Chapter 3.1.1

RURAL CLINICAL EDUCATOR SUPPORT

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Introduction

Rural doctors usually work in relative isolation and often with insatiable clinical demands and high patient expectations. Taking on an additional role as a clinical educator of medical students or residents[1] can appear personally unachievable, despite knowing that the future of rural practice depends on the next generation being inspired and taught, in order to prepare them to take on a rural career (1). Given this dilemma, how can universities support rural clinicians to take on this crucial and potentially satisfying role? (2)

Nearly 20 years' experience of supporting rural doctors at Flinders has revealed a key approach to clinical educator support – namely symbiosis (3). By this, we mean that the presence of a learner in the practice should be a win-win outcome for both doctors and patients, for the practice and the university, for the community and for government, and for the profession and the individuals concerned. These symbiotic axes are described in detail elsewhere (4).

The following practice pearls focus on the key elements that we have found contribute to the first two axes in particular – supporting the doctor-patient relationship and the university-practice alliance.

Preparation

- Universities - Construct your curriculum so that it enables students to stay in one practice for as long as possible – a **longitudinal curriculum**. Over time, the student gets to know how the practice works as well as the expectations of the clinical educator and develops a productive role within the practice. This results

[1] A (postgraduate) resident – also called a registrar or vocational trainee – is a qualified doctor who is part of a structured training programme.

in a subsequent return to the doctor on the significant initial investment of time during the first few weeks of the student placement (5).

- Before the students arrive in a practice, encourage the clinical educator to **participate as an examiner** in the student assessments. This will assist the doctor to know what the students need to know and take a lot of stress out of the educator experience.
- Ensure that the university has well developed **curriculum documents** in both hard copy and web-based formats that include clear and concise learning goals for the students.
- **Students** can provide a constructive role within the practice sooner if they **are well prepared** in both knowledge and, in particular, clinical skills. Having students able to confidently undertake a reliable physical examination enables the doctor to have confidence in the student's findings and therefore avoid repeating elements that have already been undertaken by the student with the patient. **Simulation facilities** can assist in this process.

Practice environment

- The positive impact on the practice can be enhanced by the university **investing in consulting space** which may be used by the students within the practice. This enables more productive teaching approaches to be undertaken and also signals the university's long term commitment to the rural practice.
- **Facilitating vertical integration** in education provides support in three ways (6). First, it brings a broader source of funding for teaching within the practice, including a stronger case for investing in practice infrastructure. Second, it supports a stronger learning culture within the practice, raising education to the level of core business. Third, it provides for flexibility in supervision requirements i.e. residents can contribute to supervising students.
- Ensure that there is **excellent web connectivity** in the practice. As most practices in developed countries will now have this as part of their standard infrastructure, this can be as simple as providing the rural clinical educators with a university email address and access to password protected resources on the university's website. In the developing world however, university investment in broadband access, either via landline or satellite, can make an enormous contribution to not only the student education but also in overcoming the sense of isolation for the practice.

People

- Crucial to supporting rural doctors as educators is **providing a good student support officer** to facilitate the smooth running of the attachment. This includes organising timetables where students may be with multiple different clinicians, arranging student travel and accommodation, and facilitating the timely completion of student assessments.
- **Linking new rural clinical educators with established teachers** is crucial to building an *esprit de corps* between rural clinical teachers. Much informal support can be provided in this way.
- Regular meetings by the **academic co-ordinator visiting** the individual rural practices is important in creating a sense of being valued and belonging. It is also important in ensuring that small problems are dealt with expeditiously.
- **Bringing rural educators together** for strategic planning and faculty[2] development is important. This recognises the valuable input that rural clinicians can have into curriculum development and facilitates greater comfort and effectiveness in their teaching role.
- **Providing opportunities for personal career development** and upskilling can make the difference between a peripheral engagement and a core contribution by rural doctors. Providing the opportunity for a rural doctor to develop an academic career whilst remaining in rural practice is a significant recruitment and retention incentive that can be delivered by medical education. This can include supporting rural faculty to undertake relevant formal postgraduate study, for example graduate studies in clinical education (7).

Resources

Rural clinical educators do not need to re-invent the wheel when supporting rural doctors as teachers. There is a wealth of material available on the internet that contains additional examples of what does and doesn't work. Bob Bowman's website has collated experience from many rural doctors into one repository (8). The Best Evidence in Medical Education groups, BEME, has produced a useful guide to faculty development (9). Free access journals also provide evidence that can guide the development of relevant and effective support strategies(10,11).

[2] Also referred to as a member of academic staff.

An illustrative case study

Rural doctors are used to being creative and finding solutions in low resource settings. This same ingenuity can be encouraged in supporting rural clinical educators, particularly if rural doctors are equipped with the fundamentals of clinical education knowledge that underpin why we teach the way we do. We saw this occur early in our experience with rural clerkships[3] as follows:

Our curriculum required students to undertake at least two sessions per week with a rural doctor where the student consulted in parallel with the doctor. This means that the student was allocated a separate consulting room and commenced the consultation with their patients on their own prior to the doctor entering the room and reviewing and completing the consultation. Usual practice was for the doctor to see a separate patient in an adjacent room whilst the student was conducting the initial part of the consultation. This practice wanted to have two students, but the doctor did not have enough time to allocate four sessions per week to this level of intense clinical supervision.

After working with our academic co-ordinator to gain a better understanding of the theory behind this approach to teaching, the rural doctor solved the problem by supervising the two students at the same time. Instead of having one consulting room for a student and one for the doctor, the two rooms were allocated to the two students and the doctor went from room to room providing the review and conclusions required. In this way, the same number of patients was seen (and billed), and only two sessions were required to provide this intensive aspect of the course.

This is a relatively simple example of how a potentially stressful situation for a clinical educator – having to commit more sessions than possible to intensive teaching – was solved through giving the rural doctor both the theoretical understanding of clinical education concepts and then the permission to trial a new approach of their own construction.

[3] Clerkships – also called placements or rotations – are structured clinical learning opportunities/ contexts.

Conclusion

Rural doctors are resourceful, knowledgeable and enthusiastic clinicians and teachers. Respecting them for these qualities, giving them a language to express their knowledge and skills, and a valued platform to be creative in their expression will inspire the next generation of students and provide our rural communities with a sustainable and high quality health care workforce.

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