

## Chapter 3.1.4

### PROFESSIONAL DEVELOPMENT AND SUPPORT FOR CLINICAL EDUCATORS

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#### Introduction

With the evolution of medical school training and the recognition that there is more than a whimsical value in the involvement of peripheral preceptors<sup>1</sup> in the teaching of medical students, the issue of how to support and nurture these teachers needs to be addressed.

Rural and peripheral sites are excellent opportunities for clinical exposure, learning and mentoring, especially with a view to graduating doctors who wish to work in a rural or community setting (1, 2, 3). As rural exposure and teaching are some of the reasons undergraduates choose a career in rural medicine (1, 3, 4, 5,6), it is important that these opportunities are inspirational as well as positive educational experiences.

#### Rural preceptors

The selection and nurturing of suitable people as preceptors is central to having faculty<sup>2</sup> who can teach learners successfully (7). The majority of practicing doctors enjoy having medical students and residents<sup>3</sup> in their practices (8). They also feel that they know what should be taught, particularly in the context of their own environment and clinical areas (3, 9).

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<sup>1</sup> A preceptor – also called a clinical instructor or adjunct faculty/academic staff – are clinicians (person who has core clinical skills) who does clinical teaching at a rural (distant) site. They may work full-time or part-time for the medical school / training institution in a paid or honorary capacity.

<sup>2</sup> Here 'faculty' are members of academic staff.

<sup>3</sup> A (postgraduate) resident – also called a registrar or vocational trainee – is a qualified doctor who is part of a structured training programme.

The increasing use of rural preceptors to teach medical students and residents is putting greater demands on these physicians, however. For doctors who have worked independently and without any formal or continuous relationship with teaching institutions, this new commitment can be challenging, as it takes up their time and affects their professional lives. If the demands of the practice are compromised by the demands of the teaching requirements, there is a strong likelihood that the teaching will suffer.

It is therefore critical that faculty support is offered to assist these physicians to balance their teaching responsibilities with the demands of their medical practice. If the teaching, assessment, mentoring and administration load placed by medical schools is too great, they run the risk of overloading these community-based faculty. So the ability to deliver quality teaching in rural areas depends on the resources available, which includes a critical mass of physicians in the community. Identifying a more experienced rural preceptor who can be a resource to the newer ones could both help with their duties as well as support a sense of collegiality among the teachers.

Rural preceptors include family doctors as well as specialists who practice in regional/community hospitals or who deliver itinerant services to these sites. Their effectiveness in training residents will partly depend on their shared belief that rural medical practice has unique challenges and requires a specific skill and mind set. While some preceptors are natural teachers and relish the opportunity to reveal the intellectual and clinical challenges of rural practice, the literature identifies many areas which can be improved to make the training of residents and the experience of the preceptors more effective and successful (9,10).

### **Setting up sites**

All the physicians in an area should be involved when a teaching site is being recruited, as a site must have at least two senior preceptors for there to be some stability and for the burden of extra demands which come with the presence of students and trainees to be shared. Preceptors should be welcomed into the programme as equals to their colleagues in the larger 'teaching' centres – and this recognition should be cultivated throughout the duration of their involvement with the medical school.

At the first meeting, the purpose of the rotation, the medical school's expectations, and the expectations of the trainees and the trainer need to be explored and clearly identified.

### **Contracting and reviewing**

In an initial contracting session, it is critical that both preceptor and programme have a clear understanding of the purpose of the rotation (9) and that the resident is briefed and that responsibilities and expectations are defined. A document outlining the infrastructure of the site, the composition and scope of the practice, and the names and responsibilities of personnel should be available to trainees at the start of the rotation.

In addition the residents and students should have set periods with the preceptor which are used for reviewing issues – and these will also allow the preceptor to find out about the trainees, about their families/dependents if any, and their career interests and plans.

In many rural isolated practices, the resident comes to depend on the physician not only for clinical teaching but also for social support, They become a friend of the doctor's family, spend time outside of work with the doctor and in some circumstances, rely on them as a confidante. In addition preceptors need to be supported in dealing with a generation of students who also have families and family lives. A contract upfront can help to keep the training task in focus alongside these more personal interactions.

While ideally the trainees should be inspired to feel invested in the practice, the attitudes of medical students and residents are changing. They are less likely to define themselves by what they do, may be less accepting of burning the candle at both ends, and may place an entirely different value on what was once considered a privileged career or vocation (11). Exercises in faculty development need to address this change in attitude and how the rural faculty might deal with it.

## Meeting preceptors' needs

As noted above, it is important that the goals and objectives of a rural rotation are defined and understood by the preceptor, medical school and trainee, from the start. These then form the basis for designing faculty development, which should address the needs identified by those in community-based practices who teach students and residents during their rotations (9,14). In focusing on the needs identified by the faculty, the medical school may feel there are areas where it can develop programmes to meet its needs. This should also be a process where the medical school's expectations can be explored and be adapted to the professional and clinical realities of rural practice without compromising academic excellence.

Areas to be addressed through faculty development might include

- contracting,
- developing priorities,
- didactic teaching techniques,
- developing specific clinical scenarios/ moulages,
- community-based research,
- use of technology, internet and web-based resources,
- providing feedback to residents,
- critical assessment, and
- evaluation.

## Design and delivery

The preceptors need to know that they can have input into the programme design/structure within the limitations of the programme's goals or purpose.

While many of the preceptors will have had informal teaching experience, they may not have had experience of formal teaching and assessment. Understanding the importance of appropriate assessment and learning how to give useful and productive feedback would help them in this more formal teaching role. If there is a competency-based component (as with CanMEDS)<sup>4</sup>, the preceptor will need to be aware of the need for observation, assessment and evaluation in this context (12).

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<sup>4</sup> 'CanMEDS is an educational framework identifying and describing seven roles that lead to optimal health and health care outcomes: medical expert (central role), communicator, collaborator, manager, health advocate, scholar and professional.'  
(<http://www.royalcollege.ca/portal/page/portal/rc/resources/aboutcanmeds>)

## **Modes of delivery**

Faculty development can be delivered in many ways. The literature supports the following as activities which rural faculty identify as useful in improving their preceptor skills.

### *The use of scenarios*

As rural faculty, preceptors often face unique clinical dilemmas - and their familiarity with these issues can belie the extent of the challenges they present. Cases can be used by faculty to develop teaching portfolios as they are often particular to rural practice and the residents needs to be taught rural family medicine in this context (3,11). In addition, faculty development should help the preceptors to not only teach standard care but also contingency care which may need to be provided in particular clinical scenarios in specific rural areas.

### *Use of moulages*

As residents and students will spend extended periods in rural sites, provision of the infrastructure /materials to teach moulages (or clinical scenarios) on site need to be supported financially by the medical school. Scenarios like those covered in ATLS<sup>5</sup>, PALS<sup>6</sup> and ACLS<sup>7</sup> can be taught equally well by rural preceptors – and can be taught in the context of the resources that exist in these areas.

As moulages can be an effective ways of teaching, preceptors should be supported in developing them and using them in their teaching, with support being offered to those who have not previously led a moulage.

### *Role playing*

While role playing is a long-established activity in the teaching of family medicine, not all rural preceptors will have had the experience of using them themselves - particularly international medical graduates and graduates of a particular generation. Given their value in teaching, support in the use of role play should be offered in faculty development.

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<sup>5</sup> Advanced Trauma Life Support

<sup>6</sup> Paediatric Advanced Life Support

<sup>7</sup> Advanced Cardiac Life Support

## *Technology*

The web and internet have significantly reduced the isolation of both the rural preceptor and the visiting trainees. Webcast workshops involving rural doctors and, more specifically, workshops and presentations delivered by rural preceptors can be delivered to the students and preceptors (11,14). Where possible

- establish a web portal which can act as a resource to the rural faculty for educational tools and for research; and
- ask the rural doctors to become more involved in the traditional activities of the medical school such as giving workshops on clinical skills or specific medical conditions. These can be presented in a contextual way, showing the students the relevance of the topic in the context of community clinical practice.

The internet also makes it easier to communicate with the faculty infrastructure and support in the 'medical school' and to be involved in the ongoing activities without leaving the rural community. Web-based communication can be used for meetings (at least in first world countries) as they allow preceptors from many sites to meet, often without leaving their offices.)

For these strategies to be viable, they need to be supported financially by the medical school. As exercises in productive faculty support, this is money well spent.

## **Feedback and support**

The need for the rural preceptors to meet regularly to share and discuss issues of mutual concern has been a recurrent theme in the literature (4,14).

In addition, there has been the proposal that a discipline faculty member, whose responsibility it is to liaise support and visit the rural sites, meets with the preceptors and be a resource to those teachers. Preceptors have also indicated that these meetings should include some form of continuing medical education (CME) activity, thus making it possible to accommodate both a faculty development need and an educational one at the same time.

'Academic detailers' should be identified from among programme faculty members and allocated to specific sites (15). The 'detailers' are responsible for liaising with their sites on a regular basis, reviewing the activities of the students and the residents, getting feedback from both the teachers and the students, and being current with the status of each learner in each site. They are the first on-site contact for students - and should visit the site at least twice a year.

Student feedback needs to be brought to the preceptor's attention on a regular basis in order to review the activities of the site and the usefulness of the rotation. The preceptors, in turn, needs to keep the programme aware of the progress of the students, emphasising both their weaknesses and strengths.

Communication between the medical school, its various programme directors and the dispersed faculty is key to maintaining and cultivating the involvement of these preceptors - and there should be a face-to-face meeting with a faculty member after the initial contact. This would ideally as a site visit, as this is the best way to understand the environment in which the new preceptor works. Not only will it give the programme director a sense of the geography of the area which often defines the scope and challenges of the physician's practice, but it will clarify, to some extent, the infrastructure and personnel available and will provide a better understanding of the extent of the practice, the potential for procedural exposure and bedside teaching. This can give the director a sense of the likely impact of learners on a site and the professional demands of the preceptor.

Ready and easy access to the programme director and the programme's administrative staff needs to be available to the preceptors - and the cost of meetings needs to be borne by the medical school. (It is often easier to have these meetings outside of clinic hours and associated with a funded social function such as a meal or barbeque.)

### **Peer support**

Peer-to-peer group meetings have been identified as extremely useful to rural preceptors. Not only do they provide opportunities to exchange ideas and experiences, but can also provide help with difficult conundrums that occur in rural practices and which can best be understood and appreciated by physicians in similar professional environments (4,14).

## **Recognition and reward**

Preceptors need to be appropriately recognised by the medical school by acknowledging their position in the core curriculum of the programme (10,11) .

Academic appointments, either stipended part-time or full-time, are an acknowledged method and can contribute to ensuring continuity of faculty. Ideally recognition and reward should elicit a sense of being 'part of' the faculty and medical school – and any privileges which are associated with this also extend to the rural faculty.

## **Practice pearls**

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

- 1 Good communication.
- 2 Develop rapport.
- 3 Understand the preceptor's environment.
- 4 Identify and clarify early the expectations of the programme.
- 5 Listen to the feedback from preceptors.
- 6 Involve them in curriculum development.
- 7 Assign an academic detailer to visit regularly
- 8 Acknowledge the work of the preceptors.
- 9 Be available to help with locum relief.

### ***What not to do***

- 1 Do not take the preceptor for granted.
- 2 Do not overload the preceptor with excess demands.
- 3 Ignore the feedback that they give on trainees.

## **Conclusion**

Rural preceptors are keen and enthusiastic teachers and have proven to be excellent mentors for students and residents. It is well established that rural exposure and rural training can result in well-rounded and appropriately skilled medical graduates who are specifically suited to work in these environments.



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### **Further reading**

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