

## Chapter 3.1.2

### TEACHING RURAL CLINICAL EDUCATORS

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#### Introduction

Community-based training has become increasingly recognised as a really valuable learning environment for trainees, and is also now acknowledged to be a productive workforce support (1). As such, teaching in rural practices is now also seen by governments as a pathway for resolving the rural and remote medical workforce crisis. It is within this context that rural doctors are increasingly taking on trainees - comprising nursing and medical students, as well as pre-vocational doctors and registrars<sup>1</sup> (general practitioner/family physician trainees).

Rural general practitioners (GPs) are regarded as naturally effective teachers, given their broad scope of work. They deal with all aspects of their patients' lives - their health and lifestyle, family, work, life and death issues – and are called upon to be healers, counsellors, advisors, teachers and mentors (1). In addition, rural doctors usually have a wider range and depth of clinical responsibility, including hospital in-patient responsibilities, than their city colleagues as there are usually few (if any) specialist medical services readily available.

Trainees placed in rural community practice, therefore, have far greater opportunities for direct hands-on experience across the full range of clinical presentations than they might in metropolitan university and hospital environments, where this would be increasingly hard to obtain.

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<sup>1</sup> A registrar - also called a postgraduate resident or vocational trainee – is a qualified doctor who is part of a structured training programme.

### ***Supporting rural medical educators***

Rural and remote doctors often work in environments where they have limited access to education resources, however, and may need to travel significant distances and rely on electronic media to obtain the professional development they need to maintain and extend their skills.

Given their increasing roles as medical educators, providing these rural doctors with some formal teaching skills is becoming an imperative. This has led to the development of a raft of 'teacher training' programmes designed for busy practitioners.

This medical education model is consistent with the growing reliance on apprenticeship models of vocational education and the trend towards longer-term clinical placements in undergraduate medical education.

In addition, it is important to note that supporting rural doctors to be educators and mentors for these medical and nursing trainees can also contribute to an effective retention strategy, as it provides these relatively isolated professionals with peer contact and support; refreshes their clinical skills; and engages them in academic and non-clinical organisational activities that revolve around maintaining and building the rural medical workforce cohort.

This chapter will explore some of the practical aspects of supporting clinical educators.

### **Discussion**

Rural medical educator teaching programmes need to meet the requirements of doctors who teach in a wide range of environments and at different levels. Doctors may have medical students in their practices for a few weeks of the year who are mainly observing, or they may be part of an academic teaching unit with students actively involved in their practice for extended periods.

They also may still be trainees themselves, with responsibility for teaching more junior medical staff. They may teach their peers, and they may teach multi-disciplinary teams. They may teach procedural skills, life support skills, the full undergraduate curriculum, or be responsible for supervision and mentoring. They may teach in their rooms, or in a hospital, or both. Whatever they are doing, they are very busy people, and programmes that aim to teach them how to teach must take this into account.

Selecting participants who like teaching and want to facilitate learning would be ideal. Many doctors find themselves thrust into an educator role, however, and may initially engage somewhat reluctantly in teaching. With adequate support, they usually find it very rewarding, as long as it does not become a burden.

Supporting doctors as educators provides credibility and acknowledgement, reinforces good teaching skills, teaches reflection, and helps to standardise learning programmes.

### ***Teach-the-teacher programmes***

Teach-the-teacher programmes can be generic, particularly in the academic context. In the service delivery context, however, these programmes are also targeted at teaching how to teach specific clinical skills. For example, teacher training for procedural skills is highly focussed and very rewarding. Much of it is protocol driven, and can be taught by other health professionals, including nurses and paramedics. It has specific challenges, including the need for competence in the specific skills, an understanding of the context in which the skill can be carried out, and the patient communication aspects of procedural care. It requires appropriate equipment and a structured approach to teaching the skill.

Teach-the-teacher programmes should include an outline and explanation of the value of various modalities of education activities such as lectures, tutorials, group discussions, feedback, simulated skills sessions, and simulated scenarios. Preparation, orientation, delivery and feedback are important elements of teaching, and need to be included in these programmes.

Maintaining professionalism and being aware of the impact of the teacher's clinical behaviour is an essential ingredient of any teaching activity. There is increasing emphasis on professionalism and patient safety, patient-centred and team-based approaches to learning, and separation of competency-based procedural learning.

Many doctors have been exposed to the 'See one, Do one, Teach one' system of learning. This approach has been built on to include other elements, including a range of learning approaches as well as practice and reinforcement. For example, in many advanced life support courses, skills training includes 'Watch the skill performed silently, Watch and listen as the steps of the skill are spoken out loud while being performed, then Perform the steps yourself silently for the next person'. This is done in small groups so that each person carries out the psychomotor components of the skill, and can observe it multiple times in the one session.

There is evidence that small group learning is an effective learning environment because it allows knowledge to be shared amongst participants and discussion of the topics helps to clarify issues and support retention of information. It is especially effective when it includes different levels of learners, and different professions, as the shared knowledge builds the content. The opportunity for learners to teach different levels of learners also promotes learning. The groups need to be facilitated by a teacher experienced in managing small group interactions.

The educator's ability to reflect on their own outlook, attitude, and learning method will help them to provide positive constructive teaching and support to their learners and mentees.

### **What's the evidence?**

There has been theory on learning since ancient Greeks developed pedagogy and andragogy and there is now considerable theory on teaching. Educational theory, in particular principles of adult learning, is a necessary component of any teacher training activity, and is appreciated more if it is presented so that it is relevant to the context of the activity. Otherwise it is useful only mainly as reference material.

A number of analyses of research into the effectiveness of different teaching methods indicate that CME is effective in producing both short-term and long term gains, and that multimedia, multiple techniques, and multiple exposures produce better outcomes. However the strength and quality of the evidence is low. The common themes are:

- print media is less effective than live media;
- interactive techniques are more effective than non-interactive ones, and
- multiple exposures to CME activity seem to be more effective than a single exposure.

***An illustrative anecdote: The REST case***

The Rural Emergency Skills Training (REST) Programme (2) was developed in Victoria, Australia in 2000 by the Rural Workforce Agency with a view to supporting rural doctors to maintain their emergency skills, as well as providing these skills to doctors who were moving into rural practice. The course was compiled from many sources, but in particular, from rural doctors who were considered to be excellent clinicians and teachers. The REST Instructor Training course was developed at the same time, and rural doctors were invited to attend.

REST was developed as a two-day interactive hands-on skills training course, incorporating lectures, skills stations and simulated scenarios. Assessment was built into the course. The Instructor Training Course was developed as a one-day programme for rural practitioners experienced in emergency care and/or rural teaching.

Within a few years, there were more than 70 rural doctors trained as instructors, and REST courses were being held for experienced rural doctors as well as trainee doctors every two months somewhere in rural Victoria and also the Northern Territory. It is now being delivered across Australia.

In 2009, the REST course and the REST Instructor Training Course were taken to South Africa, and adapted for their rural and underserved areas. This course continues to be delivered there.

The REST course is particularly useful because it is adaptable, it is easily transportable, it is standardised and quality controlled, it is delivered by rural doctors, it is intensive and covers the range of emergency skills and scenarios rather than being focussed on a single clinical domain.

## **Practice pearls**

### ***What to do***

- Improving the teaching skills of rural doctors and supporting them as clinical educators, builds their confidence as teachers, improves learning, broadens professional responsibilities and helps to standardise the learning environment and reduces the burden of teaching.
- Small group learning is effective and ideally suited to the rural and remote context (3).
- Preparation, orientation, delivery and feedback are important elements of teaching and must be addressed in rural medical educator programmes.
- Multi-media, multiple techniques, and multiple exposures tend to produce better outcomes.
- Simulation teaching tends to produce improved skills.
- Flexible, adaptable and transportable education packages are necessary to support busy practitioners, especially those who take on the role reluctantly as they find teaching thrust upon them
- Medical educator teaching should be transportable, adaptable for delivery in different environments, able to be supported and/or delivered electronically, preferably taught by peers, and assessable and standardised.
- Understanding how people learn provides the basis to learning how to teach.
- Trial and error is invariably a part of learning, but the aim of teacher training is to minimise risk and potential harm to the learner and thus to their future patients.

### **What not to do**

- 'See one, Do one, Teach one' is no longer enough to promote professionalism and patient safety.
- Including a lot of educational theory in medical educator teaching courses is not appreciated, and therefore should rather be included as reference material.

### **References**

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### **Further reading**

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