Organisational change readiness: The role of negotiated order in rural GP clinics

Melanie Bryant

School of Management and Marketing, Charles Sturt University, Australia

Email: mebryant@csu.edu.au
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ABSTRACT: This paper uses theory of negotiated order to explore organisational change readiness in two rural general practice clinics involved in teaching medical students (learners). Successful change programs are often attributed to individual, group or organisational readiness, often associating it with cognitive decisions to accept or reject change. Negotiated order takes a different approach by focusing on whether and the degree to which social order, such as accepted routines, roles and patterns of interaction, are ingrained or negotiated into daily organisational practice. I argue that GP clinics that continuously negotiate learners into daily tasks and reinterpret organisational rules are more likely to be change ready in comparison to those that manage learners on top of rigidly adhered to routines.

Keywords: Change management; negotiation; researching change and development; healthcare management

Change readiness is described as the level to which ‘those involved [in change] are individually and collectively primed, motivated, and technically capable of executing change’ (Holt & Vardaman, 2013, p. 9). On the one hand, change readiness literature has documented a number of issues that influence the success of change programs ranging from individual psychological factors (Armenakis, Bernerth, Pitts, & Walker, 2007; Armenakis, Harris, & Mossholder, 1993) through to structural organisational factors (Bouckenooghe, Devos, & Van den Broeck, 2009; Holt & Vardaman, 2013). However, other arguments suggest that readiness as a concept is not easily understood as much of the behaviour that takes place in organisations is ‘automatic and non-conscious’ (Gondo, Patterson, & Palacios, 2013, p. 36). In this paper I engage with the social constructionist turn that has been taking place in organisational change and development research (Bryant & Wolfram Cox, 2013; Bushe & Marshak, 2009) and use the theory of negotiated order as an alternative lens through which to explore change readiness. Negotiated order focuses specifically on how social order, particularly
around ways in which work is performed, is negotiated and determined on a day-to-day basis. While organisations are governed by formal rules, roles and procedures, in reality these are negotiated and informally contested and worked around according to the immediate needs of the organisation, and often in a manner that can enhance productivity and performance. I argue that such practices can add to an organisation’s ability to engage with change on the basis that flexibility and an acceptance of *reinterpreting the rules* creates a culture in which innovative problem solving and decision-making is likely, thus increasing the likelihood of change receptivity and readiness.

To explore these arguments, I examine organisational examples from a study of general medical practices that engage in formal training of medical students in rural and regional Victoria. The broader research project focused on a comparison of six general practices, three of which trained a single-level of learner (such as an undergraduate medical student) and three of which trained multiple levels of learners (ranging from interns to registrars). In this paper I focus on two of these practices as a point of comparison comprising of a single and a multi-level practice. The broader study aimed to develop an understanding of current training practices and whether single-level practices had capacity to expand to multi-level practices; and whether multi-level practices could expand into academic practices in which the focus was equally on patient care, education and research. In using the examples of two practices, the aim in this paper is to explore how learners are negotiated into the day-to-day order of the practices to determine whether the extent of negotiated order is likely to play a role in change readiness.

**Change readiness and negotiated order**

To date, the essence of change readiness literature has largely centred on the key question: ‘what do change recipients consider when making their decision to embrace and support a change effort or reject and resist it?’ (Armenakis & Harris, 2009, p. 128). While this has added much to our knowledge and thinking about preparedness for change, a limitation is that readiness is often linked back to a conscious action or behaviour demonstrated by an individual, group or collectively at the organisation level (see for example Holt & Vardaman, 2013). This creates a challenge for change managers as overall attitudes to change are perceived as being a product of ‘individual schema’ (Amis...
& Aïssaoui, 2013, p. 72) thus guiding change managers to look at individual organisational members and their attitudes rather than the broader social processes and contexts that they function in. In other words, change readiness, and the subsequent success and failure of change programs, tends to be individualised with concepts such as employee resistance often unfairly associated with failed change programs that employees themselves largely do not have enough knowledge of to resist (Pardo del Val & Fuentes, 2003). Attention has been drawn towards these challenges by a growing body of change scholars who have argued for further emphasis on the social and processual aspects of change rather than continued focus and measurement of singular variables (see for example Jaros, 2010). Within the specific context of change readiness research has demonstrated how focusing on concepts such as mindfulness can enable managers to move away from individualising change to becoming aware of the role of behaviours that are routinized within the organisation’s culture and day-to-day functions but rarely addressed or questioned (see for example Gärtner, 2013; Gondo et al., 2013). Amis and Aïssaoui (2013, p. 73) provide an alternative way to explore change readiness through engagement with institutional theory, which ‘emphasizes the processes by which structures, including schemas, rules, norms and routines, become authoritative guidelines for social behaviour’. While this approach is often associated with a macro view of organisations, it provides scholars with an opportunity to explore how macro social processes shape the ways in which organisational members engage with concepts such as change.

The theory of negotiated order is based upon a principle in which although social contexts, such as organisations, are governed by formal rules and policies, in reality order about how day-to-day tasks are performed is negotiated (Strauss, 1978; Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963). In using this approach, I argue that both change readiness and willingness are products of broader social contexts within organisations rather than inherent cognitive views held by individual staff. Negotiated order is embedded within the interactionist approach which is largely concerned with everyday micro-interactions that individuals engage in on a daily basis and how these shape the construction of meaning (see for example Goffman, 1961, 1963). Consequently, organisation studies using the interactionist approach are more likely to engage in questions around how ‘workers interpret what they do [and] … how patterns of interaction constitute negotiated orders that shape how work is
accomplished’ (Hallett, Shulman, & Fine, 2009, p. 489). In going about their day-to-day tasks in organisations individual’s meaning about work is constantly interpreted, with interpretations subject to ongoing modification (Blumer, 1969). That is, negotiated order has ‘temporal limits [and order is] …evaluated, renewed, adjusted or changed as a result of ongoing interactions between the involved parties’ (Pedersen & Huniche, 2010, p. 408). Consequently, work is not viewed as a set of rigid and standardized practices, but as a system comprising the formal organisational structure and less formal social structures.

There are a number of different examples of how negotiated order has been used to explore organisational issues. Becker et al’s (1961) seminal study of medical students found that constant negotiation took place between personal values and organisational values and rules around how medical work should be practiced. Strauss and colleagues (Strauss, 1978; Strauss et al., 1963) found that patient care is subjected to constant negotiation between the various professional roles as well as the patient, regardless of the formal roles determined through professional training, rules and policies. This was later reflected in Svensson’s (1996) arguments that although models of medical dominance that determine power structures and authority within medical decision-making are well documented, in reality decisions are shared across professions such as doctors and nurses. Further, the immediacy of patient needs and available resources at the time influence the daily reality of how work is conducted, making a ‘rigid division of labour extremely difficult to sustain’ (Allen, 1997). Within non-medical contexts, Schulman (1993) found that organisational reliability may be more achievable through negotiating order to manage day-to-day fluctuations as opposed to attempting to limit organisational ‘slack’ by rigidly following formal rules, policies and regulations. Further, negotiated order has been used to explore how accounting practices in organisations have been derived and the role that power and visibility play in their construction (Shiraz-Rahaman & Lawrence, 2001), the determinants of successful lean implementation (Pedersen & Huniche, 2010), and how middle managers involved in managing organisational change negotiate competing roles (Bryant & Stensaker, 2011). For organisations to develop change capacity flexibility in terms of how things are done is important. I argue that exploring organisations through the lens of negotiated order can provide important insight into how day-to-day organisational practices can play a role in willingness
and capacity to change, which could be useful in avoiding costly change-related mistakes, or unfairly blaming change failure of concepts such as resistance.

**Methodology**

The research was based upon a case study methodology (Stake, 1995, 2006) informed by a social constructionist approach (Berger & Luckmann, 1967; Patton, 2002). This particular approach to case studies focuses on uniqueness and peculiarity and the development of understanding as opposed to a more post-positivist approach such as Yin’s (2012) that seeks to generalize findings. The broader project sample included six practices located in rural Victoria of which two are discussed in this paper. These cases are practices that are similar in size in terms of number of practice staff and patients, but differ in their numbers of learners with one hosting only one learner as any given time and the other hosting up to four or five learners at any given time. Data were collected across a diverse population within each practice using semi-structured interviews. To understand the role that practices play in facilitating medical education, practice principles, practice managers, patients, nurses and learners at levels ranging from intern to registrar as appropriate in each organisation were interviewed, with 7-8 interviews per location. Each of the semi-structured interviews was audio recorded and transcribed for analysis.

Data were initially analysed using the principles of grounded theory in which a first level of open coding was conducted across the interviews, followed by a second level of axial coding, both of which preceded a thematic analysis across the interviews (Miles & Huberman, 1994). With these themes in mind, the transcripts were then re-read through the lens of negotiated order to develop a specific understanding of the data from this framework. As highlighted above, a criticism of the interactionist approach from which negotiated order is derived is that as a theory it presents a way of thinking about interaction in organisations rather than providing tools from which to specifically analyse social processes. To develop a specific analytical tool from the theory would arguably risk limiting it to a functionalist position, which would contradict the philosophy of interactionism. However, Bryant and Stensaker (2011) argue that researchers can develop a series of questions develop further insight into patterns of interaction. Consequently, the re-reading of the transcripts
was guided by a set of questions about organisational practices concerning learners and the cultures of
*the way things are done around here* to develop an understanding of how learners were integrated into
the practice (see Table 1). For the purposes of this paper a limited set of questions has been used to
demonstrate how data were interrogated as featured in the first column of Table 1. The second
column provides details of additional questions used to interrogate data for the broader study.

Findings

As per the key questions highlighted in Table 1, Table 2 displays examples of data from the
interview transcripts that highlight various practices and attitudes concerning learners as reported by
participants in each practice.

In seeking to understand issues such as change readiness, it is firstly important to understand
the broader philosophical views towards teaching learners that each practice principal holds as this
arguably shapes the cultures, or patterns of behaviour and accepted norms and practices within each
organisational environment (Schein, 2013). From Table 2 it is evident that both practices engage with
teaching as a way of contributing to broader workforce shortages, with the single-level practice
principal commenting on the need to address shortages within his clinic and the multi-level principal
reporting on the need to address shortages within the industry more broadly. Consequently, it could
be argued that the broader teaching philosophy in both practices is driven by the need to attract and
retain more staff at the present and in the future. Further, both practice principals’ report of a personal
enjoyment of teaching. In following Schein’s (2013) arguments, the personal satisfaction derived
from teaching and a desire to *give back* to the profession expressed by each principal has the
propensity to shape values around teaching in the practice more broadly through the development of a teaching philosophy that forms part of each organisations’ culture. Further, a strong teaching philosophy is also likely to set patterns of behaviour within each practice that influence change willingness around teaching practices such as the expansion of teaching programs.

Where the two practices diverge in their philosophy is more evident in further comments around the justification for hosting learners. For example, reports from the single-level practice indicate that hosting learners provides ‘kudos’ or status that those that do not teach do not possess. This is further reiterated by the single-level practice receptionist who reported that hosting learners ‘gives the outward appearance … [that] doctors think about what they are doing’. Status is not reported as being a significant reason to teach by multi-level practice staff. Rather, the rationale for hosting learners tends to be linked back within the practice principal’s interview to the desire to help address long-term workforce issues in rural general practice. I argue that these values are likely to shape the ways in which learners are viewed in each practice, as well as the extent to which their presence is negotiated into the daily order. While hosting learners was reported as being core business of the single-level practice, reports as to how learners were integrated, managed and viewed highlight a number of ambiguities. On the one hand the practice was reported as wanting to be a ‘top teaching practice’ (Practice manager) suggesting that a learning culture was central to the organisation. However, learners tended to be viewed in a negative light through changing the nature of the consultation with patients and creating tensions with the core business of practicing medicine. Learners were also reported as adding to the workloads within the single-level practice through adding to ‘the burden of the doctor’ (Practice staff 1); ‘increasing workload by 20% but [the practice] benefitting by 10%’ (Practice principal); or increasing ‘stress levels’ (Practice manager). Further, a practice staff member added that learners did not add great value to the practice as they ‘don’t really change anything much’ (Receptionist) in terms of enriching the experiences of staff, patients or doctors. I argue that such reports are indicative of teaching activities taking place and being managed on top of day-to-day activities surrounding patient care, with tensions between the two being perceived as an ongoing problem requiring careful management, rather than learner presence being
accommodated or negotiated into the day-to-day business of the practice with learners perceived as important in the overall functioning of the organisation.

In comparison, participants from the multi-level practice held quite different views about the presence and importance of learners. When asked about the experience of hosting learners, practice staff reported of learners contributing to change in ‘the model of practice’ within the clinic, or ‘it keeps it fresh, it makes you question your policies and procedures because somebody might say to you ‘why do you do your after-hours like that?’’ (see Table 2). Learners were not only considered to be an integral part of the practice, but also as important contributors to the community in which the practice was located, and community members as important contributors to their medical education. This provided a sense from the interviews that integration of learners into both the practice and the community was integral to their educational experience, which links clearly back to the philosophy of the multi-level practice principal highlighted in Table 2. A key example of learners being negotiated into the order of the multi-level practice is evident in the Practice Principal’s comments about how learners are integrated into daily practice. The principal’s report suggests that learners were possibly once managed in a way that is evident within the single-level practice in which the student had to fit in with the supervisor’s consultations and play a more passive observational role. As the multi-level principal commented, teaching in this manner ‘slows you down, it takes longer to see patients, I have to work so much harder’. Whereas, the model of parallel consulting adopted by the multi-level clinic means that learners have their own patients and ‘contribute to the practice workload’ (Practice principal), meaning that they are not only integrated into the normal practice order but also have a degree of responsibility for their own learning.

Negotiating learners into the practice order was reported as being well received by practice staff, patients and medical students. As evident in Table 2, practice staff reported that having learners involved in the delivery of patient care led to a team-based culture, added variety to day-to-day activities, and kept the practice fresh in terms of new faces and questioning of taken-for-granted assumptions. Patients in the multi-level practice reported that waiting time to see a doctor was minimised and that learners might look at medical problems differently from the regular GP on the basis that they were new to the patient’s medical history. This model of teaching was also well
received by medical students who were interviewed as part of this study with reports that they felt ‘comfortable to say ‘yes I am a doctor’ rather than being ‘oh, I’ve just graduated from my medical degree’ (Student 1) as well as within the succinct presentation of diagnoses to the supervisor (Student 2 – see Table 2). This is juxtaposed by the report provided by the medical student within the single-level practice. Although she reported of an enjoyable learning experience, she also felt that barriers were put in place by the way in which the potential presence of medical students was communicated to patients, which she felt excluded her and other students from learning opportunities on the basis of gender. These experiences of learners triangulate other reports that refer to the level of integration of learners into each of the organisations, providing further evidence of learners in the multi-level practice being negotiated into the practice order as opposed to on-top of the practice order in the single-level practice.

Discussion and conclusion

This paper has provided only a brief discussion of the data. Therefore, a limitation of it is that I have only partially engaged with the complexities of organisational practices within the two clinics. However, I argue that the cases provide some insight into how the degree to which organisations negotiate order on a daily basis creates an environment of change readiness. From the data provided, I argue that the multi-level practice is more likely to be ready and willing to engage in organisational change on the basis that they report of negotiating learners into the practice culture as part of normal practice rather than attempting to manage them on top of normal practice. Although the supervisor maintains authority over learners within the practice, reports of participants suggest that roles, decision-making responsibility and patient care in the multi-level practice is subject to constant negotiation (Strauss, 1978; Svensson, 1996), meaning that division of labour is more fluid rather than rigidly adhered to (Allen, 1997). I argue that under such circumstances organisations are more likely to have the ability to reflect on their practices (as it evident within the multi-level practice data) and change organisational norms such as taken-for-granted behaviours and activities.

In comparison, reports from the single-level practice indicated that while teaching medical students was considered as core activity within the practice, roles, decision-making authority and
routines around such activities were structured and based on assumed norms that guided learner behaviour. Therefore, learners were expected to comply with these routines and fit into the order of the practice, which clearly created ongoing tensions and issues between teaching roles and patient care. As learners played a more passive role in the practice, opportunity to question organisational activities or take responsibility for their own learning appeared not to exist and a lack of integration with practice staff more generally may mean that such activities would not have been encouraged. While it is undoubtedly challenging to meet the needs of the practice, patients and learners simultaneously, a limitation of managing learners on top of normal daily practice is that space for flexibility and reflection regarding organisational routines and norms is prohibited and both are arguably essential for change readiness and successful change implementation. A further limitation is that a coercive order (Carnall, 1986) may be imposed onto the organisation in which a top-down individualised culture is developed as opposed to a team-based culture, which can lead to further individualising behaviours such as attributing organisational failure to individual actions or cognitive traits rather than consideration of established patterns of behaviour that are ingrained into the organisational culture.

The negotiation of order and how it impacts upon the likelihood or readiness of an organisation engaging in organisational change is a complex area, which would certainly benefit from more in-depth empirical work. However, it provides management scholars with an alternative way in which to explore the informal patterns of interaction around work and how organisational reality is socially constructed, contested and subjected to ongoing interpretation. This approach enables researchers to move beyond more functionalist approaches to exploring change readiness – such as through focus on individual decisions to support or reject change - which may only provide a partial explanation for why change programs do not work. Further, a flexible organisational culture in which rules and norms are negotiated by different levels of hierarchy is arguably more likely to provide an environment in which growth or innovation is possible and organisational fluctuations become more manageable.
References


Table 1: Examples of questions used to guide data analysis

<table>
<thead>
<tr>
<th>Key questions used to analyse data featured in this paper</th>
<th>Additional key questions used to analyse data for the broader research</th>
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</thead>
<tbody>
<tr>
<td>• What is the philosophy behind hosting learners in the practice?</td>
<td>• What processes does each organisation use to engage learners before and during their tenure?</td>
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<tr>
<td>• What is the attitude towards change in the practice?</td>
<td>• Do day-to-day processes (when learners are present) followed rigid policies and procedures?</td>
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<tr>
<td>• What is the rationale for teaching medical students in the practice?</td>
<td>• Do learners have responsibility for their own patients?</td>
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<tr>
<td>• How do learners affect the day-to-day practice in the organisation?</td>
<td>• Does the practice culture change with the presence of learners, or remain the same regardless of whether learners are present or not?</td>
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<tr>
<td>• How are learners integrated into the practice?</td>
<td>• Are practices engaged in locked-in pathways of doing day-to-day medical practice? That is, do they question the way they do things or do things the way they are on the basis of that’s how it has always been?</td>
</tr>
<tr>
<td>• How does hosting learners affect patient consultations?</td>
<td>• Does the culture allow for negotiation and re-interpretation of daily practices and procedures?</td>
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<tr>
<td>• What are the experiences of learners in the practice?</td>
<td>• Are learners allowed to shape the how the practice functions or do they have to fit in?</td>
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<td></td>
<td>• Are there high levels of differentiation between staff and/or separation between learners and GPs; learners and other practice staff?</td>
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<td></td>
<td>• Are rules, processes, policies and procedures, organisational cultures rigid?</td>
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Table 2: Examples of data derived from analysis

<table>
<thead>
<tr>
<th>Teaching philosophy</th>
<th>Single-level practice</th>
<th>Multi-level practice</th>
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<tr>
<td>I like to teach. I take quite a bit of trouble to equip myself with the skills to teach (Practice principal).</td>
<td>Having young, enthusiastic learners is the solution, as far as I’m concerned, for the long-term workforce issues, even if it only provides short term solutions. We’re increasingly getting young Australian graduates who have a genuine interest in rural general practice, who spend time in our practice (Practice principal).</td>
<td></td>
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<tr>
<td>To be able to put up a sign saying we’re a teaching practice probably has some kudos; certainly within the profession it probably has some kudos. I know all the Allied Health people are desperate to be able to fly the flag and be teaching practices…if distinguishes them from non teaching practices. So it’s a bit like I’m better than you (Practice principal).</td>
<td>[We try] to reproduce the concept of being one of us, and so the whole idea is about giving them an experience which enables them to make a clear decision based on their own experience about what the role of general practice will play in their future. So it gives them real insight into what GPs actually do…They’re discouraged from fence-sitting; they’re encouraged to be actively involved in the decision-making process (Practice principal).</td>
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| The effect of learners on day-to-day practices | In general, I think the patients in this practice are long-term patients so they become quite used to the fact that [teaching learners] is the role we were taking on and this is the direction this practice was taking as far as establishing itself as a top teaching practice (Practice Manager). | I’ve always looked at innovative solutions for problems (Practice principal). |
| In general, I think the patients in this practice are long-term patients so they become quite used to the fact that [teaching learners] is the role we were taking on and this is the direction this practice was taking as far as establishing itself as a top teaching practice (Practice Manager). | [Having multi levels of learners] changes the philosophy a little bit and it changes the model of practice. It does change the feel of the practice that it’s focused on learning rather than on a business model (GP). |
| [To take on learners, there is] a list of stuff you have to do, all of which takes you away from your core business, which is basically earning a living and keeping the place on the rails. Perhaps for me as a sole principal with a bunch of contractors, these issues are more difficult to arrange than perhaps in a practice with several partners, but given that myself and the manager are the main glue, I generally found that anything that took me out of the [day-to-day practice of medicine] did not improve the business side at all (Practice principal). | From our perspective as a practice, it is really lovely to have new people, new faces coming in all the time. It keeps it fresh, it makes you question your policies and procedures because somebody might say to you ‘why do you do your after-hours like that?’ and they might have a little idea about what they think. So I think that’s [great] because the longer you’re in a place you just get so used to the processes (Practice manager). |
| [Having learners in the clinic] gives the outward appearance of well, if they can teach new students then they must be all right to the outside person, but they don’t really change anything much. I guess they make the doctors think about what they’re doing, as in, you know, not be blase about it (Practice receptionist). | The main reason [I like working here] is partly because of the learners, but also because of the atmosphere of the clinic. I think it’s a really team focused clinic; there’s no real hierarchy about it; everyone is considered equal with a different skill set (GP). |
| [Having learners in the clinic] gives the outward appearance of well, if they can teach new students then they must be all right to the outside person, but they don’t really change anything much. I guess they make the doctors think about what they’re doing, as in, you know, not be blase about it (Practice receptionist). | [Having learners] gives you a lot of variety. It breaks up the day from just sitting in your room and consulting patient after patient. It means you are interacting with a whole bunch of different people; you see a |
| Integration of learners into daily practice | It’s the tensions between the teaching role and getting through the day’s work [that are difficult to manage]. General practice unfortunately is very time pressured, and there are numerous trivial interruptions so if you’re at the head of the primary health care team, everybody … they can’t do anything without ringing you. So you have a stack of patient stuff, you’ve got the pharmacist here, you’ve got that, all the stuff has to be fitted in when you’re teaching (Practice principal).

[We don’t see them] a lot. We see them when they go in, we see them when they go out…We know they’re there. We have to ask the patients whether they want to be seen by them. But, no we don’t really see them (Receptionist). |

| Impact of learners on patient care | [Having learners] always changes the consultation, always, because you’ve got a third party in the room, quite often it will change the way I ask the question, and it’ll change the way I give the answer. It increases the time quite considerably because you’ve got to debrief…the student at the end of the consultation. Sometimes it changes the way I charge because if I … extend the consultation to twenty minutes with a patient that I would have got through myself in twelve, (I would then charge them) a private fee, I may end up bulk billing the twenty; because it’s quite legitimate to do it but I may actually recognise their contribution and I wouldn’t have taken that long, really, if the student hadn’t been there (Practice principal).

I had a student; I saw the first patient, set the student up…So I finished the first patient, debriefed the student and completely forgot I had set the other one up. And I hadn’t even got the needles into her…what if I put the needles in there for too long? (Practice principal). |

| | much different range of cases because the learners tend to get a lot more walk-ins than the regular GPs do [like] a bit more of the acute stuff rather than just chronic disease…It also keep me motivated to stay up to date as well (GP).

I think that the community have a bit of buy in…I think the people that do [see the learners] sort of feel like they’re contributing. So they’re much more a part of their health system and their health care (GP).

The system we had in this past, which is unfortunately a system which is still widely used by practices hosting medical students, is that they came in as passive observers and sat in the corner and watched. And when you have learners in your practice…they actually make life harder because it slows you down, it takes you longer to see patients, I have to work so much harder when they’re here. And when they’re passive observers the one thing they learn quickly is how to go to sleep and lose concentration…because you’re not actively involved…In fact they’re desperate to do things…All of our learners actually have their own appointment book…[and] see people with parallel consulting…They actually contribute to the practice workload. There are times when my role as the supervisor is just supervising…and so there’d be some sessions where I won’t see any patients book in for myself (Practice principal).

I see [having learners] as a positive thing because you get in [to see a doctor] quicker…I know that before they started [having] the interns here it was hard to get an appointment…[now] it’s usually straight away (Patient). |
Well, I always say that if they don’t see people like me, how are they going to diagnose people when they do come across someone that has these problems? And I always say that, you know, they’ve got to learn somewhere, and if people say oh, no, I couldn’t discuss my problems in front of a student, there’s something wrong. You know, they’ve got to learn, and so I see it that way, that this is probably the best way they can learn (Patient).

Learner experiences

Obviously [patients are] told I’m female at the start, and I think some of the patients that don’t want to see me are men. So they put the barrier up straight away. I think a better way to deal with it would be just to introduce the fact that we have a medical student on board, rather than indicating whether they’re male or female; just to make sure that both we and the patients get a chance to experience both female and male doctors, and also the chance that we get to see some men’s health, as well as women’s health, and vice versa for the boys because you don’t want them to be excluded from pap smears just because they found out it’s a male medical student, and things like that. Because we all have to learn equally. There’s always the opportunity then if it’s really too personal for the patient, they don’t feel comfortable, they can ask us to leave the room, and we’d be happy to do that (Medical student).

Here it’s a lot different to anywhere else I’ve been. We have a lot of independence and [our supervisor] encourages us to make all the decisions and then just come to him when we need a final signature and he’ll look over it…but otherwise he’s happy to let you be in control of all the patient management…We have a fair bit of responsibility…it makes me feel like I can say that when I graduate I will be comfortable to say ‘yes, I’m a doctor’ rather than being ‘oh I’ve just graduated from my medical degree’ (Medical student 1).

I can present [patient diagnoses] quite succinctly to [the supervisor] and he can ask a few questions to see whether or not I’m on top of the issues and he then asks me why and makes me justify my position…Its good to have the responsibility and most of my decisions he’s happy with and that makes me feel pretty good (Medical student 2).