Academic GPs combine clinical work with research and teaching

Academic general practitioners enjoy the contrast between the three main components of their career: clinical practice, research and teaching.

A typical week for Associate Professor Marie Pirotta, from the department of general practice at the University of Melbourne, could include teaching medical students and GP registrars, consulting in a suburban general practice, conducting research on the use of complementary medicines in primary care, or advising the Therapeutic Goods Administration on complementary medicines.

Professor Pirotta loves the variety of her work and that her various roles operate on different schedules. For instance, she switches between the 15-minute patient consultations of general practice to the multiyear time scale of large research projects.

Being an academic GP has also allowed her to develop a wide range of additional skills, such as project design, statistical analysis and qualitative research techniques.

Most importantly, she has had the chance to have an impact on patient care beyond the consulting room. For instance, her PhD research, which she completed in 2005, found that probiotics were ineffective against postantibiotic vulvovaginitis, contrary to popular belief.

“I’ve had the chance to develop new knowledge and evidence for or against treatments that will directly help other GPs and their patients”, she says.

Professor Mark Harris, professor of general practice at the University of NSW, says academic general practice can be particularly satisfying when research is taken up in practice.

“We’ve done a lot of work showing that having an organised system of care for people with diabetes is associated with better disease control”, he says. “Seeing that translated into guidelines and policies, and linked to practice incentive payments, is very rewarding.”

Professor Harris says the career also offers considerable flexibility, with doctors able to change their mix of clinical, research and teaching responsibilities over time. There are also plenty of part-time academic roles, and many female academics. Professor Harris emphasises there is also “not a huge glass ceiling” for female academic GPs interested in becoming professors of general practice.

The misconceptions

Academic GPs say there is sometimes a misconception that all the exciting or important research is conducted in the non-GP specialties.

However, Professor Harris says general practice research is crucial because the patient population is different to the hospital population.

“Things that might seem like a good idea in hospitals, such as a screening tool, may not be appropriate in general practice”, he says.

Professor Pirotta agrees, and gives the example of depression research.

“If all the research is done in specialist or tertiary care patients who are more likely to be severely depressed, will that apply in general practice where most depressed patients are at the mild-to-moderate end?”

Professor Harris says general practice...
The vast majority of patient consults happen in primary care, but the vast majority of research doesn’t

continued from page C1

The big issues
Professor Pirotta says there is a real need for increased research capacity in general practice. “GPs need to set the research agenda for our own discipline … the vast majority of patient consults happen in primary care, but the vast majority of research doesn’t.”

She says additional funding is needed to encourage more GPs to add an academic component to their practice, and to establish a national general practice clinical trials network. In terms of this coordination, Professor Pirotta says general practice research is trailing behind other specialties, which makes it more challenging for GP academics to secure researchers are particularly well placed to study non-pharmacological interventions, such as cognitive behaviour therapy for simple depression.

Training as an academic GP
General practice registrars can complete an academic post as part of the Australian General Practice Training program. The 12-month, salaried position allows registrars to develop skills in research and teaching (see Registrar Q+A, right). More information is available at: www.agpt.com.au/TrainingPosts/AcademicPosts/

Other useful qualifications include a Masters of Public Health, another Masters degree with a research component, or a PhD.

The inside story
What are the insider tips to kick start your career in academic general practice? Professors Pirotta and Harris suggest that anyone considering this career needs to find a mentor.

Professor Harris says it is often as simple as emailing an academic GP at a university department of general practice and expressing your interest. “Most senior academic GPs are delighted to help mentor younger GPs who are interested in academic work”, he says. This is especially true because the increase in medical schools means there’s a need for more academic GPs.

Professor Harris also advises budding academic GPs to introduce an academic component to their practice early on, although he says there is no need to get too ambitious. For example, registrars could get involved in a research network or pursue part-time lecturing rather than attempting to start their own research project. “Clinical experience counts in GP academia, so you don’t have to go straight from being a registrar to being an academic”, he says.

What advice would you have for doctors interested in this career?
For registrars, I would strongly recommend the academic post. It gives you a good taste of academic general practice, but it’s also realistic — you’re not expected to churn out papers. It gives you a foundation in research and teaching and allows you to explore different types of research. GPs with their fellowship could ask their nearest university department of general practice for opportunities to assist with a research project. There is a lot of clinically relevant primary care research being done, so chances are there will be a project that you’re interested in.

What do you enjoy about being an academic GP?
I like that I have to think in different ways when I’m a clinician, a researcher or a teacher, which helps me stay fresh and not get burnt out. The three jobs complement each other. For instance, when I’m teaching students, being able to talk about the primary care research I’m doing makes it more interesting and up to date.

What challenges have you faced?
Time management is an ongoing challenge. The ethics process has also been frustrating, but in a good way, because it has helped me to understand my own research.

Could you describe your main research projects?
My research has looked at young men’s attitudes and behaviour towards screening for chlamydia. We recognise that it is important to test and treat young people for chlamydia in general practice, but we are seeing that this is only being done by young women, as it has easily been linked with Pap smears. I wanted to identify the barriers and facilitators for young men. I am hoping that this could inform primary care guidelines and protocols for testing young men for chlamydia.
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Medical mentor

Professor Mark Nelson reflects on a career in academic general practice

Professor Mark Nelson is chair of the Discipline of General Practice and senior research fellow at the Menzies Research Institute, both at the University of Tasmania. He is part of a team that recently secured US$50 million in research funding from the US National Institutes of Health. Professor Nelson is also an honorary associate at Monash University and a GP in Lindisfarne, Tasmania.

“I was always pretty undecided about what I was going to do when I left school. I come from a rural background where no member of my family had been to university. I started studying science but, after a month, I realised I didn’t like it, so took a year off and worked as a labourer. I was very glad to be accepted into undergrad medicine at Monash University the next year.

After a few years of postgrad clinical work, I travelled around the world for a year with my then girlfriend, who is now my wife. When I returned I worked in Australia’s first private emergency department, in Melbourne. I enjoyed working there for 6 or 7 years, but there were slow times in the emergency department and I became interested in further study. I enrolled in a graduate diploma in family medicine through Monash and that’s what got me interested in general practice.

I started working in general practice part-time while continuing my graduate diploma. I converted that into a masters, which I really enjoyed and completed in pretty much record time. I was approached by [Professor] Chris Reid, who was looking for a GP coordinator for the 2nd Australian National Blood Pressure Study. I joined that study, and decided to do a PhD within that program.

The national study included a run-in phase where people gradually came off their blood pressure medicine until their blood pressure returned to a high level and they could enter the study. But we found that the blood pressure of 17% of people who stopped their medication never returned to the high levels. For my PhD I tried to identify predictors for this group of people. I used to call it my John West study after those old tuna advertisements, because I was interested in the ones that got rejected. There’s a lot of work on choosing who we can medicate but very little on ‘unmedication’—determining who might be able to stop their medication.

I am a principal investigator on ASPREE, the ASpirin in Reducing Events in the Elderly study. This is a huge randomised controlled trial, which looks at the risks and benefits of aspirin in people aged 70 years and over. The study expands beyond the usual associations with cardiovascular disease to look more broadly at the effect of aspirin on disease in general. We’re recruiting 19 000 people, including about 4500 from the US and 14 500 from Australia. I originally wrote the research protocol 10 years ago and the study should be finished by 2018. Our initial studies received funding from the Heart Foundation and the National Health and Medical Research Council. In 2009, we succeeded in getting US$50 million from the US National Institutes of Health to fund the full study. It shows that research in primary healthcare is an export industry, because we brought all that money into Australia.

I’m interested in research for a number of reasons. I’m a rationalist and believe in evidence-based medicine. Yet in clinical practice we often just continue doing what we’ve always done without thinking, ‘is there a better way of doing this?’ The objective evidence you find in medical research is not always popular because it often shows that what people thought was working actually doesn’t. You learn just as much from a negative study as you do from a positive one.

I’m a full-time tenured academic at the University of Tasmania and split my time 60:40 between the Menzies Research Institute and the school of medicine. Being a full-time academic usually includes two clinical sessions a week, but I choose to do a third in the evening to maintain continuity of care. Combining research and clinical work keeps me busy, but the quality of life in Tassie is fantastic. I go for a run every day, and I’ve started going for bushwalks to remote areas. Being in Tassie also reduces the travel times—in Melbourne I used to refuel my car once a week, but here it’s once a month.

Keeping connected to clinical work is very important. It means you can speak with more authority to fellow general practitioners as someone who’s working in the system and also understands the pragmatic aspects of getting research results into practice. We need more clinician researchers, because translational research is important. There are several ways GPs should be involved in research. Firstly, 100% of doctors should use the findings of research, but probably only around 60% do so. Secondly, I reckon about 40% of GPs have the altruism to participate in research in some way, such as becoming involved in a clinical trial or responding to surveys about what we do in general practice. Those people are very much appreciated. Finally, probably about 2% of GPs are interested in running research. That’s probably a bit of an indictment of our profession, because if you look at other specialties, research is taken for granted. For our profession to really prosper, we need more people to participate in research as investigators.”

Interview by Sophie McNamara
In 2008, Dr Mike Cadogan set up a small blog to record his preparation for the emergency medicine fellowship exams.

His study technique had involved writing summaries of books and journal articles, so he had amassed a collection of one-page summaries on various topics. He had also collected about 100,000 clinical images, all of which had patient details and signed consent forms.

“The blog was a means of trying to get some data together, mainly for my own purposes because I had it all scattered on various hard drives, but I thought if I put it out there maybe a couple of people might see it”, he says.

In the first year, a few hundred people each week visited the blog, Life in the fast lane (lifeinthefastlane.com), but the traffic soon increased.

Now the blog attracts about 20,000 unique visitors each day and, in May this year, the site had its 5-millionth unique visitor.

Dr Cadogan is writing a paper with some of the world’s top emergency medicine bloggers, with the aim of creating a ‘blog impact factor’ similar to the journal impact factor. While doing this research, Dr Cadogan has realised just how popular his blog is.

“It is great to see the emergence of medical blogs as a source of medical information, education and debate with 100,000 readers visiting the top 20 medical blogs on a daily basis.”

The blog, which now has several other authors as well as Dr Cadogan, includes a wealth of detailed clinical information. There’s an electrocardiogram (ECG) library that combines 5000 ECG images and cases with specifics on ECG clinical interpretation and links to reference sources. There is also a comprehensive clinical care compendium, a toxicology overview and more than 200 clinical cases.

The site also has an exam section with links to emergency medicine fellowship exam questions from recent years, including images and resources by topic.

Following the success of his blog, Dr Cadogan branched out to other online education projects including iMeducate (www.imeducate.com) and the recently launched Global Medical Education Project (gmep.imeducate.com). This project encourages users to submit, answer and provide feedback on multiple-choice questions in an open peer-review process, where users can rate the difficulty of questions, and provide references to the questions. Users can also upload clinical media including images, video and powerpoint presentations to create an online education database.

Dr Cadogan says while medical education has been transformed through social media such as blogs, podcasts and vodcasts, traditional forms of medical education such as the colleges and journals could embrace online opportunities a lot more.

He says he regularly uses clinical techniques that he has learnt from audiocasts or vodcasts, such as the Lewis Lead technique, which is a modified ECG lead system used to detect p waves in broad complex tachycardia.

“If I have a question about it, I’ll write back. If I have an experience with it, I’ll add a comment ... having that interaction with health professionals all round the globe is just fantastic.”

Dr Cadogan says his main motivation for developing online projects is the same as his motivation for becoming a doctor — to help people.

“There’s a lot of information out there which I’m happy to share and other people are happy to share. It annoys me when people hide things behind black boxes and logins and paid subscriptions.”

In addition to the online projects — or hobbies as he calls them, as he doesn’t make any money from them — Dr Cadogan continues to work full-time as an emergency medicine physician at Sir Charles Gairdner Hospital in Perth.

He grew up in the United Kingdom and studied medicine at the University of Edinburgh, and also studied at Oxford, before moving to Australia in 1998.

He is also team physician for the Western Force rugby union team, which includes travelling for overseas tours.

Somehow he has also found the time to set up a service called VIP Medicine, which provides medical advice and treatment to VIP visitors to Western Australia, with clients of the service including Michael Buble’s entourage.

Dr Cadogan says the service, which again makes no money, is “just for fun” as it allows him and his family to interact with some of these luminaries.

His hectic schedule begs the question of time management, which Dr Cadogan says would be impossible without the help of online tools such as Google Docs and iPhone apps.

“I set myself a series of limits”, he says. “Every day I do my day, come home and do the homework with the kids, and kick a ball and read to them, then I work from 8 pm to 2 am. Then I do it all again.

Sophie McNamara
Patient complaints come with the territory in a medical practice, but most grievances will stay within the practice if they are promptly acknowledged and addressed.

A complaint can pack an emotional punch, so the biggest challenge is keeping a clear head to mount a professional response and avoid a potential lawsuit.

This is where a formal complaints-management policy can help, according to medical defence organisations.

This policy should outline the steps to take if a patient complains. It should cover who deals with the complaint, how it’s handled, at what point staff should involve a doctor or practice manager, and when to call your medical defence organisation.

Last year Keryn Hendrick, risk education manager for medical defence organisation MIGA, conducted workshops for doctors entitled The complaining patient.

“What was interesting is many doctors in attendance said they either didn’t have a complaints-handling policy or if they did, they weren’t particularly aware of it”, Ms Hendrick says.

She says a clear written complaints policy provides staff with direction and support in managing potentially difficult situations.

Depending on the size of the practice, this policy can be in writing or more informal, says Dr Sara Bird, the manager of medicolegal and advisory services at MDA National. The most important thing, she says, is that everyone in the practice is on the same page.

A successful complaints-management policy should include the following key elements:

1. Listen
   It’s natural for people to respond with anger, frustration or distress in the face of a complaint, but listening is a far more effective strategy.
   Hear the patient out, get a good handle on their version of events, and attempt to stand in their shoes, Dr Bird advises.
   “Sometimes the patient is correct and sometimes not”, she says. “More often a complaint is the result of the different perceptions of the patient and the doctor: there hasn’t been a shared understanding of exactly what’s happened.”

2. Acknowledge
   Ms Hendrick says that once the patient has voiced their concern, it helps to show empathy and acknowledge that something upsetting has occurred.
   “If they don’t get that, that’s when they may look to a complaints entity to step in and resolve [the situation] for them”, she says.
   Dr Bird says it’s worth designating a skilled staff member to handle complaints, but because you can’t always press a pause button, your front-line

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**Why do patients complain?**

According to MDA National, one in 20 medical practitioners will be the subject of a formal complaint to the Medical Board of Australia or the Australian Health Practitioner Regulation Agency each year. Dr Bird says doctors tend to attract the most complaints in two key areas:

1. Not fulfilling expectations
   This includes allegations about delays in diagnosis and treatment, complications of treatment and inadequate or inappropriate treatment, including failure to examine properly or order investigations, or prescription of incorrect medications.

2. Failing to communicate
   This includes allegations of inadequate, incorrect or misleading advice, and complaints about the doctor’s manner, such as allegations of rudeness or an uncaring attitude.

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Risk management tips

Medical defence organisation MIGA offers the following approach to resolving complaints:

- Where possible, deal directly with the complainant
- Try to resolve complaints as quickly as possible
- Have a complaint-handling procedure led by a senior staff member
- Ensure all staff — doctors, nurses and practice staff — are aware of the procedure, and that locums receive instruction as part of their induction
- Display your complaints procedure in the waiting room.

A study published in the Medical Journal of Australia in 2004, which examined complaints made by patients attending Victorian hospitals, found that 84.5% were resolved easily and more than half were resolved with an apology or explanation.

However, Dr Bird says if a patient puts their complaint in writing, you should seek advice from your medical defence organisation.

3. Promise to take action
Most patients who complain are not seeking financial compensation — they tend to have altruistic motives. “Patients often don’t want others facing similar problems and they are looking for a sense that the service has improved for them and others in future”, Ms Hendrick says.

“If things need to change in your systems and procedures, tell them about those changes.”

She says your initial conversation should include an assurance to the patient that their concerns will be investigated and addressed. It’s also important to provide the patient with an explanation, she says.

Medical defence organisation Avant agrees. Ms Georgie Haysom, special counsel in medicolegal advisory service/health law at Avant, says timely and skilful handling of complaints can help to reduce the risk of a formal complaint or a claim being made.

“Leaving a patient complaint unanswered can exacerbate the patient’s dissatisfaction

Amanda Bryan

staff still need skills in managing distressed or angry patients.

“In surveys of patients that ask about what they want when making a complaint, they said they wanted acknowledgement”, she says. “Allow them to tell their story and really try to understand where they are coming from.”

Sometimes issues can be resolved on the spot. Dr Bird says an apology for distress or a misunderstanding, for instance, may be appropriate and sufficient.

“Patients may have unrealistic expectations of what the practice can provide, and sometimes they are anxious and unwell and therefore more easily aggrieved”, she says. “There are many matters where the doctor involved would just phone the patient and resolve the problem then and there — and that’s the ideal way.”

Amanda Bryan

Your heart rate is accelerated, your blood pressure is high, and your hair is falling out.

I advise avoiding all court related activities for the foreseeable future.

continued from page C7

Dr Sarah Bird

Allow them to tell their story and really try to understand where they are coming from

Leaving a patient complaint unanswered can exacerbate the patient’s dissatisfaction
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