

Practice-based medical student and registrar teaching and supervision

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CEPHRIS

Centre for Equity and Primary
Health Research in Illawarra and
Shoalhaven

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- contribute to teaching in these areas

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GP Summary

If you can only read two pages, please read pages 1 and 2 and pass the remainder to your practice manager or other appropriate person.

- **This paper is designed to assist you to think through the issues involved in providing clinical placements in your practice for medical students.**
- It is based on a review of the international literature and on **research** interviews with GPs undertaken in the Illawarra, Shoalhaven and Greater Green Triangle area of Victoria/South Australia. IT was commissioned by Coast City Country Ltd which is a GP Registrar vocational training agency and Conducted by CEPHRIS, University of New South Wales Research Centre for Primary Health Care and Equity.
- The international literature, backed up by interviews with GPs, shows that **GPs take medical students because they find it intrinsically satisfying and challenging.** They want to contribute to the profession and the community.
- Taking medical students adds variety to GP's working lives, especially in fee for service, office based settings.
- **A new wave of medical schools** is in development and they need large numbers of clinical placements for their students. These placements cannot be found in hospitals and many new schools are looking towards general practice. Many GPs are familiar with short student placements either from taking students or from their own student days.
- These **clinical placements are taking three forms:**
 - Short "familiarisation" placements
 - Sessional placements, and
 - Extended placements
- **Familiarisation placements** have been used by established medical schools for many years. Students visit a practice for about a fortnight and observe consultations and the process of care in the practice.
- **Sessional placements** take place where a GP takes one or more students for one session per month for 12 or 18 months. This session is integrated with the teaching curriculum and students see patients with relevant conditions. The impact on the practice is less intense than the familiarisation model and may be more satisfying for the GP since the learning is timely and appropriate for the student.
- In an **extended placement** two 3rd or 4th year graduate students will be placed in a practice for 12 months and will undertake about 2 clinical sessions per week. They may take patient histories; take part in health assessments, and care planning or other activities that may generate income for the

practice. These students will see unselected patients and the GP will attend part of the consultation and take clinical responsibility. Consultation models are discussed in the paper that follows this summary.

- Each of these placements can attract PIP payments which are currently \$100 per clinical session.
- The paper which follows addresses the following questions for each type of placement:
 - What will students do?
 - Will taking students assist patient care?
 - Will taking students assist GP workload?
 - What impact will taking students have on practice income?
 - What will it cost the practice?
 - What resources will be made available for practices?
 - What sorts of agreements do practices typically make with the sending medical schools?
- Some practices already have **GP Registrars** who are different from students in important ways. They are qualified doctors, working under supervision, who bill for their services and are employed by GPs for two main reasons: they may assist in boosting the number of local GPs and ameliorating medical manpower shortages and they provide another “pair of hands” in the practice who can help with the workload and add flexibility for holidays and peaks in demand.
- Medical students have commented that it is good to be in a practice where another doctor is studying for exams and although Registrars cannot supervise students they can be an integral part of education and teaching sessions.
- GPs considering taking medical students will want to find answers to the following questions which are discussed in the paper that follows:
 - Can a student get an appropriate range of experience in general practice?
 - What if have no spare consulting rooms?
 - Can two practices share a student?
 - What teaching will I be expected to do?
 - Can I choose which student comes?
 - How is the student indemnified?
 - Where will the student live and who provides accommodation?
 - Who pays student expenses?
- Each of these questions is discussed in the main text below. **Since every medical school is unique the answers will differ** and so will have to be answered in relation to the particular medical programme.
- **In conclusion, the research shows that by setting up appropriate systems, sessional and extended placements can prove stimulating to the GP and**

satisfying to the student and practice without an excessive increase in workload or decrease in income.

- The need for appropriate systems cannot be overstated. With careful and informed planning the new forms of placement may turn out to be an attractive and stimulating part of the GP's workload and not an additional burden.

Introduction

This document is based on a review of international literature on practice based training and on empirical research conducted by CEPHRIS in the Illawarra, Shoalhaven, Riverina and Greater Green Triangle designed to identify those factors which GPs should consider in deciding whether to offer placements to medical students from University Medical Schools, whether to take GP registrars and whether to take both students and registrars for short and long term placements.

It was commissioned by Coast City Country Training Ltd, the agency responsible for vocational training of GPs in the Illawarra, Shoalhaven, Riverina and the ACT.

The question is important since the success of placements is central to medical school curricula and the pattern of placements differs considerably between medical schools.

The purpose of the document is to address key questions likely to be asked by practices and to provide research findings to inform GP thinking. Each practice is unique and so the considerations will differ accordingly. However, practices will need to address similar issues and this document is designed to assist in that process.

Each medical school has its own curriculum and pattern of clinical placements. This document cannot answer all questions which GPs might raise but it does identify those that have arisen in interviews with a wide range of GPs and addresses many of the issues that they will want to address. It is designed in a question and answer format. Readers may wish to go direct to the questions of immediate interest.

Acknowledgements

I would like to acknowledge the GPs, Practice Managers, Nurses and Academics who answered the questions on which this research is based.

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1. New Medical Schools and patterns of placements

Why do GPs take medical students for clinical placements?

An extensive literature review shows that GPs take students because they find it intrinsically satisfying and challenging. This is particularly so for longer placements. GPs report that they want to contribute to the profession and the community and that taking students adds variety to their working lives, particularly in a fee-for-service setting.

Why are some Universities establishing new medical schools and others increasing the number of places for medical students?

In the mid 1990s following various analyses of medical manpower needs the Australian Government decided to reduce the number of medical students place. In due course this led to a reduction in the supply of doctors and increased reliance on attracting overseas trained doctors. In the last three years there have been calls for new medical schools particularly in regional areas since the literature suggests that such schools are more likely to increase the supply of doctors willing and prepared to work in regional and rural communities. The Australian Government has approved the development of a large number of new medical schools which are at various stages of approval by the Australian Medical Council. For example the new University of Wollongong Medical School plans to take its first cohort of students in 2007.

In what ways are the new medical schools likely to be different to the established medical schools?

The new medical schools have distinctive approaches to providing medical training in the classroom and in the clinical setting. They can choose from the best international approaches to medical education in Australia and around the world and are developing clinical placements in non-traditional settings such as General Practice and Community Health.

It is this new approach to clinical placements that has the most immediate impact on GPs. In short, medical schools are developing programs in which students have different types of placements with GPs which have implications for GPs, their patients and their practices.

There are three main types of placements being used by medical schools in Australia at the moment:

- Short familiarisation placements
- Sessional placements, and
- Extended placements

They have different implications for the GP, patients and practices.

Familiarisation placements

These are the placements which have been used for many years by established medical schools whose extended clinical placements are located in hospitals. This is a pattern of placement experienced in their own training by most practising GPs. A student comes to the practice for about two weeks and most of their time is spent observing the work of GPs and other staff and talking to patients.

The GPs who took part in this research commented that they provided these placements for altruistic reasons, they enjoyed having students in the practice and they wanted to make a contribution to the profession and the community. The down side was that the students were only around for a short period of time and were unable to undertake work which generated fee income. This resulted in slower and longer consultations for the GPs being observed and either reduced fee income or lengthened the working day. GPs reported that they liked having students around but that it was physically tiring and that it was as well that placements were for limited duration.

There is every reason to believe that these “familiarisation” placements will continue to be used by established medical schools which provide most of their clinical placements in teaching hospitals. It is likely that GPs will be asked to take medical students from both established and new schools, that requests for placements will increase, and the pattern of placements be more varied.

Sessional Placements

Sessional placements take place where a GP is asked to take one or more medical students for one session per month or per fortnight over an extended period of time, for instance 12 or 18 months.

Often two students will attend sessional placements since it is a more cost effective arrangement and the medical school has to recruit fewer practices to meet demand.

This has some obvious advantages for the GP, the medical school and the student. The GP is able to get to know the student over a longer period of time and the impact on the practice is less intense than in the familiarisation model.

The medical school is able to integrate the experiences within the practice with the taught curriculum. It often does this by asking the practice to book in patients with particular conditions when the student is present. For instance, the practice might be asked to book in patients who have Asthma for a particular session since this fits with the disease process being studied by students that week or month. This enables a close link to be established between theory and practice but it means that the practice must be aware of the medical school curriculum and active in booking in patients with appropriate conditions. This type of placement may prove more satisfying for the GP since the experiences they are able to offer are immediately appropriate and timely for the student.

Extended placements

The placement of one or more students is a new development in Australia and overseas and raises a series of questions, particularly in a fee-for-service environment such as general practice. These placements largely replace the long hospital placements used by the established medical schools and experienced by many practising GP when they were medical students.

Typically, two third or fourth year students will be placed in a practice for up to 12 months and will undertake about two clinical sessions per week. The GP takes responsibility for their clinical work and a series of models have been developed in which they see patients alone for part of the consultation and the GP is present for the second part to ensure that the consultation is properly concluded and to take responsibility for the actions that follow. The students may undertake a series of tasks such as taking histories, taking part in health assessments and care planning and other activities which may generate income for the practice. The GP takes responsibility for the consultation and fees are charged in the normal way.

It is these placements which raise most questions for GPs since they are new and few GPs have direct experience of how they work in practice.

The research has shown that GPs have a consistent set of questions to address when deciding whether to accept medical students on placements within their practices. The answers are likely to differ depending on the type of placement. This paper is structured by type of placement and finishes with some questions on the role of GP registrars.

The questions identified in the research are as follows:

What will the student(s) do?

Will taking medical students assist patient care?

Will taking medical students assist GP workload?

What impact will taking medical students have on practice income?

What will it cost the practice?

What resources will be made available for practices?

What sorts of agreements do practices make with the sending medical schools?

2. Placement types and General Practice

Familiarisation placements

What does the student(s) do?

In this model student usually observes GPs and other clinicians in a range of practice activities. They may also undertake some local visits to as better to understand the context in which the practice operates and the needs of local residents and patients. The placements are usually too short to allow the student to develop their consultation skills since the GP needs to be confident of the student's skills and this cannot usually be established in a couple of weeks. A few GPs report throwing the student into the deep end by asking the student to conduct the consultation but there were no reports of this happening in a familiarisation placement without the GP being present.

Will taking medical students assist patient care?

There is little evidence that taking students on short placements assists with patient care. It may be that in some cases the explanations given to students when the patient is present is of interest or value to the patient but the main beneficiary is the student.

Will taking medical students assist GP workload?

The most common report is that taking students in this model increases the GP workload, lengthens consultations and is tiring to GPs given the intensity and the wish to provide a good range of experience in a limited time.

What impact will taking medical students have on practice income?

Practices reported that taking students in this model tended to increase consultation time by about 20% and to reduce practice income for the short period of the placement.

What will it cost the practice?

There was little evidence of a cost to the practice other than temporary reduction in fee income.

What resources will be made available for practices?

This varies according to the University sending the student. Some Universities will send information about the structure of the medical curriculum and some will have agreed learning objectives for the student during the placement. Some students will arrive with little in the way of briefing or learning objectives. The practice can claim \$100 per session where the GP is teaching the student. In this model the student is usually observing the GP and discussing patient care. There can be a maximum of 10 sessions claimed in any week.

What sorts of agreements do practices make with the sending medical schools?

Under this model the agreements are usually simple and often relate to a single placement. Universities will approach practices that have taken students previously since they have to provide these placements for each medical student. Rural practices will be of considerable interest as they enable students to obtain important learning experiences.

Sessional placements

What will the student(s) do?

Under the supervision of the GP, the student may take a history, conduct an examination, discuss the disease process, propose a diagnosis or treatment or undertake similar activities appropriate to their skills and experience. The essence of the placement is to relate classroom teaching to clinical practice. They may see a group of patients with common conditions during the session and so the GP can be clearer about the extent of their relevant knowledge.

Will taking medical students assist patient care?

Sessional placements are often an alternative to familiarisation placements discussed above. They usually take place once a month over an extended period of time, often 12 or 18 months in the early part of the medical degree programme and so the GP is able to establish a sense of the student's skills and to develop a relationship of trust. The use of such placements to focus on particular conditions linked to the teaching curriculum enables a review of the needs of particular patients and so may well benefit those patients who attend the particular sessions.

Will taking medical students assist GP workload?

Under this model there is no evidence that GP workload will be reduced and the particular sessions will have to be planned in advance so that the appropriate patients are booked in. However the sessions are relatively infrequent, take place over an extended period and so the impact is likely to be less than the more intensive familiarisation model even though it takes place over an extended period.

What impact will taking medical students have on practice income?

Practices will be able to claim a sessional payment of \$100 under the PIP arrangements. This supplements the fees charged to patients for the session and recognises the additional cost of teaching.

It is likely that these sessions will have a higher proportion of long consultations and some of the activity may relate to chargeable PIP or chronic disease items.

What will it cost the practice?

The GP will have to participate in some briefing arrangements and become familiar with key elements of the relevant medical curriculum. He or she will need to be involved in the planning of each session so that appropriate patients are booked in and the receptionist will need to contact patients and make the appropriate appointments or direct patients to the appropriate session. It will usually be possible to use the consulting room that the GP would have used for a normal session.

What resources will be made available for practices?

There is a closer connection with the medical school curriculum in this model and so the medical school needs to provide clear information about the conditions the

students are studying and what sorts of patients should be invited to the session. Practices would expect to be clear about the learning objectives for each session and about the GP's role in assisting students to learn.

GPs taking students for sessional placements will expect the medical school to provide various forms of support including training in teaching skills, the provision of teaching and other materials, the appointment of named faculty members of the medical school to assist in solving problems such as those associated with poor student progress and learning difficulties.

What sorts of agreements do practices make with the sending medical schools?

An agreement will be needed for the duration of the sessional placements which may be 12 or 18 months. Medical schools will need sessional placements for each intake of students and so may seek to make agreements for more than one intake. Agreements usually take the form of an exchange of letters rather than a formal contract.

Extended placements

What will the student(s) do?

Students on extended placements will be able to contribute to patient care in a number of ways. They will be able to make observations, collect histories, research conditions and other medical information and talk to patients about their conditions. They will be able to take part in screening, health prevention and promotion activities, provide health information, undertake examinations and recommend diagnoses, collect information and support processes of health assessments, care planning and case conferencing? They may be able to spend longer talking to patients than the GP is able to in normal circumstances.

Will taking medical students assist patient care?

Students on extended placements are able to undertake a wider range of activities than those on familiarisation or sessional placements because they are more experienced, there is more time and that time is structured around the clinical consultation process.

Some research supports the view that patients welcome students since their presence enables the patient to get a clearer explanation of their problems and the best options for treatments. Other findings suggest that some patients are not willing to consent to intimate or similar examinations by students. Patients will need to consent to seeing a student and this can take place at the front desk. Unlike GP Registrars, who are qualified medical practitioners, students cannot act independently.

Taking students may have a number of indirect benefits for patient care since they bring up to date knowledge and a questioning approach to medical practice, they provide a facility for researching issues and obtaining further information for the

practice and they may be able to spend more time with patients than the GP who faces business pressures and heavy clinical workloads.

Will taking medical students assist GP workload?

Taking medical students for extended placements will increase the variety of work for many GPs which will be a welcome development according to GPs interviewed. By using one of the parallel consulting or similar models and by using students to assist with the preparation of chronic disease and similar items GPs may be able to manage an increased workload during the period of the extended placement.

What impact will taking medical students have on practice income?

GPs can claim PIP payments which are currently \$100 per session for time spent supervising students. This can include time spent planning a student's programme.

Evidence from the research suggests that students become an asset to the practice after a few months and that where a practice has appropriate systems in place the student is able to contribute to the Enhanced Primary Care and Practice Incentive Programme items, and that using one of the parallel consulting models (see page X) the GP can claim for the same number of consultations as in an ordinary (non-student) session.

What will it cost the practice?

Taking one or more medical students has not generally been a money spinner for the practice but there is evidence from the Flinders medical school that it need not become a drain on resources if appropriate patterns of teaching and supervision are employed.

A practice may face four sorts of costs in taking medical students: set up costs, overhead costs, opportunity costs and costs of teaching. These costs need to be examined for each practice and each set of placements since every case is different.

Set up costs include those costs that will be necessary as a one-off cost to enable the placement to go ahead. In some cases these have included finding space in the practice for a student, setting up telephone or computer access, costs associated with security and access to the building such as keys etc. They may also include costs of training and briefing the GP and other practice staff on the purpose and processes associated with the placement.

Overhead costs include those costs that are incurred due to the presence of a student. These might include telephone, computer access, printing and similar costs.

Opportunity costs include those activities which the practice cannot pursue because it is taking medical student placements. If space is at a premium in the practice it may mean that a consulting room is not available for one or more sessions for practice staff or other clinicians.

Direct costs: Taking students for placements is going to require some degree of preparation and this will vary depending on the level of support provided by the University. It is as well to be aware of the degree of support and the amount of necessary reading and any associated paperwork required by the University.

What resources will be made available for practices?

Practices can claim a teaching fee through the MBS system which is currently \$100 per session.

Capital grants have been made available by some Universities to practices to provide necessary facilities such as space, computer access, and other resources needed for teaching.

What sorts of agreements do practices make with the sending medical schools?

Some Universities and practices wishing to avoid the need for legal contracts have deemed that a short letter of agreement including the following items is sufficient:

- Number of students
- Name of supervisor/s
- Arrangements for space and facilities e.g. phone, computer etc
- Time span of agreement (e.g.5 years/intakes)
- Capital payments if any, to be made to practices
- Form of supervision/experience to be provided by the GP
- Support to be provided by the University
- Names and arrangements for addressing any problems which might arise

3. GP Registrars

GP registrars are qualified doctors who work under supervision as they study for their RACGP fellowship and the status of vocational trained GP. They are able to bill for their services and there is a substantial support system of medical educators provided by the local training agency who support the registrar and the GP supervisor. GPs are used to this system which has been in operation for many years in various formats.

There are two main reasons why GPs take GP registrars: these concern the need in the context of manpower shortages to increase the number of GPs who wish to practice locally; and to increase the number of “hands” in practices which are often stretched in meeting the clinical workload. It is often reported that while registrars may not be as efficient as experienced GPs, they are not a financial burden on the practice and they provide increased flexibility for holidays and periods of peak demand. Some practice such as Aboriginal Medical Services may offer the Registrar the opportunity to gain important specialist experience and these opportunities may be very popular with students.

The number of training places for GP registrars has been tightly controlled by the Australian Government and some practices who have wanted to employ a Registrar have found that they have to wait or that there is no immediate possibility of employing a Registrar.

Depending on the stage of a Registrar’s training, there will be requirements to attend training out of the practice to spend time preparing for exams.

Can GP Registrars support students?

A series of interviews was conducted to identify actual and potential roles for GP Registrars (GPRS) in the teaching and supervision of medical students. In each of the examples the formal supervisor of a medical student in a GP practice was a GP but GPRs played a role within a model of whole practice supervision or as a mentor. The GPRs were usually closer in age and educational experience to the student which was an advantage in developing a constructive relationship and a positive experience.

Overall there was limited evidence of the systematic involvement of GP registrars in the teaching and training of medical students but a number of instructive examples emerged:

- A GPR acted on behalf of a GP who had agreed to train and was unexpectedly absent.
- Whole practices effectively took on the supervision of John Flynn scholars.
- A GPR mentored a local rural medical student in first year of medical school including short practice visits during vacations.

- A Training agency encouraged GPRs to reflect on teaching skills they had developed in non-medical and volunteer settings.
- An academic Department of General Practice encouraged GPRs to act as tutors for University based medical school seminars and structured case studies.

A GPR as supervisor.

The GPR contacted the sending University and the local GP training agency for support and responded positively. The 3rd year graduate student took histories, made observations, and conducted the first part of consultations with appropriate and consenting patients. The GPR double checked and observed the student and in 2-3 weeks was confident of the student's knowledge and skills. All decisions and prescriptions were signed off by the GPR and this constituted an additional but interesting part of the workload.

The presence of a male student may have inhibited anxious and young patients from raising difficult issues and he was excluded from some consultations and physical examinations. This needs to be considered when planning for student placements.

The student required 30 minutes for a history or consultation and this impacted on the GPR's workload who was the doctor with the longest average consultation times in the practice.

The time commitment for teaching impacted on practice income but the experience was worthwhile for the GPR who had a strong attachment to rural medicine, was keen to encourage students to join the rural GP workforce, and was interested in developing teaching skills.

As a rural practitioner, the GPR held a hospital appointment and so the student accompanied her to the hospital and obtained important experience outside the practice which is more easily available in rural settings.

GPRs need to examine the financial implications in taking on practice based teaching roles since they may reduce fee income due to slowing the consultation rate. In this case the GPR received no financial compensation for the additional workload but was still positive about the teaching experience.

Whole practice supervision

An interesting model emerged where the whole practice effectively took on the supervision of medical students. The formal arrangement was that a GP was the supervisor but informally the student observed all areas of the practice including medical and non medical staff. The setting was a rural one where John Flynn Scholars attend the practice for 8 weeks split over four years and so good working relationships could be built and developed over an extended period.

This model might be examined for placements where the medical student visits the practice for an extended period and where the burden on particular GPs or GPRs might be regarded as excessive if supervision is restricted to one person.

Interesting Variations

In one instance a rural division paid an honorarium to a GPR to mentor a local resident in their first year as a medical student at a metropolitan university. The mentorship involved spending two weeks in the practice in the first year vacations and being in contact by email and phone to support the student when they were at University. The mentorship ended after 12 months. The student spent their time in the practice taking medical histories and observing.

The GPR felt that she was able to advocate for rural general practice in an environment where the medical school was focussed on specialist and hospital medicine. She also reported encouraging the student in preparation for University exams. This experience suggests that there is considerable scope for practices, training agencies, Divisions of General Practice and perhaps schools to work collaboratively or to extend existing collaborations to provide broader exposure to general practice.

Encouraging GPRs to develop teaching skills

One training agency had developed a programme to encourage GPRs to consider teaching and to review their existing teaching skills acquired largely in non medical and volunteer environments. They were working with a University Medical School department of general practice who were keen to co-opt GPRs to teach within University settings.

GPRs Tutoring in Medical School settings

GPRs reported being asked to tutor in University settings by leading small group case studies or problem based learning classes as part time of casual tutors.

GPRs training to teach alongside GPs

A number of medical schools are offering training in teaching skills to GPs and it may be worthwhile to open these sessions to GPRs who are increasingly taking part in and showing an interest in teaching medical students.

What does it mean to take a GP registrar AND medical students

There may be some benefits in taking a GP registrars and medical students since the registrar may be able to contribute to the education of the medical students. Students elsewhere have reported that it is good to have a registrar who is studying and preparing for exams in the practice.

GPs interviewed in practices which took Registrars and students reported that they had separate supervision arrangements for GP Registrars and medical students.

Registrars are not homogenous; they have different levels of experience as evidenced by the rural hospital appointment described above. Likewise, medical students from different programmes and at different levels in their programmes will vary considerably in skills and experience. One model will not fit all situations. A basic term GPR may be an appropriate teacher due to experience and skills and a subsequent term GPR may not be an appropriate teacher.

In some cases GPRs will have teaching interests and experience and teaching practices or Universities might actively seek those Registrars and encourage those skills.

While University and AMC requirements may preclude GPRs from taking on formal supervisory appointments at this stage, they will be involved in teaching in informal roles and will need to be prepared for teaching as GPs when they obtain their fellowship. It may be worth considering how such preparation can take place and whether it can be integrated with current training being offered to GPs.

4. Frequently asked questions

Can a student get an appropriate range of experience in a general practice?

International research shows that students who undertake their clinical training in general practice settings score as or more highly than their hospital trained peers in well designed and supported programmes.

What if I have no spare consulting rooms?

This is a common problem. The models discussed in this paper have different requirements. It is usually assumed that in “familiarisation” and sessional placements” the student and GP will use a single consulting room. In extended placements two rooms might be used if a form of parallel consulting is used. Those rooms are only needed for the session in question.

Can two practices share a student?

There are a number of instances where two practices wish to work together to take a student. This arrangement is common but needs to be worked out on a case by case basis.

How much formal teaching/tutoring will I be expected to do?

In some comparable programmes the GP supervisor conducts a weekly tutorial for an hour and materials and case studies are provided by the University in extended placements. However the point of the placement is that it is to supplement the formal teaching which takes place in the medical school.

How is the student insured/indemnified?

This needs to be explicitly agreed with the medical school. Medical students are the responsibility of the medical school. However, the student is working in the practice and so GPs are likely to feel responsible even if the formal responsibility lies elsewhere.

Do I have any choice over which student comes to my practice?

This is an issue for negotiation with the particular medical school.

Where will the student live and who will find accommodation?

This is a matter for the university/student. It will be particularly important to resolve it in rural and remote settings where accommodation is in short supply and transport difficult.

Who pays student expenses?

This is an issue for negotiation in advance with the particular medical school.

Are there other roles which GPs can take in the new medical schools?

Appropriately qualified GPs can apply for roles as University teachers, demonstrators, tutors, designers and developers of course materials amongst others. Some of these roles are advertised in the press. Interested GPs would be well advised to contact their local medical school.

It might be expected that more of these roles will become available as more medical schools are approved and student places become available.

Is it legitimate to charge a consultation to Medicare which is conducted for teaching purposes?

The consultation must be clinically necessary as recognised by peers and the service billed must be based on time and complexity as in the Medicare Benefits Schedule.

5. How do parallel consulting models work?

Model A

Parallel consulting models are designed to address two problems. Students are not able to work as quickly as experienced GPs and in the Australian system a GP must see a patient if a fee is to be charged.

If we assume that the GP sees 4 patients per hour at 15 minute intervals and the student sees 2 patients per hour.

One student model

	GP room	Student room
9.00	Patient A	Patient B + student
9.15		Patient B + student + GP
9.30	Patient C	Patient D + student
9.45		Patient D + student + GP

This model allows the GP to see the same number of patients and charge the same fees. It can be modified such that an inexperienced student might only see one patient in an hour and the GP might see three or four others and then join the students for a joint consultation. It assumes that there are two consulting rooms available one for the GP and another for the student and that the GP moves to the student's room for the joint consultation/teaching session shown above at 9.15 and at 9.45.

When the GP and the student are seeing the patient together, the GP will combine consultation and teaching roles and the student may present what he/she has learnt in the first part of the consultation. Clearly the consultation takes precedence over the teaching and the GP may need to focus on a small number of learning points. Further consideration of the consultation may be raised at the end of the session or in a weekly tutorial.

The patient is usually asked if they consent to seeing a student and the GP doctor when they are offered the appointment and are free to refuse.

A similar model can work if the GP sees six patients per hour. The model depends on good time keeping on the part of the GP in particular. The same patient consent requirements apply. Depending on the student's experience the GP might instruct them to undertake a range of tasks which might include taking a history, looking at and analysing patient information such as pathology or imaging data, talking to the patient about their condition or their treatment.

Model B

Two student model

	Student A		Student B	
9.00	Patient A	GP		Patient B
9.10			GP	
9.20	Patient C	GP		Patient D
9.30			GP	
9.40	Patient E	GP		Patient F
9.50			GP	

Model B assumes that the practice has two students being supervised by the same GP.

Patients are booked to students in 20 minute intervals. The GP moves between the student's rooms supervising and confirming student decisions. This model requires two rooms, one for each student. The GP does not require a room since he/she is moving between the two rooms. This model allows six patients to be seen in an hour. The consulting interval can be changed to meet the needs and experience of the students.

Interestingly, GPs report that this is a stimulating model in practice.

Summary of issues for GPs considering taking medical students on clinical placements within their practices

Placement model	Familiarisation	Sessional	Extended
Type Medical School	Established	New	New
Typical duration	2 weeks	1 session/month for 12/18 months	2 sessions per week for 12/18 months
Typical activity	Observation	Condition specific session	Supervised consultations
Stage of course	Varies	Year 1/2	Year 3/4
Impact – intensity/duration	Intense + short	Low intensity + extended	Med. Intensity + extended
Impact on practice including costs	Significant and short Slows consultation	Low intensity, extended period Each session requires planning Arranging/inviting patients	Medium intensity + extended Students may require space other than consulting room for session, computer/web/phone access etc.
-Set up	Exchange of letters	GP briefing/training and practice manager (PM) briefing re. Fit of placements in curriculum, fee and MBS/PIP item charging, student needs, relationships with medical school	GP briefing/training re. Supervisory/teaching role & pattern of consultations, GP/PM briefing re. Fee and MBS/PIP item charging, student needs, relationships with medical school
-Continuing	No	May require long consultations, could make use of chronic disease and similar item structure. Practice admin. Booking patients etc.	Direct costs of students' use of facilities. Contact with medical school – GP and PM.
Key issues for agreement	Dates of placement Student experience Any learning objectives Liability agreement	Dates of placements Student experience Training briefing arrangements and funding for GPs/PMs. Teaching/supervision role required. Sessional learning objectives Liability agreement Key contacts re student progress Role in examination/assessment, if	Dates of placements Student experience Training briefing arrangements and funding for GPs/PMs. Teaching/supervision role required. Sessional learning objectives Student liability agreement Responsibility for capital, continuing and other costs.

		any?	Key Med School contacts re. student progress Role in examination/assessment, if any?
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