Procedural skills of Australian general practice registrars: A cross-sectional analysis

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Aims

1. To investigate the type, frequency and rural/urban associations of clinical procedures performed by GP registrars;
2. To establish levels of concordance of clinical procedures performed with a core list of recommended procedural skills in GP training

Background

The provision of clinical procedural services has been, and remains, an integral part of general practice. Thus, procedural skills are an essential component of GP vocational training. In Australia, as in many other countries, GPs' provision of clinical procedures is especially important in rural areas.

Methods

A cross-sectional analysis of a cohort study of registrars' consultations, 2010-2016, in the Registrar Clinical Encounters in Training (ReCEnT) study. In ReCEnT, registrars record 60 consecutive consultations each six-month training term. The outcome factor was 'procedures performed' using a core list of 112 procedures (derived from a previous Delphi process of expert GPs and expert GP medical educationalists), plus a supplementary list containing 79 other procedures (lesser ranked procedures from the above Delphi process). Procedures were defined as in Box 1.

ReCEnT
Registrar Clinical Encounters in Training

Box 1: Criteria used for defining a general practice clinical procedure^

- Discrete activity performed on a patient
- Requires knowledge and psychomotor/ manual skill
- Diagnostic or therapeutic
- May or may not require the use of equipment
- Invasive or non-invasive
- Excludes manual skills which are part of routine clinical examination
- Excludes purely interpretive skills
- Excludes complex surgical procedures that require a general anaesthetic

^based on Sylvester S, Magin P, Sweeney K, et al. Procedural skills in general practice vocational training - what should be taught? Aust Fam Physician. 2011 Jan-Feb;40(1-2):50-4.

Findings

- In 182,782 consultations, 19,411 procedures were performed.
- Procedures (except pap tests) were performed more often in rural than urban areas.
- Registrars commonly sought help from supervisors for more complex procedures.
- The majority of the 112 core procedures recommended as essential in registrar training were infrequently performed.

See Table 1 for the 20 most common procedures performed by registrars.

Table 1: List of the most common procedures performed by registrars

Procedure	All areas		Major cities		Inner regional		Outer regional/ remote/ very remote	
	N	per 10000 encounters	N	per 10000 encounters	N	per 10000 encounters	N	per 10000 encounters
Intramuscular injection	5778	316.1	3424	330.0	1262	258.9	1082	359.0
Pap smear	4160	227.6	2526	243.5	1046	214.6	585	194.1
Cryotherapy	1968	107.7	1107	106.7	500	102.6	358	118.8
Wound dressings	880	48.1	522	50.3	239	49.0	119	39.5
Syringe ear	712	39.0	394	38.0	172	35.3	145	48.1
Skin excision	622	34.0	254	24.5	202	41.4	166	55.1
Perform 12 lead ECG	550	30.1	195	18.8	180	36.9	173	57.4
High vaginal swab	443	24.2	257	24.8	107	21.9	79	26.2
Venepuncture	398	21.8	117	11.3	40	8.2	234	77.6
Punch biopsy	373	20.4	157	15.1	115	23.6	100	33.2

Conclusions

- Registrars have low exposure to many relevant clinical procedures.
- There may be need for greater utilization of laboratory-skills-based training and/or review of expectations of the scope of GP procedural practice.

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Quality assessment of systematic reviews of vitamin D, cognition and dementia: An overview

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Introduction

- Dementia is a common problem worldwide with 46.8 million people living with dementia in 2015.
- The cause of dementia and cognitive decline is complex.
- Studies have shown the beneficial effect of dietary factors on cognitive function.
- There is conflicting evidence regarding the associations of vitamin D with cognition performance and dementia.
- Objective: To summarize the evidence on the associations of vitamin D with cognitive performance, dementia and Alzheimer's disease through a qualitative assessment of the available systematic reviews and meta-analyses.

Methods

- Design: An overview of the systematic reviews
- Medline and Embase were searched for systematic reviews of all study types up to February 2017.
- Two independent reviewers screened 17 full texts from 196 abstracts to identify systematic reviews with or without meta-analyses on vitamin D and either Alzheimer's disease, dementia or cognitive performance.
- Data were extracted for study characteristics, analytical methods and key findings.
- AMSTAR (A Measurement Tool to Assess Systematic Reviews) checklist being applied to assess methodological quality of each review.
- Main outcomes: Associations between vitamin D concentration and cognitive performance and/or risk of dementia

Conclusions

- This systematic evaluation of available systematic reviews provided a clearer understanding of the potential link between low serum vitamin D concentrations, dementia and cognitive impairment.
- Still, there is little known about the function of vitamin D in relationship to different cognitive domains.
- This evaluation also showed that the quality of the available evidence is not always optimal due to both low methodological quality of the reviews and low quality of the original studies. Interpretation of these systematic reviews should therefore be made with care.

Findings

- Eleven systematic reviews were identified, nine of which were meta-analyses with substantial heterogeneity, differing statistical methods, variable methodological quality and quality of data abstraction.
- AMSTAR scores ranged from 2-11 out of 11, with 5 reviews assessed as having 'low' and 5 of 'moderate' methodological quality.
- Out of 6 meta-analyses on the association between low serum concentration of 25(OH)D and risk of dementia, 5 showed a positive association.
- Meta-analyses on the association between low serum concentration of 25(OH)D and memory function tests showed conflicting results

First author, year	Inclusion criteria	Outcomes	Databases searched and search window	Articles included in review, Articles included in meta-analysis	Number of patients	Design of the included articles	Main conclusion
Annweiler, 2009	Data on serum 25(OH)D and cognitive status or diagnosed dementia, only studies with a healthy control group and use of a regression model for analysis in French and English	Cognitive status or diagnosed dementia	Medline, Cochrane library, PsychINFO between 1979 to December 2008	5 studies, N/A	19,597	Cross-sectional (n=4), Case-control (n=1)	Inconclusive results on the association between serum 25(OH)D and cognitive performance
Annweiler, 2013	Any type of observational/ interventional studies, data on serum 25(OH)D and AD, adult human, written in Latin alphabet	AD	Medline, PsychINFO from inception to May 2012	10 studies, 7 studies	1,005	Case-control (n=7), Nested case control (n=2), prospective (n=1)	Patients with AD had lower serum 25(OH)D compared to matched controls
Annweiler, 2013	Any type of observational/ interventional studies, data on 25(OH)D and cognition, adult human, written in Latin alphabet	Memory and executive dysfunction	Medline, PsychINFO from inception to May 2012	17 studies, 12 studies	39,975	Cross-sectional (n=11, prospective (n=3), pre-post design (n=2), RCT (n=1)	Lower serum 25(OH)D concentration predict executive dysfunction (mental shifting, information updating, processing speed), uncertain association with episodic memory
Balion, 2012	Any type of observational/ interventional studies, data on 25(OH)D, cognition and dementia, human >18 years, written in English	Cognitive function, dementia	Medline, Embase, AMED, Cochrane library, PsychINFO from inception to August 2010	37 studies, 4 studies (AD), 10 Studies (MMSE test)	≅ 35,000	Cross-sectional (n=21, case-control (n=10), prospective (n=2), pre-post design (n=1), RCT (n=3)	Lower 25(OH)D concentration are associated with poorer cognitive function and a higher risk of AD
Cao, 2016	Cohort studies including Caucasian subjects with follow up for 1 y, present data as RR or HR with 95% CI or with enough data to calculate these numbers, data on any type of dietary pattern or food consumption and dementia or mild cognitive impairment, on human subjects and written in English	dementia or mild cognitive impairment (MCI)	Medline, Embase, BIOSIS, Cochrane library from 1997 to September 2014	3 studies 3 studies	12,702	Prospective cohort (n=3)	Low levels of vitamin D related with increase in dementia
Etgen, 2012	Cross-sectional or longitudinal studies, at least 100 participants, data on vitamin D and cognitive impairment, results presented as OR or HR	Cognitive impairment	Medline, Cochrane library, from 1980 to April 2012	15 studies 7 studies	7,688 in meta-analysis	Cross-sectional (n=9), prospective (n=2)	An increased risk of cognitive impairment in those with low vitamin D
Lopes da Silva, 2014	Data on any type of plasma nutrient status and AD	AD	Medline, Embase, Cochrane library from 1990 to March 2012	5 studies 5 studies	865	Case-control (n=5)	No association between low levels of vitamin D and AD
Shen, 2015	Data on 25(OH)D concentration with cut-off point of < 50 nmol/L and AD or dementia, results presented as OR, RR or HR, written in English	AD and dementia	Medline, from inception to February 2015	AD: 5 studies, 5 studies Dementia: 5 studies, 4 studies	AD: 10,019 dementia: 5,073	AD: Cross-sectional (n=1), prospective (n=4) dementia: Cross-sectional (n=3), prospective (n=2)	Lower vitamin D status is associated with increased risk of developing AD and dementia
Sommer, 2017	RCTs, prospective cohort and nested case controlled, systematic reviews of longitudinal studies with data on the effect of sunlight exposure or vitamin D serum concentrations (as surrogate) and dementia, among adults, written in English and German	Dementia: AD vascular, fronto-temporal, Lewy body	Medline, Embase, Cochrane library, SCOPUS, Web of Science, ICONDA, PsychINFO, the Open Grey database, from 1990 to October 2015	6 studies, 5 studies	18,933	prospective (n=5), retrospective (n=1)	Vitamin D deficiency increases the risk of dementia
van der Schaft, 2013	Observational studies with data on vitamin D (serum concentration or dietary intake) and cognition in adult human, available measure of association	Cognition	Embase, Pubmed from inception to June 2012	28 studies NA	59,576	Cross-sectional (n=25), prospective (n=6)	Hypovitaminosis D is associated with worse outcome on one or more cognitive function tests and a higher frequency of dementia
Zhao, 2013	Comparative analysis of 25(OH)D of individuals with AD against healthy population	AD	Medline, from 1983 to March 2012	6 studies 6 studies	892	Case-control (n=6)	Patients with AD had non-significant lower levels of 25(OH)D relative to healthy controls

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Creating a PREM for Primary Care Using Cognitive Interviewing

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Introduction

- Patient reported experience measures (PREMs) have been shown to be a useful tool in determining how well a clinic is meeting the needs of its patients and in allowing the clinic to focus its energies on improving areas that are not working well.
- The Health Quality Council of Alberta (HQCA) had developed a PREM tool for use in Canadian primary care practices.
- Initial testing found underperforming questions. Further testing was required to ensure that the questions measured what was intended and that respondents understand and correctly interpreted questions.
- Testing to determine which questions were the most important to patients for evaluating the care they had received was also performed.

Methods

66 cognitive interviews were conducted in three primary care clinics in Calgary with English speaking patients aged 21-84 years.

Patients were asked by clinic staff sequentially to participate as they came to their medical appointment.

Interviews lasted on average 10 minutes
In total four rounds of interviews were conducted: round 1 in November 2016 and round 2 to 4 from February to mid-April 2017.
Cognitive interviewers were instructed to:

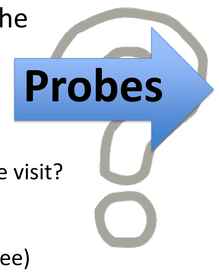
For Rounds 1-3, interviewers were instructed that the intent was to get a sense of the patient's preference for different question wording and response formats. Particular attention was paid to:

- questions patients seemed to find the easiest to respond to
- how the patients responded (including a sense of whether there was more variability in response to one format than another)
- body language and lags in response
- emotional responses (to eliminate questions that cause sensitivity issues)

Methods Example

I would like to ask you about 3 different ways to word the same question and different response choices:

a. Does your doctor listen to you?
(yes mostly, unsure, rarely, no)
b. How would you rate the way this doctor listened to you during the visit?
(excellent, very good, good, fair, poor)
c. My doctor listens to me
(strongly agree, agree, unsure, disagree, strongly disagree)



- Which of these questions do you like the best? Like least? Why?
- Which do you think would work best for most people?
- When you thought about the responses how you did come up with your answer?
- Which set of answers was easiest to choose from-which was hardest?

'Does your doctor listen to you?'	How would you rate the way this doctor listened to you during the visit?	'My doctor listens to me'
Direct question in which you can give a direct response	Complicated question wording	Leads into an answer, pushing into a direction & too short
Vague, just a yes or no question and can't be evaluated based on %	More neutral and a little more descriptive	Knowing your standards and then you can evaluate based on that

Methods Cont

Patients comments and thoughts were analyzed identifying consistencies across subjects. Questions were refined and then retested in further rounds.

Round 1 covered very broad PREM concepts (such as access),
Round 2 and 3 covered PREM sub-concepts (such as wait until appointment) and
Round 4 ranked the importance of the new survey questions

Conclusions

Survey questions from existing instruments did not resonate with interviewed patients.
Patient input was used to modify the survey to better reflect the Canadian Primary Care Context.

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The use of chaperones for intimate exams: documentation and influence of regulatory guidance

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Background

Some medical regulatory bodies have guidance on the use of chaperones for intimate examinations, however guidance is variable. Recommendations from the College of Physicians and Surgeons of Alberta (CPSA) state physicians should use chaperones when conducting intimate examinations and that chaperones should document their presence during the exam in the patient's medical record. How family physicians are applying this guidance in their daily practice is unknown.

The purpose of this study was to to examine whether family physicians have awareness of provincial recommendations, are influenced by provincial guidance in their decisions on the use of chaperones, and are documenting the use of chaperones for intimate examinations.

Methods

This was a mixed methods study consisting of an anonymous, online survey and individual semi-structured interviews. All participants were practising family physicians.

Survey: Physicians were recruited by email and newsletter sent to 1154 family physicians in the Department of Family Medicine in Calgary, and during an annual family medicine symposium.

Interviews: Invitations were sent by email to academic teaching clinic physicians. Interviews were recorded and transcribed, and 3 investigators performed thematic analysis (constant comparison).

Conclusions

Half of physicians are not aware of CPSA recommendations, with male physicians more likely to be aware and to document chaperone use. Awareness of the recommendations however, does not equal compliance. Physician reasoning for chaperone use and documentation is a thoughtful and complex process. There appears to be a disconnect between theory/recommendation and application/practice.

The authors would like to acknowledge the Department of Family Medicine at the University of Calgary, who funded this research project through a Research and Scholarship Sabbatical Seed Grant.

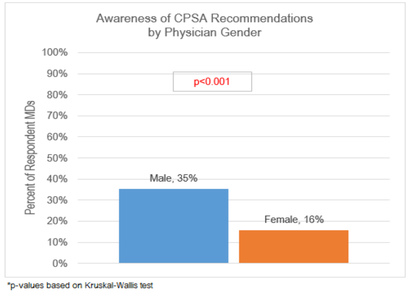
Results

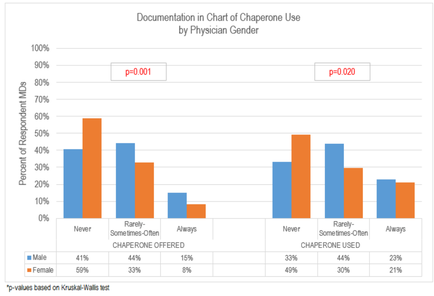
Survey: Total of 396 responses (34% response rate), 350 used for analysis. 41% male, 58% female, age 27-88 years.
Interviews: 17 physicians, 10 male, 7 female.

Theme: More Than Awareness

Are you aware of College recommendations?

AWARE		
	Don't follow	Tried but found impractical Stay with current practice/clinical judgement
	Didn't read/don't care	
	Follow	
	Follow with modification	
NOT AWARE		
	May/may not change practice	





"I personally feel, and have discussed this with many colleagues, that these recommendations applied in a blanket way for all of the various types of exams for all genders are way over the top. I have no intent of changing my routine practice but will continue to use my own judgement about who merits having a chaperone with me."

"I had no idea that the College expected me as a female family physician to have a chaperone when doing all the 1000's of pap tests and pelvic exams and breast exams and ano-rectal exams on all the women I have examined since this policy was put out in 2014. This policy is impractical and would be expensive to adhere to, as it would require an extra staff person just to come in for the examination part of every visit."

Theme: Variable Influence

Do College recommendations play a role in your decision making?

R1: "Probably should. Not currently.."
R2: "I didn't even know they were there…"
R3: "I read about them here, they never really interested me…"
R4: "Well when various recommendations come out I look at them and I think, yeah, okay that's the current consensus of ideas, So yeah, it sort of tunes in but it doesn't dominate. I mean basically mostly I continue doing what I've been doing."

Quotes for Theme: Documentation Continuum

I: Do you document chaperone use?

R:Not unless I have indicated that, for instance, a child or a teenager has come with a parent and … I will usually indicate when the parent has been asked to the leave the room or, you know, what … doing my documentation that way. Otherwise, no.

I:Okay. And what's your thinking around the documentation that you do or don't do?

R:Well, I suppose if there were ever … a complaint or a concern came forward then it would be very difficult to defend, if you indicated that there was a chaperone present but hadn't actually documented that that was the case. I certainly don't … you know, when I'm doing … if I'm doing a procedure and one of the nurses is helping me with that I don't document that the nurse is in the room either, so … which, again, would be similar to a chaperone, so … yeah.

I:Okay, okay. So you just don't …

R:I don't .. I will document when a family member is present but I don't document when anyone else is present. And, generally, if a resident is seeing the patient I will document when I've been there during a procedure.

Theme: Documentation Continuum

NO	Probably should
	Usual practice
YES	Specific
	Non-specific
SOMETIMES	Don't always remember
	Only if discussion or refusal or outside of expectations
	Only if family member
	If for patient comfort

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Chaperone Use During Intimate Examinations: What We Do and What We Teach

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Introduction

Some medical regulatory bodies provide guidance on the use of chaperones during intimate examinations. The College of Physicians and Surgeons of Alberta (CPSA) states physicians should use chaperones when conducting intimate examinations.[1] Despite these recommendations, there has not been extensive or recent research on the use of chaperones in family medicine in Canada.[2]

The purpose of this study was to identify family physicians' use of chaperones during intimate examinations with adult patients, and their teaching practices.

Methods

This project used a survey-based study design, based on a scoping review of the literature and pilot testing with family physicians. Recruitment was by email, newsletter, and during an annual family medicine symposium, between May and August 2016. Surveys were sent to 1154 community-based family physicians in the Department of Family Medicine in Calgary. Data was collected using FluidSurvey™ .

Outcomes included physicians' self-reported chaperone use with adult patients, and their teaching practices.

Conclusions

Chaperone Use

Despite CPSA recommendations, not all physicians routinely use chaperones during intimate examinations. Both patient gender and physician gender appear to influence chaperone use.

- Male and female physicians do not routinely use chaperones when performing intimate examinations with male patients.
- Male physicians use chaperones significantly more than female physicians when examining female patients, across all exam types.

Teaching Chaperone Use

This is the first study to address teaching practices around chaperone use, and results suggest that the gender of the learner, patient, and physician influence teaching practices.

- Less than 10% of physicians regularly teach male learners to use chaperones with adult male patients.
- The majority of male learners are taught to use chaperones with adult female patients. Male physicians are more likely than female physicians to teach the use of chaperones for gynecological and genitourinary examinations.
- More male than female physicians teach female learners to use chaperones with adult male patients.
- Physicians do not regularly teach female learners to use chaperones with adult female patients, with male physicians more likely to teach chaperone use.

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Acknowledgements

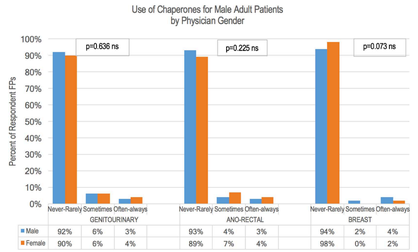
The authors would like to acknowledge the Department of Family Medicine at the University of Calgary, who funded this research project through a Research and Scholarship Sabbatical Seed Grant.

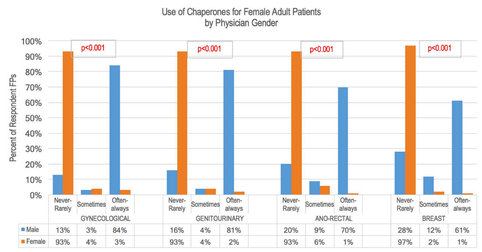
Results

A total of 396 surveys were completed and returned (response rate of 34%) with 350 used for analysis.

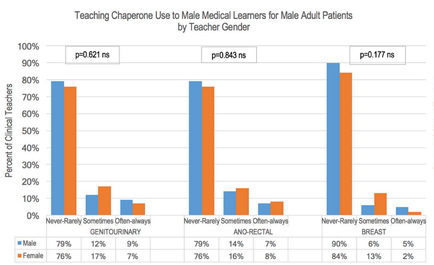
- 41% male, 58% female, <1% other

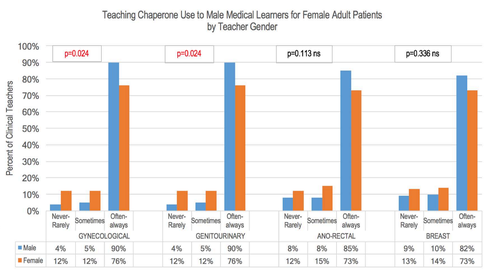
Family Physician Chaperone Use*



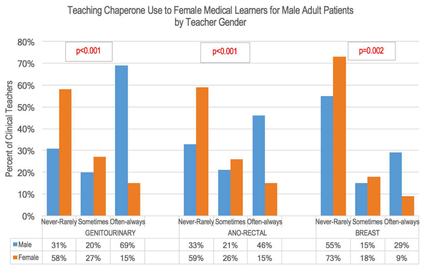


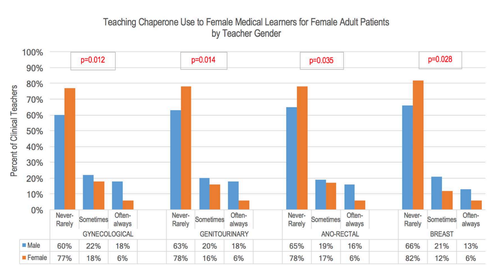
Teaching Chaperone Use to Male Learners**





Teaching Chaperone Use to Female Learners**





*p-value based on Kruskall-Wallis test
**p-value based on Pearson chi-square test

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Barriers and Facilitators to Colorectal Cancer Screening for Canadian Immigrants: A systematic Scoping Review

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Introduction

- Colorectal Cancer is the 2nd most commonly diagnosed cancer in Canada. It is the 2nd leading cause of death from cancer in men and the 3rd leading cause of death from cancer in women in Canada.
- Secondary prevention through screening can detect cancer before having any symptoms and may contributes to less aggressive treatment, less time spent on recovery, better survival, and thus reduce cancer morbidity and mortality.
- Despite the substantial evidence signifying the importance of screening in reducing colorectal cancer mortality and mortality, the rate of cancer screening among Canadian immigrants is still sub-optimal contributing to the high cancer burden in Canada.
- We systematically identified the literature regarding the barriers and facilitators of cervical cancer screening among Canadian immigrant reported by immigrant populations, health care providers, and stake holders.

Methods

- This review followed the five-stage framework of scoping reviews by Arksey and O'Malley (2005): (I) Identification of research topic, (II) Identification of relevant studies, (III) Study selection, (IV) Data charting, and (V) Synthesis.
- We used comprehensive keywords and MeSH terms for barrier, facilitators, screening, colorectal cancer, and Canada.
- We searched published articles in : MEDLINE; EMBASE; EBM Reviews (including Cochrane); PsycINFO; CINAHL; Scopus; Academic Search Complete; Family and Society Studies Worldwide; Web of Science; Social Work Abstracts; Family Studies Abstracts and SocINDEX with Full Text.
- We also searched grey literature in: Google; Google Scholar; ProQuest; OpenDOAR, Health Sciences Online; Turning Research into Practice (TRIP); Canadian Institute for Health Information (CIHI); Public Health Agency of Canada (PHAC); Health Canada; National Institutes of Health (NIH).
- Data from selected literature were extracted in an excel file and results were classified under different themes.

Results

- In total, 33 articles were identified for data extraction. Figure 1 provides a flow diagram of the study selection process.
- These 33 publications presented physicians' perspectives, patients' perspectives as well as stake holders' perspective
- Outcomes of the selected studies are analyzed and organized into the 4 themes:

1. Subject related barriers and facilitators
2. Utilization level barriers and facilitators
3. Health service level barriers and facilitators
4. Health policy level barriers and facilitators

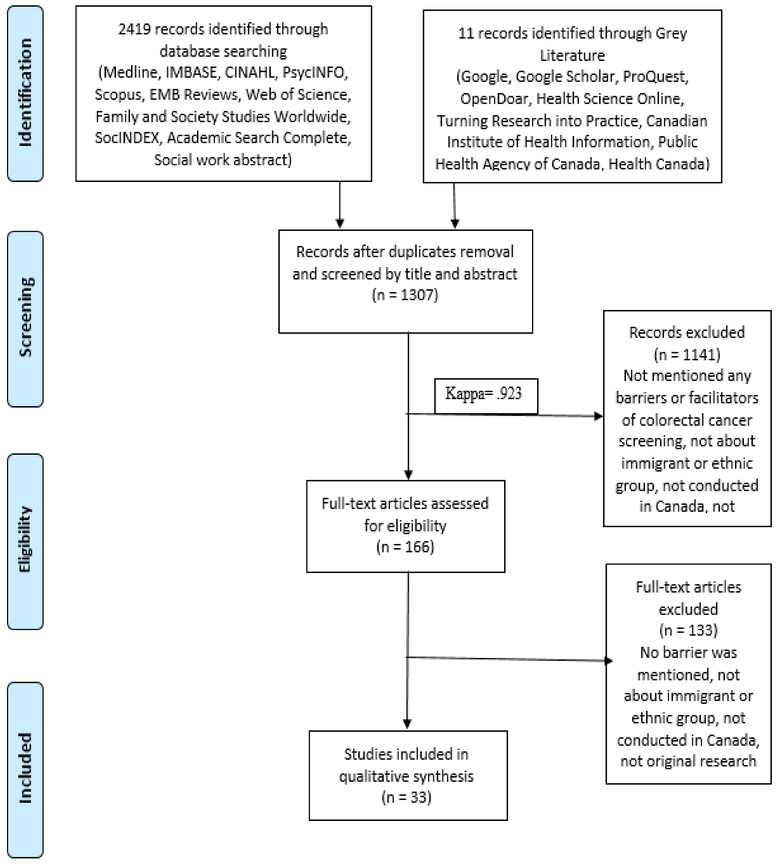

Figure : Study selection process for this scoping review

Major Barriers identified from the literature:

- Lack of Knowledge regarding Colorectal Cancer risk factors and Screening
- Lack of effective communication skills
- Lack of physicians' recommendation
- Fatalism
- Cultural taboo about cancer
- Belief that screening is not necessary in absence of symptoms
- Having no regular family physician
- Less acculturation
- Low socioeconomic status
- Lower level of education

Major Barriers identified from the literature:

- Having recommendation from the physician
- Multiple source of trusted health information
- Higher education level
- Having a regular family physician
- Longer time of stay in Canada
- Having proficiency in one of the official language in Canada (English or French)

Conclusion and Implications

The synthesized knowledge in this literature offers to generate a framework for researchers, policy makers and health care providers to better understand the barriers confronted by Canadian immigrants while accessing colorectal cancer screening along with the facilitators to direct future research in this field.

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Using Cultural Probes to Explore the Relationships Between Walkability and Health in Immigrant Communities

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Introduction

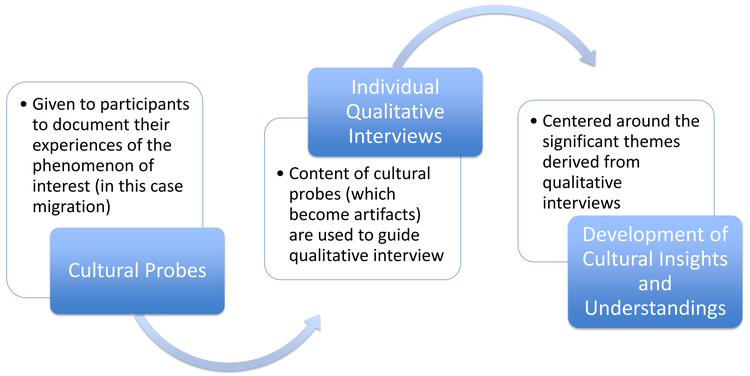
Walkability viewed from a population health intervention perspective, holds enormous promise with research showing that the more walkable a neighbourhood, the healthier its residents. But, how to harness this across diverse populations and identified harder-to-reach groups is a difficult question from both a social justice and equity perspective. ·

Newcomers to Canada (i.e., individuals who migrate, seek refuge, or claim asylum in the country) face a special set of barriers to leading physically active lifestyles: despite the known benefits of physical activity, studies have shown that the physical health of many newcomers declines significantly following their transition into the host country. While there is speculation in to the research as to why this is the case – acculturation or loss of protective cultural barriers there is a dearth of research exploring the everyday links between culture, motivation and utilitarian physical activity.

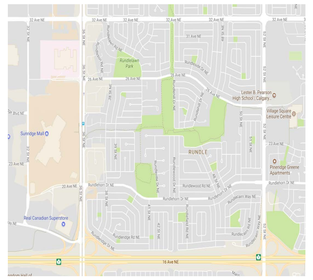
Rundle, and its nearby communities, in Calgary's north-east have been identified by the City as a community with a significant newcomer presence and a low –mid walkability score. In this poster we present preliminary findings from our pilot research project which explores the motivation and barriers to 'walking for health' and 'transportation walking' among first and second generation SA Canadians living in Rundle, Calgary. The focus is on the interrelationships and interactions that play-out between culture, identity, and walkability in determining patterns of walking behavior in a high-risk population.

Methods

The arts-based ethnographically derived approach to data collection and participant engagement is informed by a social justice epistemology (Sinacore, 2014), where creativity and collaboration are tapped into in a way that inspires and engages newcomers to share their experiences of health and well-being from an everyday, culturally informed perspective. Specifically, this research approach combines the use of cultural probes with qualitative interviews to collect in-depth, multi-layered, contextual data.

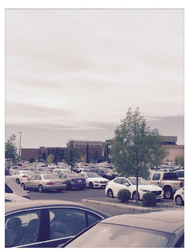


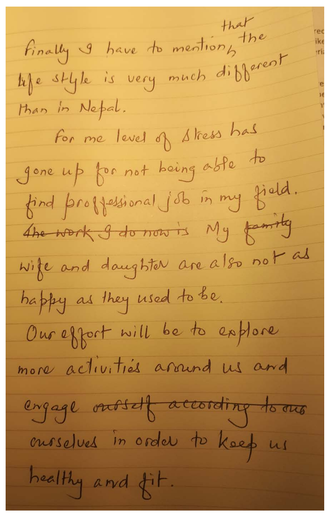
- ✓ Employs an iterative process for data interpretation and analysis
- ✓ Highly effective where research must be completed quickly regarding a pressing concern, such as cultural transition or school integration
- ✓ Outcomes are targeted at gaining socio-cultural data to provide a human-centered approach to solving existing issues
- ✓ Has its basis in anthropology and draws on multiple techniques and interdisciplinary teams



Preliminary Findings suggest that…

- ✓ Internal and external motivators or features of daily living, as representative of cultural practice (at a personal level), act as barriers or facilitators to health and wellbeing in ways that are not always considered.
- ✓ There are valuable insights to be had regarding the role that identity, gender, expectations, settlement experiences and culture play in mediating health and well-being.
- ✓ The process itself encourages participants to raise and consider experience that in other circumstances may be silenced or not considered as possible barriers or facilitators for health
- ✓ Identity – what it means to be Canadian, a desire to belong, a need to also maintain cultural identity – have significant influence on health and well-being.
- ✓ Walkability and access to public transit is a key determinant in health and well-being as it impacts access to health care, employment, food, and social connectivity.





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