Blended Learning for teaching General Practice, the Monash experience

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Blended learning

Blended learning is learning that is facilitated by the effective combination of different modes of delivery, models of teaching and styles of learning, and is based on transparent communication amongst all parties involved with a course.

2004 Heinze and Procter
Monash DGP

- Monash approach to blended learning
- Monash DGP approach to curriculum development
- Monash approach to faculty development
- Monash DGP rotation experience to date
- Revisions to the process
- Pros and cons
- Special challenges of being Monash
- Per ardua ad astra
Blended learning; many already do this
Approaches to curriculum design 2009

- High student dissatisfaction with old course of lectures
- Stakeholder analysis of what DGP should teach about general practice
- Curricular analysis of what we should teach to the Themes (I to IV)
- Mapping exercise
- Analysis of what the community affiliate tutors can teach
- Evaluation of first teaching 2010
- Revision of teaching 2011 with move to GP focus
- Assessment challenges
2009

- In house review
- Nine weeks available for 2010 teaching
- Divided into nine themed weeks, slimmed down lecture and introduce role plays ++++
- Specialised teachers imported into DGP programme, e.g. Dermatologists, ENT surgeons, Palliative care specialists, Emergency medicine specialists
- 1.5 days in community based environments, some specialised teaching too with Dermatology and Palliative Care
- Review at end of 2010, by tutors and students, favourable evaluations but some room for improvement
2010

- Danielle Mazza new Head of Department
- Close inspection of message to students:
  - Change from the “best evidence based care available in the health service” (this includes the views and perspectives of secondary and tertiary care) to the best evidence based care available in family medicine settings”.
  - Focus moved from secondary care specialities to primary care speciality and what good family medicine practice would offer
  - Decision to reflect gold standard, not necessarily what happens in the real world of busy GPs, one of whose many tasks is teaching students
  - Open up to more themes to showcase diversity of what constitutes daily practice
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Overview of teaching:

- Every Monday and Wednesday dedicated teaching Nottinghill
- Senior GP tutors deliver lectures and lead small group activities (role plays, simulated patient encounters, consulting skills sessions, and PACES).
- Proportion of didactic to small groups 50:50 in 2011.
- Every Tuesday, Thursday and Friday students attend community placements to provide:
  - 1 day with main GP tutor
  - 2 x 0.5 days with other GP tutor(s)
  - 2 sessions at ENT, 2 sessions at dermatology, 2 sessions at ophthalmology, none now at palliative care
  - 1 session at CDDHV, 1-2 at alcohol and other drug clinics, 1-2 at out of hours service, 1-2 at locum service, 1 session doing formative OSCE
  - Close to 1 session per week in self-study.
Most highly evaluated:

- Clinical simulations/simulated patients
- Role plays
Also highly commended: practice OSCE
Most important innovation in 2011?
Lectures and small group activities 2011

- Range is 0 to 5
- Lectures range from 2.5 to 4.5 /5
- Most are 3.5 to 4.0
- Prof John gets 4.5
- Small groups get 4 to 4.8
- Poorly evaluated are:
  - Motivational interviewing
  - Mental health and difficult consultations and somatisation lectures but not practical sessions
  - Some musculoskeletal lectures but again not practical stuff
  - Disability health day
Student evaluations:
Planned developments for 2012

Campus Teaching

- Format teaching further room for small group activities in 2012
- Further room for expansion of PACES
- Moving sessions to be web based or Moodle or Equella.

Community Teaching

- Role of hub and spoke approach to develop closer ties with department
- Further recruitment of additional teaching practices, competing with the Melbourne double year
- Further recruitment of additional placements, more emergency cover or out of hours sessions, anything really
- TOTR and clinical supervision training
Additional responsibilities:

- Representative committees for the overall teaching (years 1, or 2, or 3+4+5)
- Theme (I to IV) committees
- Assessment loads:
  - Formative:
    - 4 x different EMQ papers to whole cohort every quarter
    - Formative OSCE at end of each rotation
  - Formative feedback from small group tutor
  - Summative (25% of overall year 4 MBBS) in final examination
  - Summative: chronic disease project and referral letter
Challenges to this format

- Inadequate placement numbers
- Variation in maturity and experience of students (1 through to 4)
- High dependence on experienced GP lecturers for positive role modelling and case examples
- Moving staff to clinical teaching role or teaching focussed ones
- Obsolescence of almost all GP lecturers, exactly profiling Australian general practice profile
- High cost of staffing the in-house teaching
- Does it really matter in the end?
- Biggest challenge is the Monash conundrum
Monash conundrum:

- Teaching exists in the medical curriculum across many sites and each has operates a different model

- At last count there was:
  - Clayton: Nottinghill (260 students)
  - NVRMEN (60), which could be subdivided into:
    - Bendigo and
    - Mildura
  - Graduate school (Gippsland 40), which could be subdivided into:
    - East Gippsland
    - West/North Gippsland
  - Clayton: Peninsula cohort (30), ex-GMS, now central
  - Malaysia: Monash private medical school (110) between KL and Johor Bahru
  - In total = 500 students
Conundrum 1: teaching

- What constitutes general practice teaching and what should be in our curriculum?
- Is there a best way of teaching general practice medicine?
- What should be the role of central DGP in curriculum design? At the moment though teaching situated in GP settings and run by GPs in the non Clayton sites it is not directly influenced by DGP but is almost independent.
- GP teaching is situated in several different schools (Central, SPHC, Rural and NVRMEN).
- What resources should be shared or at least commonly held, e.g. PACES and mock OSCE and EMQ formative papers.
- Who really knows the complete network?
Conundrum 2: assessment

- How can we craft mutually agreeable and similar assessment items?
- How can we share the load of writing assessment materials?
- How can we standardise examinees' expectations?
- How can we standardise formative or hurdle tasks?
- How can we administer the same examination simultaneously across 5 sites (central, Gippsland, NVRMEN, Peninsula)
Improving networking

- Build Monash GP identity from within School by:
  - Regular face to face meetings:
    - 2011 Malaysia
    - 2012 Bendigo
    - 2013 GMS
  - Sharing as much as possible teaching materials
  - Sharing as much as possible formative assessment materials
  - Every site contributing to assessment through:
    - Blueprinting
    - Writing
    - Critiquing
    - Reviewing
    - Ebelling
    - Standardised performance
    - Evaluation, and audit
  - Regular conferencing and building virtual web
Monash DGP

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- We could try to offer a longitudinal experience in year 4C Clayton
- Resources changed through new orientation
- Can we support community tutors as much as they would need?
- Pilot scheme for 2014
- Who dares wins
- Who cares gets all the work and pains!!!
- Can we afford this and would the other disciplines support it?
- Faculty would welcome the initiative but what should DGP offer now?
- Take the lead and spend valuable resources in this initiative?
References
