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ReCeNT FAQs

What is ReCEnT?

Clinical encounters are the core learning activity of general practice training in Australia. However, exposure to different patient demographics and presentations is highly variable between registrars and practices. This has a clear impact on the nature and quality of training.

The Registrar Clinical Encounters in Training (ReCEnT) project aims to document and analyse the nature of the clinical and educational content of general practice registrar consultations. You will record details of sixty consecutive consultations on three occasions during your training time. Educational factors related to the encounter will be recorded along with clinical consultation details.

For the first time, the project documents the content and nature of Australian GP registrars' clinical consultations over time. This information will be of great value in supporting both your individual learning, as well as informing your education and training program overall. The study will also provide a platform for further research and audit activity by GP registrars.

When did ReCEnT begin?

That's easy, in the second term of 2009 a few brave souls at (the now former) General Practice Training – Valley to Coast (in the Central Coast, Hunter Valley and Manning River areas of NSW) undertook the 'pilot round' of ReCEnT. Full-scale operation of the project commenced in 2010 and other Regional Training Providers (General Practice Training Tasmania, Victorian Metropolitan Alliance, Adelaide to Outback General Practice Training, and Tropical Medical Training) commenced participation between 2011 and 2014. With the change in GP vocational training from 2016, ReCEnT is now conducted in the Regional Training Organisations GP Synergy, General Practice Training Tasmania and Eastern Victoria General Practice Training.

What is the point of completing ReCEnT? How will it help my training? How will it promote better patient care? How will it make us better doctors?

The educational point of ReCEnT is to give you insight in to your own practice via a process of reflection. It can allow you to identify areas where you are not getting enough experience or where your practice varies from your peers. This in turn allows you to adapt your own learning to fill knowledge gaps or make up for areas you have little exposure to, and to modify aspects of your practice or clinical approach accordingly. That makes you a better doctor right now, as well as placing you in a better position to attempt your college's fellowship exams.

Reflection on your ReCEnT feedback report is also a chance to practice your critical evaluation skills – was this a typical week? If not, how will that have affected my results? Are your results on any parameter different to your peers? If so, why is this? Is it due to the patient profile at my practice? Or due to structural issues at my practice (high workload etc)? Or due to practice styles of my supervisors that I have adopted? Or is it due my personal practice approaches and style? If so, do I need to address this or is it OK?

Remember, the report is intended to prompt a reflective process. It is not a benchmarking exercise. It may well be, after reflection, quite OK to be different to your peers on any particular parameter.

Embrace the process and maximise its benefits to you!

Why do I have to do it more than once?

Because you grow and change throughout your training and this is one way for you to monitor how effective you have been in areas you wanted to progress. You also change locations while training and so your patient group and the clinical experiences you have vary as well. ReCEnT characterises these things very clearly and being able to compare your data from different practices can inform your choice for the next practice.

How long does it take to complete ReCEnT?

Once you are familiar with the format (this takes a few consultations in your Term 1 round of data collection) you can complete a typical consultation in about a minute. Occasional consultations may be more complex and require more information to be recorded and may take a little longer (for most consults only a fairly limited amount of the ReCEnT form is applicable and needs information to be recorded). But it is important to take this little extra time in longer consults as this is important information, capturing the complexity of these occasional challenging consults.

It is essential that you record your information contemporaneously (for accuracy). It is also faster to record the data at the end of each consultation (after the patient has left) while you still have their file open, rather than to leave it to the end of a session when you will have to go back and access each patient's file again.

Many registrars found that making one appointment unavailable per session provides enough time to make up for recording data without adding extra stress to your day. If you elect to do this it must be with the approval of your supervisor and practice manager. Your practice manager should be familiar with this strategy as we advise them when ReCEnT will be operating in their practice and suggest that blocking off an appointment per session is a common approach.

Why can't the ReCEnT data be extracted/recorded electronically?

While it is possible to create an electronic version of the encounter form for you to complete, this does not save time because you would still need to manually enter all the data from the consultation. It doesn't give you what you really want, which is to have data from your system default in to the encounter form, which would save you time and minimise errors. We would love it if that sort of system were feasible, but to build it would require creating complex software which is not financially viable.

Why can't you have an automatic link to my computer system for the data?

General practice uses many different software platforms for recording consultation data. Unfortunately, it is not financially viable to build an electronic system to interface to these many practice systems. Also, it would require negotiating with practice owners to allow a third-party piece of software to access their confidential patient database.

Why is the form so 'busy'?

We have reduced the data being recorded from the early days of ReCEnT in response to previous feedback. Almost all the data on the form is used in your personalised report. The major exceptions to this are the 'FRESH' question section and the 'Medications Ceased' sections that are new areas of interest in general practice. While there are a large number of sections on the form, in most consultations many of these will remain unpopulated as the consultation content is usually fairly constricted.

Why do I have to do 60 encounters?

The BEACH (Bettering the Evaluation And Care of Health) study of general practitioners in Australia was used as an example when designing many of the aspects of the ReCEnT project. The GPs in the BEACH study record 100 consecutive consultations. In discussion with supervisors and medical educators it was thought that a good sample of a registrar's practice could be gained from between half a week to 1 week of consultations. This worked out on average to be about 60 consultations (taking account of how registrars generally see more people per day as they progress through their training).

Why don't you include other forms of management on the forms (guidance, reassurance, advice, exercise, diet)?

While these are undoubtedly important forms of management, they are not easy to characterise as data that can be classified and analysed in a meaningful way. For example, one practitioner may briefly or glibly mention improving diet in wrapping up a consultation (e.g. 'you need to watch your diet') while another may have spent 15 minutes discussing diet in detail with their patient. These clearly are not the same thing but could feasibly be recorded as 'dietary advice' thus implying the two consultations were similar when they weren't. To characterise the data more accurately would be too great a burden on you. Consequently, these sorts of management actions, that are not simple to define and record, were not included in ReCEnT.

What encounters should I exclude from recording?

The data you record is used by you to reflect on your practice, so it is intended to capture the variety of presentations that you see. So, don't record things from single-purpose clinics or sessions or designated portions of sessions where you do the same thing for each patient – for example, Immunisation clinics or Pap smear clinics or INR clinics.

Also, it is about what you see in your practice office so don't record home visits, nursing home visits or patients you see in the hospital or emergency department. While this means that we don't capture all the richness of some registrars' practice experience, the practicalities of recording data in these settings can be difficult and to ensure consistent data collection we have elected not to include them. This also means your data will be from a comparable context to that of your peers (and the one where you do the most work!) and so you will be able to make better comparisons when reviewing your data.

Again, use critical evaluation skills to interpret the numbers: for example, your ReCEnT data suggests you may have seen less older patients than most of your peers, but you are confident that you have still had sufficient exposure to geriatric medicine in your current term via your fortnightly morning session at a local nursing home, so there is no problem.

I work at more than one practice, what do I do?

Record data for ReCEnT from the practice where you do most your sessions. If your sessions are evenly split across practices then just choose one practice and record all your consultations from there.

If you work for the Australian Defence Force as well, do not record data from your ADF consultations because they do not represent community general practice which is what your ReCEnT data is compared against.

In the 'follow-up' section why isn't there an option for 'appointment of GP as required'?

This section is intended to record when you think a patient must be followed-up and so a definite arrangement is made. 'Follow-up as required' (or 'safety-netting') is something that could apply to almost all consultations and so is not informative data for you.

Why is there only room for four problems?

In prior analysis, the great majority of consultations have three or less problems. Consequently, to balance space on the form with time spent recording data by you it was decided that four problems was sufficient to provide an accurate sample of your practice.

If you deal with more than four problems, you pick what you think are the most important four to record.

Can you clarify what you mean by 'seen by you for this problem/s ever before' e.g. I have seen the patient before for a URTI but not for this URTI, how do I answer?

This part of the encounter form refers to the problem you are seeing in the encounter today. So, in the case above you have not seen the patient before for this particular URTI therefore the answer is 'no'.

However, if you have a patient who you have seen before for care of their COPD (e.g. prescription renewal) and today they present with an exacerbation of their COPD then this is a problem you have seen before (it is another aspect of their COPD) and so the answer is 'yes'. But, if today is the first time you have ever seen them for their COPD then the answer is 'no'. This is because this question is concerned with continuity of care – we want to know that you are getting experience of caring for all aspects of this patient's COPD.

What does it mean by 'new' or 'old' problem?

This term is relative to the patient, not you.

So, if this is the first time the patient has ever presented with this problem then it is 'new'. If this is the first time you have seen the patient for this problem, but it is one they already knew about (i.e. it is not a new diagnosis to the patient), then it is 'old'.

What constitutes de-prescribing?

De-prescribing means you have ceased a medication for a particular problem. We want you to record this, even if you prescribe another medication to replace the de-prescribed medication. Thus, if a patient developed a cough on ramipril and you ceased the ramipril and replaced it with irbesartan you would:

- record Ramipril as de-prescribed and record the reason for de-prescribing as 'side effects'; and
- record irbesartan as a medication prescribed in the consultation.

We also want you to record medications that you intend to cease in the future, but you are weaning so you reduce the dose at this consultation (this has its own section on the encounter form).

BUT

We DO NOT want you to record reduced doses for a medication if you do not intend to cease it in the future. We do NOT want you to record increased doses for a medication e.g. if you changed the dose of ramipril from 5mg tablets to 10mg tablets, we DO NOT want you to record this.

Are OTC medications included in Medications prescribed?

Yes, they are. If you recommend OTC medications, record them

Why are we collecting at this time in the term?

We choose the approximate mid-point of the term (or as close as we can get, logistics considered) to allow time for you to settle in to your new practice and for your patient load to have stabilised. This gives the best chance to achieve a representative sample of your practice. Also for you lucky registrars who are studying for exams it is timed to try and pick a lower point (relatively speaking!) in the cycle of exam stress, after the AKT and KFP and before the OSCE.

Do I need to obtain patient consent for ReCEnT?

You do not need to obtain your patient's consent to record data.

There are two aspects to ReCEnT:

- The first is: you are recording data on your experiences for educational reflective purposes (a sophisticated version of the log books kept in many medical training programs). This is a required component of your training and is a powerful tool for you to map your progress, identify gaps in your clinical exposure and plan for future training terms.
- The second is research: if you provide your consent, then your de-identified data is added to the research database and analysed to answer questions related to Australian GP education and training generally (rather than for your personal education). Two points should be made about this:
    - You (and your registrar colleagues) are the participants in this study. ReCEnT is a cohort study of registrars – we follow you and your clinical experiences for three terms. As such, you may elect to provide consent for the data you collect on your consultations for educational purposes to also be used for research purposes. This is entirely voluntary. If you elect not to consent to having your data used for research, it will not influence or prejudice your relationship with your Regional Training Organisation.
    - Your patients are not the participants in the study. As such you do not need to obtain patient consent. We do provide, however, patients with information about the project (see question 21) and are happy not to record data in the consultation if the patient so requests.

The study has been approved by, and is monitored by, the Human Research Ethics Committee at the University of Newcastle.

How does the patient information process work? What do I need to do?

Your practice will receive explanatory leaflets that your receptionist will provide to the patients when they arrive for their consultation. Copies of these leaflets are also included in your ReCEnT packs. The leaflet explains what ReCEnT is and why you are doing it. It explains that if they would not like information recorded about them, we will respect their wishes and not record any information.

You do not need to discuss ReCEnT with your patient unless they ask you about it. If so, you only need to discuss it briefly. If the patient reports that they do not want any information recorded or, after a brief explanation, has any reservations about information being recorded about them, simply do not record any information for that consultation. Record on the front sheet of your ReCEnT pad that data was not recorded for one consultation (and resume data collection with the next consultation).

What are the ethical implications of a project that is required for your training but collects data that can be used for both educational and research purposes?

Your training organisation requires you to collect de-identified data about your consultations for your own education and reflection. This is facilitated by the personalised report that analyses your data for you to reflect upon on your own, with your supervisor (if you choose to), and with your medical educator. Since this is for your own personal educational use it

does not constitute human research, therefore it does not require approval from an ethics committee for you to collect the data.

However, for your ReCEnT data to be used for research purposes then you, as the participant in the study, need to provide informed consent for this. Consequently, this use of your data does constitute human research and is approved and monitored by the Human Research Ethics Committee of the University of Newcastle (reference no. H-2009-0323). If you don't consent, then your data is excluded from the research activity of the ReCEnT project (e.g. publications in medical journals, conference presentations, informing training interventions). Also, if after your original decision you change your mind, then you can withdraw your consent at any time.