Out of Hours

Don't ask an expert

Often, when someone decides that there is an educational need in primary care, the person organising the session decides to 'think big'. If there is an internationally-renowned professor of this field then they may be invited to impart wisdom and knowledge about this subject. I believe that this is the completely wrong person for the job.

When experienced clinicians want to learn about a subject they want what is relevant to them not what is of interest to an expert. That means getting someone who faces the same clinical scenarios as them but with a greater frequency, and who can add another dimension to their knowledge. That could mean being the person on the receiving end of primary care referrals, or that they have some other reason for sub-specialist expertise. What is not helpful is someone who never faces the same clinical question in essentially the same way.

THE VOMITING BABY

Take the problem of the vomiting baby. Babies who vomit after feeds are unlikely to have a medical problem but some do, and deciding who need tests or treatment is one of the biggest challenges with this age group. If you ask a paediatrician, they will have lots of experience of vomiting babies but their population is skewed to have far more pathology and fewer normal babies, so they will need to account for this in their teaching. Also, they have probably not worked in a GP setting and have a lack of understanding about the challenges that clinicians face in primary care.

Given the choice though, many people would seek out a paediatric gastroenterologist. This will be a risky strategy. The patients that the paediatric gastroenterologist see have usually been filtered by a GP or an emergency department doctor followed by a paediatrician. They will have a very different experience of what the likelihood is of a significant pathology being found and will encounter quite rare diagnoses all the time. They may even have an area of research that applies to the treatment of cases where nothing else has worked, leading to another level of complexity in the cases that they see. Ultimately, the danger lies in asking someone who rightly assumes that every case will have pathology to talk to a group of clinicians for whom the absence of pathology is the norm.

ATTITUDE AND UNDERSTANDING

So who does make a good teacher when it comes to primary care education? The first thing that I believe is needed is the right attitude. Too many hospital clinicians go to these teaching sessions with a sense of superiority (of expertise) or worse still, an axe to grind. I have heard many a doctor stand up and start talking about inappropriate referrals or wrong treatments. I would like to see more experts begin with an acknowledgement of the difficulties of the gatekeeper role and recognition of how difficult it is to keep up to date in the treatment of every single medical condition. (I have been both GP *and* hospital consultant and I find keeping up to date far easier now as the latter than when I was a GP). Perhaps then they would engage the audience instead of losing them at the outset.

The next ingredient is an understanding of what the learners want and need. It is important that the person giving the session does bring some of their own agenda but in a respectful way. If they know that there is no point referring a certain condition, they can say so and it will be exactly the sort of thing that the GPs have come to hear. It is also useful if they understand what their audience came to find out about. Too often the session is planned completely ahead of time; PowerPoint® has much to answer for. If no time is left for discussion or questions, they may as well have written their session down and emailed it to the GPs. The likelihood is that the person giving the session does not initially know what their audience seeks from the session. The speaker needs to ask, and one of the best times to do this is before the day itself. I believe that GPs are far too knowledgeable and experienced to have a 100% prepared session. What they need from a session is much too complex to go on a slide or a handout: real debate and interaction is essential to make the most of their learning.

I suspect that many reading this will consider all of this too big an ask: a person with an understanding of primary care, who has a bit more expertise but not too much, who has no unhelpful agenda, and who has good presentation skills and provides interactive learning. However, if you accept poor quality teaching then the question is 'why?'. Does primary care view itself as relying on secondary care experts so much that it will take what it can, however it comes?

If anyone looks at these specifications and thinks that they cannot be fulfilled then it is probably because they are not being requested. I recommend that anyone asked to take a session is told what is required of them. Insist that the person makes their session interactive for at least half the time, and ask them to discuss real cases, not groundbreaking research. They should be given a brief rather than the sense that they can deliver whatever they want to cover. They should be told that teaching should be confined to the primary care management of the condition, although that can include the referral and what happens at the other end so that the patient can be well informed.

When the person gives their session, make allowances for the fact that they are secondary care doctors so their understanding of the workings of general practice is limited. However, if they are rude, patronising, or teach only what they want to teach, don't ask them back. Finally, *don't* ask a world expert. They just don't know enough.

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Also by the author: *Paediatrics for primary care — what the books and guidelines don't cover*: http://gppaedstips.blogspot.co.uk/

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