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1-1-2013

### Beyond the honeymoon period: keeping preceptors and practices wedded to the longitudinal integrated clerkship (LIC) model

David Garne

*University of Wollongong, dgarne@uow.edu.au*

Kathryn Weston

*University of Wollongong, kathw@uow.edu.au*

Belinda Smith

*University of Wollongong, bsmith@uow.edu.au*

Andrew Bonney

*University of Wollongong, abonney@uow.edu.au*

Carl Mahfouz

*University of Wollongong, cmahfouz@uow.edu.au*

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#### Recommended Citation

Garne, David; Weston, Kathryn; Smith, Belinda; Bonney, Andrew; and Mahfouz, Carl, "Beyond the honeymoon period: keeping preceptors and practices wedded to the longitudinal integrated clerkship (LIC) model" (2013). *Faculty of Science, Medicine and Health - Papers: part A*. 1504.  
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## Beyond the honeymoon period: keeping preceptors and practices wedded to the longitudinal integrated clerkship (LIC) model

### Disciplines

Medicine and Health Sciences | Social and Behavioral Sciences

### Publication Details

D. Garne, K. Weston, B. Smith, A. Bonney & C. Mahfouz (2013). Beyond the honeymoon period: keeping preceptors and practices wedded to the longitudinal integrated clerkship (LIC) model. Oral presentation that was presented at 2013 Big Sky CLIC Conference, 29 Sept - 2 Oct 2013, University of Washington.

# **Beyond the honeymoon period: keeping preceptors and practices wedded to the LIC model**

**David Garne**

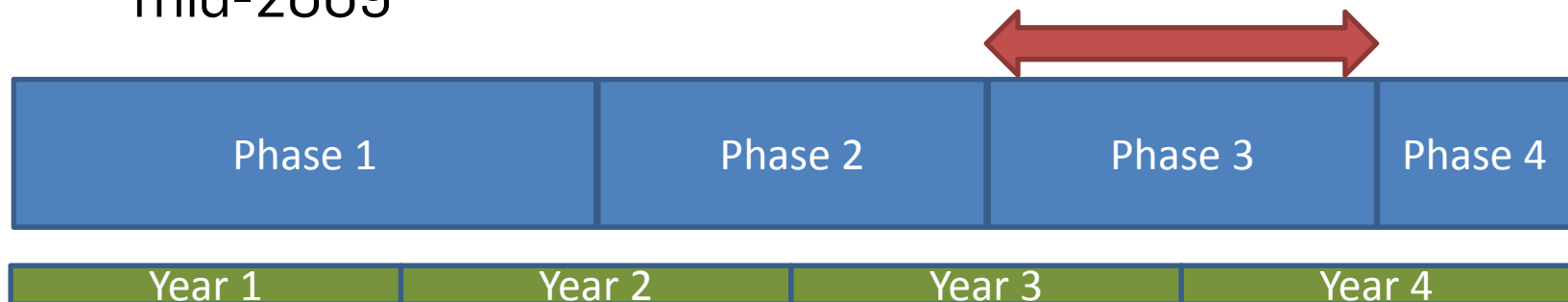
**Kathryn Weston, Belinda Smith, Andrew Bonney, Carl Mahfouz**

VISIONARY / PASSIONATE / DYNAMIC  
CONNECT:  
UNIVERSITY OF WOLLONGONG



# Background/context

- GSM at UOW is a 4-year graduate entry medical program with an integrated curriculum
- All students undertake a 12 month LIC from middle of Year 3 to middle of Year 4, 2/3rds in a rural setting
- First student intake 2007, with first LIC starting in mid-2009



## Background/context

- Received initial federal government funding for infrastructure funding for practices in rural settings  
– \$50K per student for a 5 year contract
- Those contracts expire in mid-2014 and currently no further infrastructure funding available

# Research questions

- How do our GP preceptors regard the concept of LIC, our program and students?
- What are their intentions of continuing without further funding?

# Method

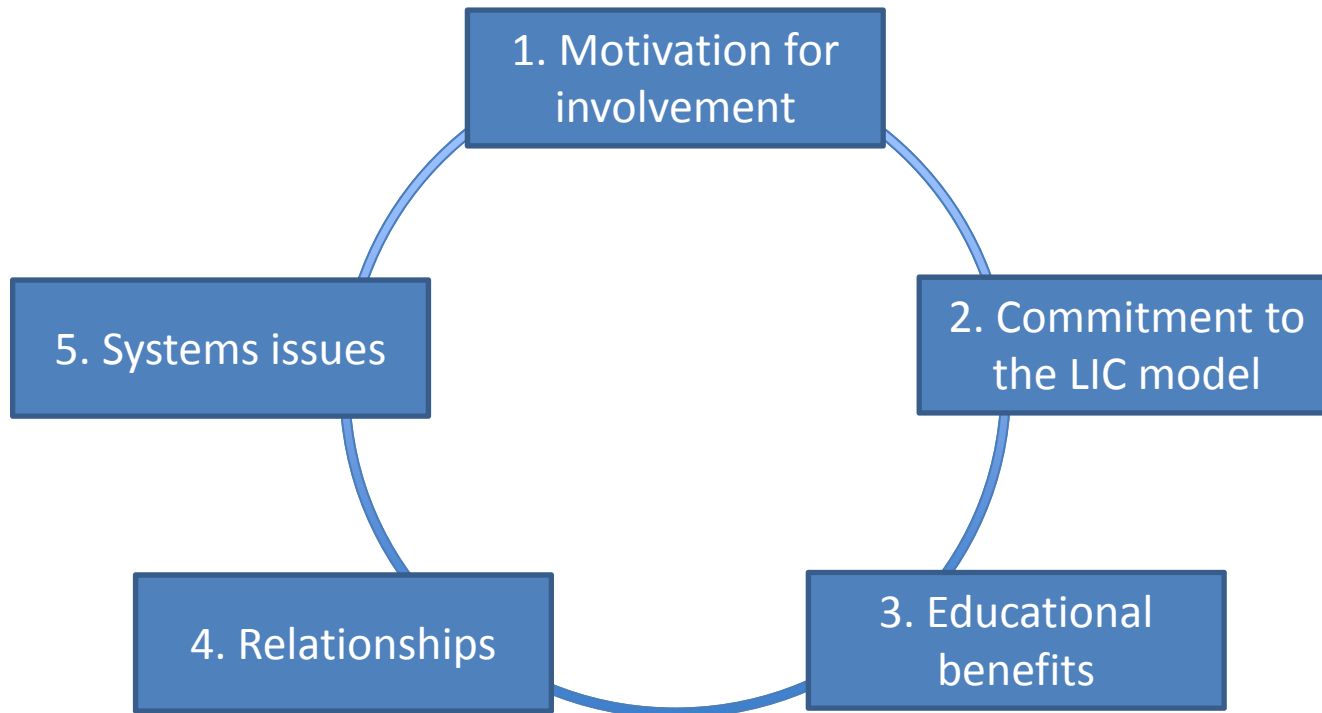
- Semi-structured interviews with preceptors and practice managers from all 9 of our rural hubs and our 1 regional hub
- Selected 2 practices at random from each hub, and thus aimed to do a total of 40 interviews, one with the main preceptor and one with the practice manager
- Ultimately analysed telephone interviews with 8 preceptors and 10 practice managers

# Method

- Interviews recorded and transcribed verbatim
- Qualitative analysis conducted independently by 2 authors to analyse themes, and then met to discuss and agree on themes derived
- UOW ethics approval received prior to participant recruitment and data collection – Approval No HE12/425



# Results



# 1. Motivation for involvement

*Sheer enjoyment of teaching* – this sentiment was expressed by many preceptors and echoed by the majority of practice managers

“... it's work on our part, but on the other hand, when you're teaching, you get some reward from that – from teaching itself”. [GP20]

“Our doctor really enjoys the teaching aspect, and I think that's the reason we would remain involved”. [PM06]

# 1. Motivation for involvement

## *Future recruitment and succession planning*

“... it's very important for our long-term planning that there will be somebody who's willing to come back to work in (name of town) so that eventually we can retire. That's part of our succession planning”. [GP14]

“... they (the doctors) like the idea of training students, because they're future doctors coming to the area”. [PM20]

# 1. Motivation for involvement

*An obligation to give back to the profession*

“I think you have a bit of a duty to teach and to pass on knowledge and experience to those coming behind you”.  
[GP20]

“... there is an ethos of supporting the profession”. [PM13]

# 1. Motivation for involvement

*A sense of feeling valued*

“We actually felt like we were valuable and we were important and that we mattered and that we were needed to make this process of having a regional university happen”. [GP10]

# 1. Motivation for involvement

*Lack of return from previous short-term placement programs* – considerable frustration expressed about not seeing any positive workforce outcomes for rural areas from previous short-term student placement programs

“... all of us GPs in town were fed up with the transient presence of students for two weeks at a time where they just sit around and do nothing and tell you they wanted to be plastic surgeons and were here only because they had to be. The idea of a longer term placement by a university with an interest in rural medicine struck us as a good idea”. [GP12]



# 1. Motivation for involvement

*Our students are very well regarded* – they have performed well and are highly regarded by preceptors, practice staff and patients; they are our best advocates

“The quality of the students is always a real positive. They are, to a person, enthusiastic and motivated, and that keeps us going with it”. [GP13]

“... we’ve been quite happy with the students. All of them have been really quite good. They’ve all gotten on really well with everybody”. [PM20]



# 1. Motivation for involvement

*Vertical integration of teaching* – the program has contributed to the development of a broader teaching culture

“... what the students have done is created a teaching environment... interns and RMOs and registrars were here first... so now we’re teaching at all levels, and we’ve got a full cross-section of people in a learning environment in a small country town”. [GP10]



## 2. Commitment to the LIC model

*The LIC model is popular* with preceptors and practice managers, but especially with the practice managers who see benefits for the practice, the patients and the students

“... the best thing being that they’re here for the longest amount of time... gives the patients a really good rapport with the students”. [PM06]

“Having the students here for a year has been good because the patients get to know them. This way they can follow their (the patient’s) process and what’s happening with them”. [PM20]

## 2. Commitment to the LIC model

Preceptors were strong in their views that short-term placements were of little value to either the practice or the student

“... it is much better than the bad old days when we had placements for 6 or 8 weeks and some of them were seen lounging around the swimming pool at the motel”. [GP15]

“What’s worked well is having student for 12 months. It’s a good system compared to the previous thing where we would have people for a couple of weeks and then they would change over”. [GP16]



## 2. Commitment to the LIC model

Although committed to the longitudinal model, some offered words of caution of potential negative impacts of the program on practices

“I support this education model but this is the real world and we have to make sure that it can maintain the place in a private business because that’s what you’re doing – they’re private practitioners that are doing this”. [GP17]

### 3. Educational benefits

*To students* – preceptors were clear in articulating the benefits to students of the LIC model

“I think the students seem to particularly enjoy the parallel teaching where they get to play doctor in real life as closely as it is possible to do without carrying the responsibility – they don’t have the right to be wrong yet but they seem to value this”. [GP15]

“There are lot of little instances where you’ve just seen the lights come on and the knowledge starts to become more constructive in their minds, and they say ‘now I understand how this all fits together’”. [GP17]

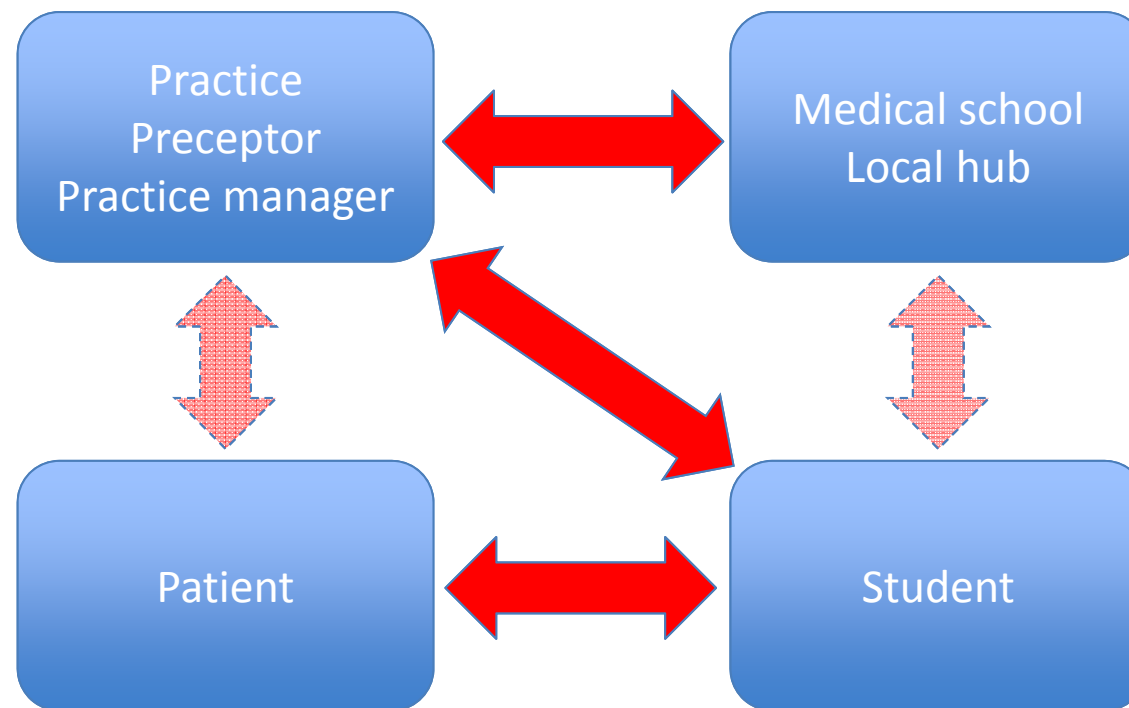
### 3. Educational benefits

*To preceptors and practices* – perceived educational benefits are not limited to students only; preceptors and practice managers feel that there educational benefits to doctors, practice staff and patients as well

“The general consensus of having the long-term students is that they bring something positive to the practice... they participate in a way that encourages quality within the practice”. [GP17]

“One student did a research project that was very beneficial to the practice – it was a men’s preventative health check which got them in when normally they would not come”. [PM17]

## 4. Relationships



## 4. Relationships

*Practice/student – in general, our students are considered to have very good attributes and are well accepted by practices and their patients; there are occasional personality clashes, but these are rare and have been managed satisfactorily*

“The students fit into the practice very well. Actually we found the students quite nice to have around. They’ve all been polite... overall I think the students were all very well presented and did a good job.” [GP16]

“Well overall I’ve been absolutely delighted in the students that we’ve been able to have from the University of Wollongong especially the calibre of the students itself. One of the main positives I think is that these students actually wanted to come to the country”. [PM 12]

## 4. Relationships

*Practice/university – the relationships between practices and the local GSM hub staff are good, but those between the practices and GSM main campus are less than ideal and need work*

“I just think the support that we’ve had from the university through (the local hub staff) has been fantastic. If we need anything... if I have any queries it’s just a quick phone call to (name of local staff member) or a quick email, the reply is always there”. [PM03]

“...we’ve lost some of that sense of belonging because for most of the doctors there’s a sense that the university doesn’t visit here anymore. I think that in terms of maintaining engagement, it’s probably quite important that the university looks at ways to re-engage”. [GP10]



## 4. Relationships

*Student/patient* – with rare exceptions, patients are very happy to participate in the learning process, longer placements allow patients to get to know students and develop rapport, patients have in many instances benefitted from their relationship with students

“We have patients that will ring and actually ask to see certain students that they’ve seen. I can’t think of a bad comment for any of the medical students”. [PM01]

“I really can’t recall a patient who had a problem with any of our students. I tend to get plenty of my chronic care patients, a few patients who are having palliative care or ongoing major problems or something involved with the students. Often the patients will look out or ask for the student if the student’s not there wondering what’s going on”. [GP12]

## 5. Systems issues

*Time and financial issues* – the majority of practices feel that there is a negative time impact on preceptors when a student is in the practice, and this in turn leads to a negative financial impact on practices

“I don't think it's any secret for me to say that we in reality take a pay cut by having student here...” [GP01]

“Yes, it takes time away and financially it's certainly... yes, never mind. Financially it can drag you down a bit but that's life”. [GP06]

“... you can't expect GPs to keep doing more and more for less and less, which is what seems to be happening at the moment”. [GP17]

## 5. Systems issues

*Time and financial issues* – most felt that PIP needs to be increased and the process needs to be improved

“I think that there has to be some sort of better remuneration for having a student load. I think basically the PIP needs to be doubled. I think that \$100 a session represents probably three patients – you’d probably in a lot of ways halve what you do, you know so there needs to be some upswing there”. [GP10]

“Well to me it’s compelling really because it (PIP) hasn’t changed in recent years – that increasing it would be helpful”. [GP12]

“... we need a significant increase (in PIP) if we’re going to come anywhere close to making up for the time that we lose”. [GP15]

## 5. Systems issues

*Physical space issues* – some practices still struggle with physical space despite the initial infrastructure payment

“The negatives I think are really going to be issues of space and timing; flexibility of timing is always tricky because a lot of practices are now getting to be a bit like sardine cans and we’re really looking at squeezing people in to available half days...” [GP13]

“We are absolutely critical for space because we’re waiting on the council approval to put in another room. Until that point, we’re really critical because I’ve now actually got three registrars on the books and... but we are critical for space”. [GP14]

## 5. Systems issues

*Patient issues* – some concerns that patients may feel pressured into seeing students and find it hard to refuse; some patients were unhappy about the longer waiting times that having a student generated; some patients did not want to see a student because this resulted in having to repeat themselves

(NOTE: this does not support earlier UoW research about patients being happy to be involved, and *Relationship* theme mentioned earlier)

“The other thing, our GPs feel that sometimes patients just come in for a prescription only and have booked in with the student – reception staff not knowing that and they’re there for 40 minutes”. [PM10]

## 5. Systems issues

*Curriculum* – one preceptor felt that there should be a more structured approach to the student learning experience

“Well it would really help if there was a curriculum because at the moment we’re flying blind. The students are sitting in, they’re seeing the clinical stuff that’s coming through the door but there’s no actual curriculum set up that says ‘This is what you’re supposed to get them to see, this is what they need to know by the time they’re finished with you so that they will get through their exams properly’. If we actually had a curriculum it would be very helpful”. [GP08]



## 5. Systems issues

*Curriculum* – there were more concerns were raised that the current experience-based curriculum would change to an inflexible tick-box type approach

“I see the greater curriculum loss of flexibility as a downer. We got sold the program initially as a year of real experience that covers most things that you’d want without us ticking off boxes and saying ‘We’ve done this or done that or whatever, or covered such a disease or had this lecture’ – I can just see it just drifting gradually into that. I’d try and make it more experience-based and make sure students are busy rather than give a tutorial on something because someone else has”. [GP12]



## 5. Systems issues

*Student issues* – there were rare comments about personality clashes and negative student attitudes

“... the instance where the supervisor didn’t particularly get on well with the student which only has happened with one. It’s just a long time with that clash of personalities”. [PM06]

“If you have a student who doesn’t turn up or is ungrateful or slags off Phase 3 or something like that, that can tip some people; they just go ‘Oh I can’t be bothered’”. [GP10]





## Discussion

- The UOW programme is seen as one factor in future workforce solutions, and practices are pleased that there is a medical school that is genuinely interested in rural health
- The majority of practices **want to remain involved** in the UOW programme, but want a more flexible contract arrangement
- The majority of practices **want better remuneration** and improvements to PIP

# Discussion

- **Training** for preceptors and staff was important
- Most want **better engagement** with the GSM
- Too early to tell if we have made an impact on **rural recruitment** although early signs are hopeful
- The key is to get **new doctors into rural practice** before the existing ones are too old to practice and too tired to teach

# Conclusion

*Beyond the honeymoon period:  
keeping preceptors and practices  
wedded to the LIC model*

*What have we learned?*



Henry Ford said of marriage:

“Coming together is a beginning; staying together is progress; working together is success”

# Key messages

- We have already developed the relationship and both parties think it's good, but keeping the **relationship strong requires a commitment to working together for a common goal**
- This commitment is just as crucial at the **institutional level** as it is at the preceptor level
- **Valuing the contribution** of the preceptor and the practice is paramount, not only by providing support at the institutional level but in terms of adequate remuneration from government

# Questions?

