Promoting professional behaviour in general practitioner training practices

The views of practice managers

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Background and objectives
General practitioners (GPs) are required by the Australian professional colleges of general practice – The Royal Australian College of General Practitioners and The Australian College of Rural and Remote Medicine – to practise a high standard of professional behaviour. General practice registrars (GPRs) learn this in their training practices not only from their general practice supervisors, but also the practice managers (PMs). Little is known of PMs' views of the meaning of the term 'professional behaviour' and how they view their role in GPR education.

Methods
Nineteen semi-structured interviews with PMs were conducted. Saturation was reached and consensus achieved on the analysis.

Results
PMs held nuanced views on the meaning of the term 'professional behaviour' and actively promoted and modelled this to their staff, including GPRs. PMs believed they had a role in GPR education.

Discussion
Practice managers are well placed to model and teach professional behaviour, and their skills should be further used to educate GPRs.

THERE IS INCREASING societal expectation for medical practitioners to exhibit high standards of professional behaviour. The expectations of the Australian Health Practitioner Regulation Agency regarding professional behaviour are clearly outlined in its publication *Good medical practice: A code of conduct for doctors in Australia* and strongly focus on patient welfare.[1]

The two Australian professional colleges of general practice – The Royal Australian College of General Practitioners (RACGP) and The Australian College of Rural and Remote Medicine (ACRRM) – have defined both professional and ethical roles for a competent general practitioner (GP).[2,3] The basis of their professional standards is treating all others, not just patients, with dignity, courtesy, respect and compassion.[3]

Australian General Practice Training is a three-year to four-year program, currently delivered by nine regional training organisations (RTOs). Trainees, known as general practice registrars (GPRs), spend two to three years in supervised general practice.[4] Current RACGP and ACRRM training standards emphasise the practice and modelling of high standards of professional behaviour by general practice supervisors (GPSs) in practices where GPRs are placed.[3,5] During placements, mandated teaching of GPRs is provided not only by the GPS but also by practice nurses, allied health practitioners and practice managers (PMs).

Most Australian general practices employ a PM, although the role, experience and qualifications are poorly defined.[6–8] A recent literature search revealed only six papers on this topic.[6] Anecdotally, PMs are involved in various interactions with GPRs but little evidence exists about their involvement in GPR training. RACGP and ACRRM curriculum requirements for teaching of the professional and ethical role of a GP have ensured RTOs include this in their curriculum and have policies regarding professional behaviour of staff, GPRs and GPSs.[9,10]

Therefore, little is known of PMs' views on professional behaviour, and how they see their role as models and educators for their staff, including GPRs. Given that PMs are commonly involved in GPR education, RTOs need to consider their responsibilities in relation to educating and supporting PMs in this task.

Within this context, and given the almost complete absence of literature on PMs in Australian general practice,[6] we used a phenomenological approach that is known to assist professionals in reflective practice to understand PMs' views and experiences.[11] We explored PMs' views about:

- the meaning of the term 'professional behaviour' in the general practice setting
- the PMs' role in the promotion and modelling of professional behaviour
- the PMs' role in the education of GPRs about professional behaviour in general practice.

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Methods

Ethics

Ethics approval was granted by the University of Melbourne (Approval number: 1748998).

Recruitment

All PMs from 268 RTO Murray City Country Coast (MCCC) GP Training practices received emailed study information from their region manager and invited to participate by returning signed consent.

Data collection

Given the absence of literature, the template for the semi-structured interviews followed the research questions (Table 1). Prompts were based on both our 25 years of educational experience with GPRs and comments that arose iteratively from the interviews. Telephone interviews were conducted by CL, recorded and transcribed.

Data analysis

Data analysis commenced after four interviews to examine emerging themes and monitor data for saturation. An inductive approach was used, in which theory was developed, emergent from the data under analysis, rather than from the application of a pre-existing theoretical perspective.[12]

All transcripts were read by CL and one-third read by MTS. Initial coding was completed manually by CL and confirmed by MTS. Subsequent analysis identified key themes that were reduced with further refinement and linking. Consensus on all aspects of the analysis was achieved between researchers.

Results

A response was received from 20 PMs. Of the 20 PMs who gave consent to participate, one was subsequently unavailable for personal reasons, thus 19 were interviewed.

Demographic information is recorded in Table 2. Data saturation was reached after 12 interviews, but all 19 participants who indicated an interest were interviewed to ensure a wide perspective. Interviews were 16–38 minutes in length.

Analysis resulted in the emergence of four themes with sub-themes:

1. The meaning of the term 'professional behaviour'
2. PMs' perceptions of the importance and value of professional behaviour:
   - optimal practice functioning
   - quality patient care
   - improved workplace harmony
3. The role of the PM in modelling and promoting professional behaviour through:
   - induction procedures
   - staff support
   - addressing unprofessional behaviour
4. The role of the PM in the education and support of GPRs.

Table 1. Template for semi-structured interviews

Interview theme	Sub-theme
Demographic details	• Age range • Gender • Qualifications: secondary/tertiary • Years spent working as a practice manager (PM) • Past experience in a general practice or accredited training practice • Current experience in a general practice or accredited training practice • Experience in other forms of medical practice • Details regarding current training practice where PM is employed: – Location: Inner metro/outer metro/regional/rural/remote – Size of practice: 0–5 general practitioners (GPs)/≥6 GPs – Patient demographic • Type of practice: GP-owned/corporate/community health centre/other
Views on the meaning of the term 'professional behaviour'	• Views of the PM on the meaning of this expression as a generic term • Views of the PM on the meaning of this term in the general practice environment • Views on the degree of importance of this attribute in the general practice setting and its implications for all staff and patients • Examples of what constitutes professional behaviour within general practice (strictly de-identified)
The role of the PM in modelling and promoting professional behaviour in the general practice environment	• Views of the PM on their role, if any, in promoting professional behaviour within their general practices • Examples of how this can occur (strictly de-identified) • Views of the PM on their role, if any, on modelling professional behaviour within their general practices, with examples if appropriate • Role of the PM (if any) in addressing unprofessional behaviour by staff
The role of the PM in the education of GPRs about professional behaviour in general practice	• Views of the PM on their role in (if any) in the education of general practice registrars (GPRs) in Murray City Country Coast training practices • Views on the importance of GPRs' understanding of professional behaviour in the general practice setting • Views on their own capacity to promote, model and educate GPRs about this issue in general practice

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1. The meaning of the term 'professional behaviour'

PMs defined professional behaviour in terms of standards, values and attributes, rather than specific tasks and behaviours:

> *It's about the standards we set. Our attitude, no matter what our work is in the practice, should be about doing the right thing both morally and legally.* (Interview [IV] 4)

> *... being true to the values of the practice and also personal values, trust, integrity, honesty.* (IV 13)

> *We would expect the same [values] from [all of] our staff.* (IV 7)

The attribute considered most important was respect:

> *... respecting people we deal with, our patients, other staff members and other providers in the community ...* (IV 4)

PMs in rural communities believed it was important to meet community expectations:

> *... although [staff members] are not at work, the community does expect them to act and behave in a certain way that perhaps would be different in an urban environment ...* (IV 7)

PMs described professional behaviour as demonstrating a range of qualities:

> *Professional behaviour is being courteous, polite, a good listener, good presentation, being able to be compassionate and a firm understanding of being empathetic.* (IV 10)

Table 2. Participant demographic characteristics

Interview	Age (years)	Gender	Years as PM	Qualification*	Practice location	Size (no. of GPs)	Years training GPRs	Model
1.	60–69	Female	32	Tertiary, not specific	Regional	6	30	GP-owned
2.	60–69	Female	11	Tertiary, specific	Regional	6	4	GP-owned
3.	60–69	Female	18	Tertiary, specific	Regional	5	12	GP-owned
4	50–59	Male	9	Master of Business Administration	Rural	9	8	GP-owned
5.	50–59	Female	20	Tertiary, specific	Regional	8	15	GP-owned
6.	60–69	Female	40	Tertiary, specific	Metro	8	10	GP-owned
7.	50–59	Female	31	Tertiary, specific	Rural	7	30	GP-owned
8.	50–59	Female	22	Tertiary, not specific	Regional	9	15	GP-owned
9.	50–59	Male	15	Tertiary, specific	Regional	5	11	GP-owned
10.	50–59	Female	16	Tertiary, specific	Metro	5	16	GP-owned
11.	50–59	Female	21	Tertiary, specific	Regional	18	18	GP-owned
12.	50–59	Female	22	Tertiary, specific	Regional	5	5	GP-owned
13.	50–59	Male	5	Tertiary, specific	Regional	10	5	GP-owned
14.	40–49	Female	24	Tertiary, specific	Metro	12	8	GP-owned
15.	50–59	Female	7	Tertiary, specific	Rural	6	7	Corporate
16.	40–49	Male	7	Tertiary, specific	Regional	23	2	CHC
17.	50–59	Female	15	Nil	Regional	5	1	Aboriginal and Torres Strait Islander CHC
18.	20–29	Female	3	Nil	Metro	7	1	Corporate
19.	40–49	Male	6	Nil	Metro	5	2	Corporate

**Refers to tertiary qualification and whether specifically related to the practice manager role*
CHC, community health centre; GP, general practitioner; GPR, general practice registrars; PM, practice manager

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> *It means following a code of conduct for the organisation, being professional in your dress and demeanour and being respectful of everybody you work with.* (IV 2)

> *… knowing professional boundaries in the way I talk, the way I act, the way I behave, understanding client and staff expectations, knowing my workload, being culturally sensitive and confidentiality.* (IV 17)

PMs viewed teamwork, equality and respect between staff members as an important component of professional behaviour:

> *We don't have a hierarchy here. We have a very flat structure. It is really important to have that whole teamwork approach with professional behaviour, having that level of respect.* (IV 11)

2. PMs' perceptions of the importance and value of professional behaviour

All participants viewed professional behaviour as essential in a quality general practice:

> *As far as work place office safety and human resources [is concerned], it is extremely important for everybody's wellbeing to be treated with respect and professionalism.* (IV 2)

Some PMs felt that professional behaviour contributed to improved patient experiences:

> *If you are professional about your outlook, [patients] are more at ease, they are more trusting, they trust their doctor, they trust the clinic, that's a key.* (IV 14)

Professional behaviour also contributed to an efficient and harmonious practice:

> *For the staff, [professional behaviour] makes the interaction so much more pleasurable for everybody. It is a self-fulfilling set of behaviours; the more we do it, the more we want to do it.* (IV 16)

3. The role of the PM in the promotion and modelling of professional behaviour

All participants believed the PM had a role in promoting and modelling professional behaviour:

> *… it's very important that the PM sets the standard in professional behaviour, demeanour, dress …* (IV 9)

> *The PM is central to the culture of the practice … sets the standards in [staff] behaviour.* (IV 16)

PMs used a range of approaches to promote professional behaviour and teamwork:

> *When we have our staff meetings with nurses and receptionists and not GPs, quite often issues come up around professional behaviour and conduct.* (IV 3)

Reflecting on their own behaviour as role models elicited various responses:

> *It's how you behave yourself and how you treat others.* (IV 3)

> *The staff can learn by seeing the way someone particularly behaves in the practice as opposed to what they say should be done. [For example], if the PM is always on time themselves …* (IV 6)

All participants addressed expectations of professional behaviour for new employees at induction:

> *We include all of that [values and standards] in the job documentation we send them. We run through it as part of the interview and when we get them to start as well.* (IV 4)

Some practices required employees to give written agreement to a code of conduct; others addressed this through discussion, with the same intent:

> *We have a code of conduct … but we have created our own in-house policy, which is applicable to all staff and doctors, which is just a list of basic professional standards … all our staff members have to read and sign it before they are employed.* (IV 18)

Supporting individual staff was viewed as a priority and an effective measure in promoting professional behaviour:

> *I make an enormous effort to get to know my doctors and staff individually because you connect on a level and it changes the working relationship. It creates a really harmonious working atmosphere … PMs have got to nurture, care for and develop a workplace [such] that you are only going to get positive outcomes.* (IV 19)

PMs viewed addressing episodes of unprofessional behaviour as a component of their role:

> *If it is clinically inappropriate in regard to treatment of patients, then it is for the senior doctor [to address]. Anything else [breach of professional behaviour] is my responsibility.* (IV 15)

At times, the GP practice owner or senior GP preferred to delegate this task to the PM:

> *No, I was never supported by the GP owner [in managing unprofessional behaviour] because he does not like confrontation.* (IV 15)

Many emphasised the importance of a no-blame approach:

> *If we have an incident in the clinic … we look at what happened and use it as a training tool … we run a no-blame clinic …* (IV 9)

4. The role of the PM in the education of GPRs about professional behaviour

Most PMs expressed a view that their role included education of their GPRs about professional behaviour:

> *It is a PM's role [to educate a GPR about professional behaviour] because you have to have [education] from somebody else [not a GP] to give a much broader understanding.* (IV 5)

> *No [I do not see myself having a role in promoting and teaching professional behaviour to GPRs]. I only have an educational role as far as systems and processes.* (IV 8)

There was a high awareness of the challenge faced by GPRs in transitioning to general practice, and developing a supportive relationship was considered a priority:

> *It's a big learning curve to treat people in general practice compared to hospital. I know it's a big learning curve for [GPRs] and I am quite comfortable working with them.* (IV 2)

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> *You need to nurture [GPRs] and that is what I do.* (IV 15)

While GPRs underwent similar induction procedures, PMs viewed their role also to emphasise the values of the practice:

> *You see GPRs coming from other practices … they are still vaguely reminiscent of a hospital system … you can see the growth when they get to their Fellowship … we've got someone who is going to be a great role model for newer doctors.* (IV 5)

Episodes of unprofessional behaviour with GPRs were rare, but when they occurred, they were usually addressed by PMs, with GPSs involvement if needed:

> *We have been extremely lucky. We have had nothing but great comments about our GPRs.* (IV 6)

> *If a pattern [of unprofessional behaviour] occurs, then I would sit down and bring it to their attention, this is something we need to discuss. I would first ask is there a reason this is not working for them …* (IV 3)

> *I would definitely speak to the supervisor about [GPR unprofessional behaviour] first.* (IV 19)

Discussion

This study is the first to explore the views of PMs about professional behaviour. As there has been minimal research about the PM role,[6] this study has not only provided new information about the research topic but also insights about the PM role itself.

PM participants came from a wide range of professional backgrounds. Fourteen of the 19 participants had completed tertiary training relevant to the PM role and had varying job descriptions, as has been previously documented.[6–8] While all participants gave considered views about their understanding of professional behaviour, none were aware of the standards of the professional colleges[3,5] or the GP training curriculum, which describes the importance of GP professional behaviour.[2,5,9]

All participants articulated nuanced views about the meaning of the term 'professional behaviour' and described this as attributes and qualities rather than particular tasks. The most frequently mentioned term was respect, both for patients and colleagues. Some PMs believed that patients should also show this respect. This appeared to reflect an altruistic view that all staff should behave in ways that promote and model respect for everyone they encounter over the working day. Therefore, PMs were easily able to describe expected behaviours that reflected this, such as personal presentation and courtesy to colleagues, patients and their families.

The experience of all participants was that professional behaviour was an essential component of a high-quality general practice and as important as a high standard of medical care. They also noted various benefits they had observed that they attributed to excellent standards of professional behaviour including improved workplace harmony, reduction in staff stress, increased patient trust in the practice and, ultimately, improved patient care.

An unexpected finding was the view of some PMs in rural settings of the importance of professional behaviour outside the workplace. This reflected a high level of awareness that such behaviour could have both positive and negative implications for the good name of the practice, as it was well known which staff worked in a local practice. Therefore, these PMs took particular steps to ensure staff understood the importance of professional behaviour outside the workplace, particularly pertaining to the observance of confidentiality.

Many participants viewed effective teamwork as critical to harmony between staff members and emphasised what some described as a 'flat structure' where all staff from 'cleaner to most senior GP' had equal but different roles in contributing to high-quality patient care. This reflects attitudinal change where previously an emphasis on the value of teamwork has not been strong and not considered a necessary attribute in effective functioning of the practice.[1]

Consequently, PMs believed an integral part of their role was to promote teamwork, which they achieved through various initiatives such as meetings with open discussion of issues of concern, regular checks with individual staff members, and social occasions for all practice staff. Participants strongly encouraged staff to bring any concern about work harmony promptly to the PM. Therefore, participants showed a high awareness of the nature of the various interactions between staff and patients in daily practice.

All participants took steps to ensure new staff, whatever their roles, were aware of the importance of professional behaviour. Fourteen of the 19 PMs interviewed worked in GP-owned practices and therefore their induction procedures were internally determined. The majority of these practices had written codes of conduct or professional behaviour policies, but where these documents did not exist, PMs considered a discussion of professional behaviour expectations an integral part of the induction. In non–GP owned practices, participants still had considerable autonomy in discussing professional behaviour with new staff, although formal processes were usually carried out by human resource personnel. Many PMs required staff to give written confirmation that they had understood the content of this document. PMs generally did not greatly vary the nature of this discussion according to the different roles of the applicants, which reflected the PMs' view of the value of the 'flat structure' of the practice team. While this activity confirmed that PMs indeed saw promotion of professional behaviour as an important priority, it was not clear to what extent this also reflected the views of the practice owners, who were usually GPs.

Participants saw it as their responsibility to address episodes of unprofessional behaviour, although these instances were described as uncommon. Whether this was the result of the PMs' proactive interventions was not able to be determined. All PMs were clear that addressing unprofessional behaviour in regard to clinical and medical matters should be resolved by a designated senior GP, sometimes in consultation with the PM. All PMs elected to address such

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issues through open discussion with staff members concerned rather than an immediate disciplinary approach. This was a further reflection of the PMs' views about their role as one of providing support to staff in carrying out their work roles effectively.

Many participants had worked in GPR training practices for some years and were familiar with the challenges GPRs faced in the work transition to general practice, including, for some, the changed social circumstances of rural life. Many participants made considerable effort to get to know individual GPRs and provide personal and professional support. Provision of this support was viewed as an integral part of their role, and induction processes regarding expectations of professional behaviour for registrars were similar to all other staff. This appeared to reflect the change in the current approach to training GPRs, where in-practice supervision is now provided by a supervision team comprising PMs in addition to nurses and allied health staff.[5]

While participants were of the view that it was implicit their own work reflected their emphasis on professional behaviour, few had considered how this modelling might directly influence staff and registrars. Although many PMs are actively involved in GPR supervision, the nature of this role has not been defined. This may explain both the little consideration PMs had given to this issue and the reason why one participant did not view the PM role as inclusive of GPR education on professional behaviour. Despite this, the information obtained in this study suggests that the PM, as a member of the practice team, is able to facilitate and contribute to GPR learning.

MCCC GP Training provides regular workshops for PMs in its GPR training practices. While many of these workshops address issues relating to professional behaviour, the promotion and teaching of professional behaviour to GPRs by PMs has been little addressed here. The RACGP and ACRRM domains of practice and curricula describe the components of the professional and ethical role to be taught to GPRs. It may be useful to discuss these documents with PMs at their training workshops and thereby assist them in their education of GPRs within their practices.

Strength and limitations

The use of a qualitative framework with a semi-structured approach was the major strength of this study, particularly given the lack of literature on this topic.

Sampling was drawn from those who volunteered to participate and therefore may have reflected those with a strong interest in the research topic. However, participants worked in general practices across a wide demographic, which ensured a range of views on the research topic were obtained. Further, data saturation was achieved, providing evidence that the opinions expressed were a valid representation of PM views.

While almost all PMs had tertiary qualifications in practice management and most were older and female, it is likely this represents a fair reflection of the current PM demographic. Only two corporate practices were represented, and given their different business model and the rise of the corporate in Australia, it may have been useful to have a greater representation of participants from such practices.

Conclusions

This study has appropriately used a qualitative framework to ascertain the views of PMs about professional behaviour in general practices, a subject about which little is known. It has revealed a group of PMs committed to the promotion of a high standard of professional behaviour in their practices, and a willingness to model this in their own work life and to support staff likewise. Similarly, these PMs have shown a commitment to working with and supporting GPRs in understanding professional behaviour. Given professional behaviour is a component of the RACGP and ACRRM Standards, the RTOs should continue to use their skills when training GPRs.

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