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Enhancing General Practitioner Confidence And Competence In Acute Ent Management: A Targeted Educational Intervention

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ABSTRACT

Because they serve the local community, GPs need to know a wide range of information to successfully diagnose and treat patients. The abilities and background of GPs depend on the medical school they completed and the particular training programs involved. Learning opportunities about ear, nose and throat (ENT) diseases are not common as there are rarely planned ENT rotations, so few educational activities and various curricula, yet they are experienced every day by primary care providers. We wanted to find out if trainees felt they were not prepared to handle most ENT conditions and if they would be interested in a separate ENT teaching session. Strong interest in an educational intervention was shown by the findings. As a result, we structured a planned teaching course for managing and evaluating common ENT emergencies and then gathered information from a questionnaire completed after the session to evaluate their confidence and knowledge. It was evident after the session that participants gained a better ability to handle ENT problems. In addition, the majority of students said they were very satisfied with the program. According to this research, general practice vocational trainees need educational initiatives aimed at their specific needs in all specialties to support their effectiveness in community medical work.

Key words: General Practitioners, Ear, Nose, and Throat (ENT), Vocational Training, Clinical Confidence Medical Education

INTRODUCTION

GP Curriculum and ENT

There are approximately 300 million consultations each year in primary care in the United Kingdom, with a considerable number relating to problems with the ears, nose or throat (ENT).2–4 About one-quarter of visits made by adults and half by children to primary care involve ENT problems which makes them among the most typical cases dealt with by GPs.3–4 The field of ENT surgery covers different scenarios, from life-threatening concerns and cancer to various issues that can seriously impact patients' lives.5 Increasing age and an uptick in chronic diseases in the population affect all medical

Confidence and Competence – The Connection to Teaching and Training

Weekly education sessions are an essential feature of GP trainee programs and usually must be attended. Since attendance is a requirement without advance notice, the specialty has a minimum standard of 70% participation a year.7 The Royal College of General Practitioners has officially incorporated ENT into GP training.8 Even so, many doctors and medical students, plus trainee GPs, still feel unsure about ENT. ENT education is included in medical training at three main moments: undergraduate education, beginning training and training in specialized areas.1 Literature notes that ENT teaching is lacking in important skills, accurate information and different perspectives during all stages and in different locations.8 Clamp et al11 polled 357 GPs in southwest England and found that more than 75% believed their ENT courses during their undergraduate years did not equip them for real-world practice. The authors found that some medical schools didn't have an ENT rotation and where it was included, it lasted only eight days on average. Students regularly mentioned that they spent a lot of their ENT attachment time in theaters and clinics, not having much opportunity to take histories and examine patients with obvious diseases. Since there is not enough formulated instruction in general practice, many GP trainees have trouble handling ENT conditions and usually count on the experience and knowledge that their seniors share. The risk is that this method allows people to continue with incorrect methods, as assessment scheduled by the institution is very limited. Problems in this field are made worse by the fact that ENT topics are rarely emphasized in common profession examinations which tend to be very basic and appear in general medicine. The fact that ENT problems are so common means changes in teaching are needed to benefit patients and their outcomes. Studies from other countries find the same issues in ENT training, proving this is important

worldwide.1 As sessional duty in hospital clinics is increasingly transferred to GPs and demand for GPs rises due to a growing population, it is more important than ever to reform ENT training for GPs.

preparation for autonomous practice

At the outset, students move from medical school into their first year as foundation year one doctors. Illing and colleagues12 took interviews, collected surveys, looked at learning portfolios and did prescribing assessments on newly qualified doctors from three UK medical schools. Many graduates felt they did not have enough practice in areas they did not learn much about during undergraduate studies, including managing acutely ill patients and prescribing, but were generally very good at taking medical history. The authors of the study looked into how much support newly qualified GPs receive in their first years and whether this support makes a difference to their transition into independent practice. The researchers noted that recent graduates are often struggling with suboptimal performance, often because their training was not adequate. The GPs I interviewed felt that having stronger, planned help from experienced colleagues could boost their self-assurance as they coped with this new phase. Support for education was not equally available in all regions and deaneries when the study was carried out. Sabey and Hardy14 found that many people starting out in general practice after medical school believed they were not ready to manage all duties of their new profession. Experts said GP training should be lengthened and made more comprehensive to prepare them for the growing number of complex and elderly people being treated. If doctors are carefully taught and trained in various areas of medicine such as ENT, it supports their preparations for working solo. To improve, people are suggested to train for a longer time, receive mentorship help from different sources and follow induction, shadowing and simulation programs. Dare and colleagues15 looked at how internship training after a 5-year medical degree influenced a group of trainee doctors in New Zealand. Nearly all students (92%) who did an internship were confident in their skills as junior doctors, unlike the 53% from their fifth year who felt that way. Berridge and her colleagues studied the effects of induction programs designed for newly qualified doctors in two UK hospitals. An induction program was delivered over two weeks, with time spent learning resuscitation and shadowing doctors in their first year of the Foundation program. After the induction, people who were involved completed surveys and took part in discussions again one month and one month later. Results suggested that worries dropped greatly after the induction process and the shadowing experience was very important. For most patients with sudden hearing and throat problems, GPs are the first healthcare providers, who are expected to handle the assessment and treatment with certainty. If we design training strategies to address where GP trainees need improvement, we could help decrease avoidable primary care referrals and hospital admissions.

MATERIALS AND METHODS

Trainees were given the learning needs assessment a few weeks earlier to help assess how confident and able they were at assessing and managing general cases of acute ENT and performing basic ENT exams. The survey further tried to uncover how helpful and engaging an ENT teaching session would be for the trainees and most participants gave positive feedback. Even though official data collection wasn't carried out, we discussed the situation with a Watford GP training scheme representative and they indicated that trainees want a standalone course focusing on ENT pathology. This led to booking a single, half-day session at Watford General Hospital (UK) which involved both the ENT team from Luton and Dunstable and the GP training leaders. After that, the event was shared with trainees to encourage high participation. We carried out a cross-sectional study during a weekly teaching session for GP trainees in Watford General Hospital, Hertfordshire, UK. 16 first-year trainees from the general practice vocational scheme made up the participant group. The presentation covered how to diagnose and treat typical acute ENT disorders, including otitis media and externa, epistaxis, tonsillitis, stridor and the most common primary care cases. The presentation included basic science topics, familiar ENT vocabulary, expert classification methods and the processes used for clinical evaluation (see Table 1). At the ENT session, two doctors led the training, including a foundation year two doctor and a core surgical trainee, who both work at Luton and Dunstanbury University Hospital. They gave a short lesson on how to feel for symptoms such as neck lumps and use an otoscope.

RESULTS

All participants' confidence levels rose in all areas after the educational training. At the start, the assessment found that GP trainees had confidence in treating only some of the common acute ENT issues. Each participant, on average, wrote "not at all confident" or "minimally confident" about perichondritis, otomycosis and mastoiditis before the training session. However, everyone in the group had a moderate (3/5) or greater baseline confidence in treating and identifying both types of otitis, except for one individual who reported having no confidence at all. Once training was finished, nearly 7 in 10 participants felt either "very able" (4/5) or "absolutely ready" (5/5) to manage perichondritis, otomycosis and mastoiditis. More confidence was found among physicians for managing otitis externa and media, but this growth was less noticeable than for other common ear disorders. Improved confidence was seen in both nasal and throat

disorders after the intervention compared to before. Among the scores for confidence in recognizing and treating four common throat complaints, quinsy, stridor, epiglottitis/supraglottitis and food bolus obstruction—41% were considered "low" (2/5). Meanwhile, 87% of the participants were very or fully confident in handling tuberculosis and bone tumors before receiving instructions (see Figures 2 and 3). Another important point was that management of epistaxis and airway emergencies attracted the most "no confidence" (1/5) answers among the pre-session questions on all subjects. Just over a third of those surveyed expressed no faith in handling epistaxis and more than a fourth said they lacked confidence with airway management.

I feel much more confident now in doing basic ENT tasks, for example, otoscopy, neck lump palpation and assessments of the throat and nose. By the end of the intervention, the number of individuals in the low-confidence range dropped from 70%, to 5%. Doctors' confidence in handling infections or bleeding after tonsillectomy within primary care turned out to be comparable. Most trainees started out saying they felt confident at a rating between 1 and 3 (representing 62.5%), whereas only 31.2% felt sure at levels 4 or 5 and a single person reached the maximum of 5/5 (6.25%). The training session improved the trainees' confidence, so that 14 out of 16 (87.5%) now felt 4 or 5 out of 5 confident, while none considered their confidence to be 1 or 2 regarding these problems. Trainees were also asked about their knowledge entering a post-tonsillectomy bleeding session. The most common response was feeling only 1–3 confident, with 81.3% saying this and the highest score was 1/5 from one participant. After the intervention, a large number of trainees felt much more confident. As a result, 93.6% were confident at at least level 3 and the vast majority (75%) reached levels 4 or 5. The catalyst post-session survey concluded with a question about the trainees' general view of the teaching. Six out of 10 participants rated the usefulness of the session 4/5 or 5/5, 81% rated the involvement as 4/5 or 5/5 and nearly all of those surveyed (94%) gave the same score to the presenting team, with a similar result for the content: the participants rated it 88% as 4/5 or 5/5.

Table 1.Subjects Covered in the ENT Educational Session

Category	Topics Covered
Anatomy	Ear structures
	Nasal blood supply
	Paranasal sinuses
	Pharynx and larynx
Clinical Examination	Otoscopic examination
Common Acute ENT Conditions	External ear infection (otitis externa)
	Middle ear infection (otitis media)
	Acute mastoid inflammation
	Ear canal foreign bodies
	Auricular perichondritis
	Ear pinna hematoma
	Tympanic membrane rupture
	Nosebleeds (including nasal cauterization and packing)
	Nasal foreign bodies
	Nasal bone fractures
	Septal hematoma
	Sinus infections
	Periorbital and orbital cellulitis
	Acute tonsillitis
	Infectious mononucleosis (glandular fever)
	Peritonsillar abscess
	Respiratory stridor
	Supraglottitis and epiglottitis
	Post-tonsillectomy hemorrhage

DISCUSSION

Many studies show that giving more opportunities and structured instruction increases both the self-assurance and skills of both students and doctors in medicine. It was found by Dare et al.15 that studying on the internship year helps increase medical students' level of confidence before they practice as professionals in the field. Likewise, Sabey and Hardy showed that several GPs believed a longer training period of one more year would set them up better for working by themselves. For the first round of self-evaluation, participants felt significantly more confident about understanding otitis media and externa than with epistaxis or stridor. This difference could be explained by trainees being more likely

to face these conditions as primary care providers, helping them build up more experience. One study found that otitis media is a leading basis for GPs prescribing antibiotics to children. This is compared to stridor and epistaxis which typically come on suddenly and can be dangerous, causing patients to directly go to the ER. Between the start and end of the session, the evaluation questionnaire revealed that trainees felt more capable of identifying and handling most acute ENT conditions. People attending said they found the sessions both useful and engaging. They highlight that receiving specialist instruction in ENT improves how confident and capable trainee GPs consider themselves and that shaping the sessions in a useful way encourages these GPs to return. Hutchinson identified what makes a learning session successful and this study includes some of those points. Cultivating positivity in the learning space is very important. Awareness of who they are, their background and what they need to achieve is important for the instructor. We assessed this by finding out what basic skills were required during a learning needs assessment taken by a peer some weeks ahead of the teaching session. In addition, the instructor needs to be ready to deliver the content successfully. Because we followed these teaching principles, the doctors teaching the trainees could make the best use of the short time available for teaching. During my training, I received education mainly through lectures, but learning alternatives exist for GP trainees in ENT, too. Okuda et al.19 found in their literature review that simulation training benefits medical students by increasing skill for procedures, medical knowledge, teamwork abilities, effective communication and confidence.19 Using simulations may particularly help GP trainees in dealing with acute situations not encountered often, for example, stridor, epistaxis or post-tonsillectomy hemorrhage. Nathavitharana20 studied the benefits of online generic training programs for medical practitioners in helping protect patients, help run things more smoothly and eliminating repetitive teaching. While not specifically addressing ENT, the study's results could help develop new online materials or mobile apps aimed at improving many students' ENT knowledge. One thing we saw in our results is that one trainee had nearly no confidence in managing otitis media and externa, compared to their peers. There will be differences in educational backgrounds and the kinds of rotations within a group of GP trainees at one hospital. According to Khan and Saeed9, each medical school has its own ENT training program which causes uneven skill sets and self-assurance among doctors treating these conditions. Besides, lots of medical schools do not have set tests to properly assess how much ENT knowledge students have gained. Ensuring that all UK medical schools implement a single and organized way to train and evaluate ENT should be a priority, so that medical students all start their careers with equal knowledge in this field. This type of instruction would help trainees trust their management of acute illnesses in ENT and enjoy a better education. According to Clamp and his team, even before taking the ENT examination, around 24% of students were content with their undergraduate ENT education, but that went up to 33% afterward. Since the Health Department requires half of medical graduates to work in primary care, it is important that GPs can manage typical ENT issues.

Limitations and Future Directions

Since we had limited resources and logistics, our study took place in only one hospital and used few patients. The survey missed out on trainees' previous ENT training because many had completed similar rotations or gained that training through Summer School or working in Accident and Emergency. Moreover, it was discussed, some deaneries have more educational support than others for GP training.13 Future studies could include more participants and try to eliminate differences in initial knowledge of ENT. While we saw greater confidence after lectures in small groups, individuals have diverse ways of learning and some could advantage from interactive teaching more. Programs in the future might combine lectures with exercises such as visiting patients at their beds and comparing student knowledge with peers, but this would take careful management and use more resources. Likert scales do not fully capture the way medics feel about their clinical experience and focus group discussions with discussion and analysis of various themes could have improved our data. It would be possible to include other healthcare professionals looking after ENT patients such as nurse practitioners and physician associates, within our model. Because they treat minor ENT cases and are important in primary care, better identifying educational needs for these groups would help design a training program suited for everyone.

CONCLUSION

Most cases of acute ENT conditions are seen at primary care by general practitioners. Their basic knowledge, practice hours and belief in their skills should be sufficient to guarantee safe and skillful work every day. An effective GP must be knowledgeable and able to find those who are seriously ill, but it's also vital that they keep and increase their knowledge by continuing professional development. Specialized sessions give GP trainees a chance to learn, reinforce their learning and use new skills by being involved in discussions and practicing. Regular workshops and discussions about several ENT conditions, examining methods and related subjects may increase GPs' confidence and abilities which supports their daily practice. So, this approach might help provide better care for patients while reducing the number of cases seeing secondary and tertiary specialists. In addition such efforts might lead to better and more efficient delivery of primary care for patients.

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