit, ½ hour report writing can also be claimed. ie. 4 hours total.

For diagnostic EVTCs, additional report writing time is provided to a maximum of 4.5 hours for the visit and report.

10. Training new ECT Visitors

New MEs or GPSs who will be undertaking ECTVs will receive training in the practical aspects of conducting ECTVs and the provision of feedback. Following this, further training options will be offered including debriefing of pre-recorded role played consultations. In some instances, the opportunity to accompany an experienced ECT visitor on an ECTV may be possible although agreement must be obtained from the lead GPS of the practice. Reviewing of their first ECTV reports prior to final submission will also be undertaken.

Associated documents

TOF 002 Patient consent

Guidance Document – ECTV processes for practice Managers

The ARCADO Manual

ACRRM MiniCEX Scoring Form

Poster – GP Training Accreditation/Medical Records Access poster

Appendices

Appendix 1 – RACGP Domains of General Practice

Appendix 2 – ACRRM Domains of General Practice

Appendix 3 – Template for notes

References

1. Black F, Faux S. (Eds). ECT manual: becoming an external clinical teacher. RACGP: South Melbourne 1996.
2. Royal Australian College of General Practitioners. (2015). *Standards for general practice training* (2nd ed.). East Melbourne: The Royal Australian College of General Practitioners
3. https://www.acrrm.org.au/training-towards-fellowship/reporting-and-assessments

Further Reading

1. Bullock I, Davis M, Lockey A, Mack-Way Jones K, editors. Pocket Guide to Teaching for Medical Instructors. Second ed. Oxford: Blackwell Publishing 2008.
2. Krackov SK, Giving Feedback, Chapter 47 in Dent JA, Harden RM. A practical guide for medical teachers. 3rd edition. Edinburgh: Elsevier 2009.
3. Hays R. Teaching and Learning in Clinical Settings. Abingdon, UK: Radcliffe Publishing Ltd; 2006.
4. Hays RB. Practice-Based Teaching: A Guide for General Practitioners. 2nd ed. Melbourne: Eruditions Publishing; Cowes 2006.
5. Hillard D, Westberg J. Fostering Reflection and Providing Feedback. Springer: New York 2001.
6. Kurtz SM, Silverman JD, Draper J (1998) Teaching and Learning Communication Skills in Medicine. Radcliffe Medical Press (Oxford)
7. Moorhead R, Maguire P, Thoo SL. Giving feedback to learners Aust Fam Physician. 2004;33(9):691-5.
8. Vickery A, Lake F. Teaching on the run tips 10: Giving feedback. Med J Aust. 2005; 183(5): 267-8.

9. van de Ridder JMM, Stokking KM, McGaghie WC, Ten Cate OTJ. What is feedback in clinical education? Med Educ. 2008;42(2):189-97

Appendix 1

RACGP Domains of General Practice

1. Communication Skills and the Patient Doctor Relationship
With respect to: information gathering
Is the GPR: – Sensitive to the patient's cues? – Able to elicit the patient's issues / problems / concerns / expectations (including issues of confidentiality?) – Using a bio-psycho-social-approach?
With respect to: information giving
Does the GPR – Check the patient's knowledge and understanding? – Give relevant and appropriate amount of information tailored to patient's level and needs?
With respect to: communication skills
Does the GPR – Establish rapport and empathy? – Engender confidence and trust? – Have a non-judgmental attitude? – Have good listening skills? – Use appropriate verbal communication for different situations (including use of silence)? – Use appropriate non-verbal communication for different situations (eye contact, body language, appropriate use of touch)? – Demonstrate an awareness of the patient's non-verbal communication? – Avoid jargon? – Communicate with significant others, as appropriate?
With respect to: management skills
Does the GPR – Explore options with the patient? – Have an ability to find common ground? – Negotiate a management plan (including a contingency plan and follow up in the immediate, Short and long term)? – Agree on responsibilities and limits (for doctor, patient and others)? – Capitalise on opportunities for health promotion and education (including use of pictures / models / handouts)? – Capitalise on opportunities to increase the patient's capacity for self-care?
Overall impression
– Is there structure to the consultation?

– Does the consultation flow logically?
2. Applied Professional Knowledge and Skills
The presenting problem
Does the registrar demonstrate an orderly approach in – Taking a focused history appropriate to the presenting complaint? – Arriving at a diagnosis and/or management plan (including an ability to include/exclude serious conditions as part of this process)?
Physical examination
Does the GPR – Perform an appropriate and focused examination as indicated by the history? – Demonstrate competence in physical examination skills and an ability to recognize relevant – Explain the examination to the patient where necessary?
Procedural skills
Does the GPR – Demonstrate appropriate use of aseptic technique when it is required? – Have the ability to perform office procedures unsupervised? – Appropriately request assistance with procedures?
Investigations and referrals
Does the GPR – Make appropriate use of surgery tests? – Appropriately orders/doesn't order investigations? – Make appropriate and justifiable choice of investigations if ordered? – Explain nature of investigations to patient (including billing of these)? – Refer appropriately (for appropriate condition, to appropriate specialist or centre)?
Prescribing behaviour
Does the GPR – Demonstrate rational reasons for use/non-use of medication? – Ensure, when medication is prescribed, that the choice is appropriate for the patient and the Medical condition? – Follow PBS prescribing restrictions? – Explain the nature of prescribed medication to the patient? – Give adequately detailed instructions on the use and side effects of medications prescribed?

3. Population Health and the Context of General Practice
"Broader" bio-psycho-social issues
Issues which may impact on the patient's health: – socio-political – economic – work – spiritual – cultural – family & significant relationships Were any relevant? Were they elicited? Were they addressed? Was it done appropriately? Were significant opportunities missed?
Prevention, health promotion & disease screening.
– Was the opportunity taken to address these? – Was the patient involved? – Was the patient receptive? – How appropriately was it managed?
Recall / follow up
– How was it managed? – Was it explained to the patient?
Public health and safety issues
– Environmental – Safety concerns – Iatrogenic diseases (including adverse drug reactions) – Notifiable diseases (including contact tracing) – Access or equity issues Were these recognized? How were they managed?
Resources
– Is the registrar aware of what resources can be accessed in their area (referrals, community services, health services)? – Resources are finite. Is judicious use made of these resources? – How is the situation managed when these resources are lacking or inadequate?

4. Professional & Ethical Role in General Practice
Duty of care to the patient
Does the GPR: – Take responsibility for the optimal care of the patient and the patient's needs (putting the patient first, follow up, reporting, advocacy)? – Recognize the importance of the doctor-patient relationship? – Respect the boundaries between doctor and patient? – Have respect for cultural values and how they impact on the doctor-patient interaction? – Have respect for patients' rights (confidentiality, privacy, full information, self-determination)?
Self-care
Does the GPR show concern for: – His/her own personal health (physical, emotional, spiritual and social dimensions)? – The needs of family and other relationships? – Maintaining a professional support network (GP's, other doctors, mentor, health professionals) for personal and clinical support?
Reflective skills
Does the registrar have: – A capacity for self-awareness, reflection and self-appraisal (personal reactions to the patient and their illness, knowledge and skills)? – The ability to determine learning needs based on self-reflection? – Time management skills (at work, outside of work)?
Maintenance of professional standards
Does the registrar: – Maintain defined clinical practice standards? – Maintain professional codes and ethics? – Have an involvement in professional development (CME, teaching, research, audit, incident analysis)? – Interact appropriately with other staff in the clinic (medical and non-medical) – Have a system for managing the professional expectations (e.g. paperwork) that is – appropriate and practical – Demonstrate appropriate professional behaviour in their approach to work

5. Organisational and Legal Dimensions
Medico-legal knowledge
Does the GPR have an awareness / knowledge of: – Certification? – Confidentiality (including access to records)? – Legal report writing? – Informed Consent? – Prescribing (S8 drugs)? – Duty of care? – Litigation?
Organisational issues
Does the GPR pay attention to: – "Best practice" with respect to clinical standards, guidelines and protocols? – Accreditation requirements and practice standards? – Information management (including management of medical records / information transfer – /referrals / management of results)? – Screening and recall systems? – Appointment systems in the practice?
Time management and other personal skills
How does the registrar: Liaise with other staff including reception and practice managers (Teamwork) Deal with office policies and procedures? Handle time management issues

Appendix 2

ACCRM - Domains of General Practice and relevant themes

Domain 1: Provide medical care in the ambulatory and community setting
Themes: Patient-centred clinical assessment, clinical reasoning, clinical management
Domain 2: Provide care in the hospital setting
Themes: Medical care of admitted patients, medical leadership in a hospital team, health care quality and safety
Domain 3: Respond to medical emergencies
Themes: Initial assessment and triage, emergency medical intervention, communication and planning
Domain 4: Apply a population health approach
Themes: Community health assessment, population-level health intervention, evaluation of health care, collaboration with agencies
Domain 5: Address the health care needs of culturally diverse and disadvantaged groups
Themes: Differing epidemiology, cultural safety and respect, working with groups to improve health outcomes
Domain 6: Practice medicine within an ethical, intellectual and professional framework
Themes: Ethical Practice, professional obligations, intellectual engagement including teaching and research
Domain 7: Practice medicine in the rural and remote context
Themes: Resourcefulness, flexibility, teamwork and technology, responsiveness to context

Appendix 3

Template for Notes

Date: **Observer:**

What did the GPR do well & what more could they have done in each domain

Domains	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
	M/F Age	M/F Age	M/F Age	M/F Age	M/F Age
Communication skills & the Pt-Dr relationship					
Applied professional knowledge & Skills					
Population health & context of general practice					
Professional & ethical role					
Organisational & legal dimensions					