

ORIGINAL RESEARCH

'I felt colonised': emerging clinical teachers on a new rural teaching platform

J Blitz, J Bezuidenhout, H Conradie, M de Villiers, S van Schalkwyk

Stellenbosch University, Tygerberg, South Africa

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ABSTRACT

Introduction: Studies that investigate the impact of long-term rural exposure for undergraduate medical students often focus largely on students' experiences and perspectives. Research focusing on the physician experience in clinical exposures appears to be limited. When the Ukwanda Rural Clinical School (RCS) at the Faculty of Medicine and Health Sciences, Stellenbosch University, South Africa was implemented in 2011, the clinical specialists working at the rural hospitals were expected to take on the additional task of teaching the students in the year-long rotation. The specialists were prepared for the task through a series of workshops. The objective of this study was to explore what the implementation of the RCS meant for the practice of these physicians and to what extent the shift from full-time practising clinician to clinical teacher required them to adapt and change.

Methods: This was a qualitative study. Semi-structured interviews were conducted with lead clinical specialists who were responsible for teaching medical students in the year-long RCS rotation. Following an interpretive approach, thematic content analysis was performed to obtain a clearer understanding of how these clinicians had experienced their first year as clinical teachers in the RCS.

Results: Four overarching themes were identified from the interviews with the clinicians: attitudes towards the implementation of the new medical education model, uncertainty and insecurity as a teacher, emergence of the clinician teacher, and a sense of responsibility for training a future colleague. These depict in part, the journey from clinician to clinician teacher travelled during the first year of implementation.

Conclusions: Embracing the role of clinical teacher enabled the development of constructive relationships between clinicians and their students with a mutual sense of responsibility for learning, patient care and improvement in clinical practice. Understanding this journey ought to influence the thinking of those considering faculty development initiatives for novice clinical teachers.

Key words: clinical teacher, continuity of relationship, development, faculty, shared responsibility.



Introduction

Medical schools are exploring ways of diversifying the sites they use for clinical teaching. In 2002, Stellenbosch University extended its teaching from the tertiary hospital and urban community-based training sites to include short clinical rotations for senior students at rural hospitals. In 2011, this was expanded significantly with the establishment of a rural clinical school (RCS; Fig1). The model adopted at the Ukwanda RCS (*Ukwanda* is a Xhosa word that can be translated as 'to grow' and 'develop'; to make a positive difference) was implemented, with eight final-year undergraduate medical students spending their entire final year of studies at a regional or district hospital (and their referring community health centres) situated between 100 and 150 km from the tertiary teaching hospital.

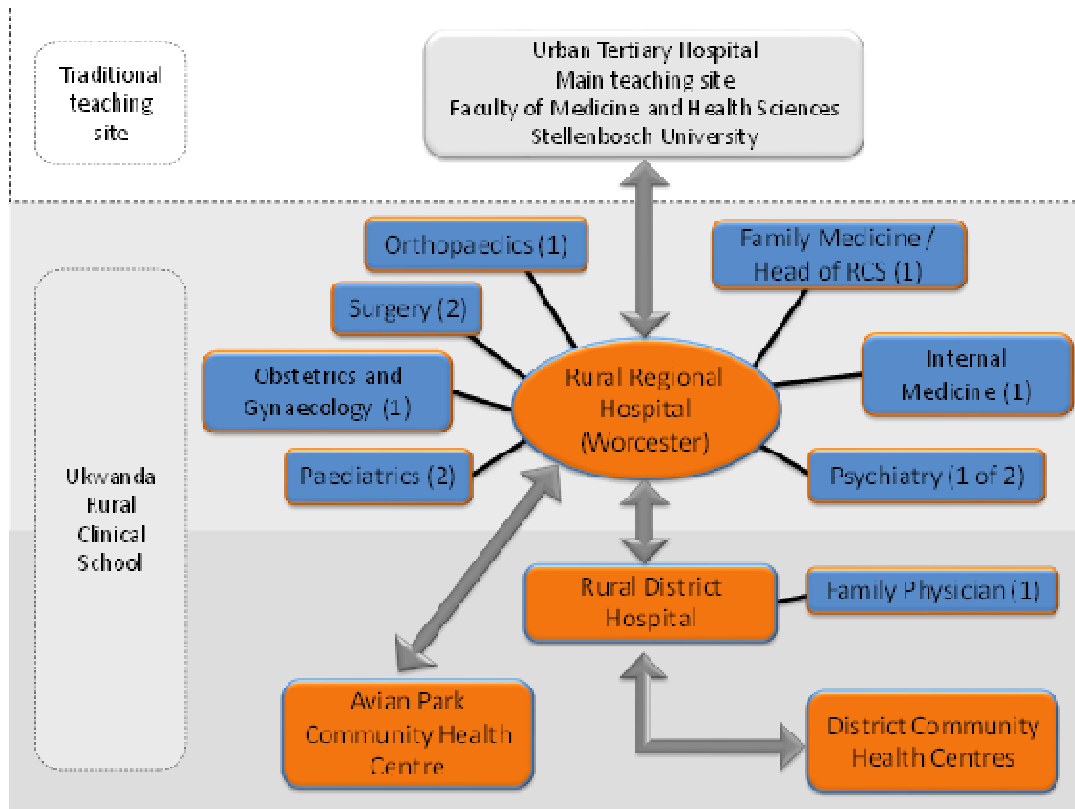
Studies that investigate the impact of long-term rural exposure for undergraduate medical students often focus largely on student experiences and perspectives. However, in any such endeavour there are always multiple role-players. In particular, the health practitioners who serve as clinical teachers for students on these rural rotations ought to be another important research focus. While the role of the clinical teacher is sometimes mentioned as an adjunct to the student experience¹⁻⁴, research that has specifically investigated aspects of the clinical teacher experience in community-based, and specifically rural, clinical exposures appears to be limited⁵. In addition, the work that has been done covers a wide range of approaches, differing lengths of exposure (duration) and location of the exposure in the curriculum (ie during which year(s) of study). These studies also consider different healthcare practitioners (such as general practitioners, family physicians, nurse practitioners) as clinical teachers in these different contexts⁵⁻⁸.

Despite all of these caveats, clinical teachers involved in rural clinical placements, especially placements of longer duration, generally describe their experiences in a positive light, expressing enjoyment in the role^{5,8-10}. While many report initial uncertainty and an impact on workload and increased time pressure, personal and professional development occur as a result of exposure to the

'teaching' role and engagement with the academic hospital and medical school^{1,5,9}. The clinical teachers tend to appreciate the opportunity to engage fellow practitioners in a different space such as during capacity-building activities facilitated by the academic institution^{2,4}.

In a recent study evaluating the first year of implementation of a rural clinical school¹¹, the data highlighted how the effects of this educational intervention had extended beyond the students to influence the practice and thinking of all the specialists who had become responsible for teaching activities. Prior to the implementation of the RCS they had predominantly clinical service responsibilities, but now they were required to incorporate a significant and continuous teaching component into their jobs. In preparation, over the year that preceded the students' arrival, they were involved in meetings that explored international models of rural clinical training, they designed an integrated curriculum based on 20 common presenting symptoms, developed the method by which each student's patient portfolio would be compiled and assessed, and completed a course on clinical supervision techniques. The clinicians were not offered any financial incentive for taking on this additional role, but were offered free access to the university library. The existing hospital teaching and learning facilities were used for this initial cohort of students.

In the regional hospital (280 beds) the students rotate through the main medical disciplines taught by specialist clinicians. In the district hospital (80 beds) the students are taught by a specialist family physician. One day a week is dedicated to a so-called 'academic day', a more formal teaching and learning opportunity involving all the specialists and the entire student cohort, including the district hospital students. Because of the small number of students who attended the RCS in the inception year, interactions between student and clinical teacher were often one-on-one. This led the researchers to consider what the implementation of the RCS had meant for the practice of these clinicians and how they had experienced this teaching responsibility that had been added into their already established clinical community and space. To what extent had the shift from full-time practising clinician to clinical teacher required them to adapt and change?



Numbers in brackets refer to the numbers of specialists interviewed out of the total number of specialists responsible for teaching in the discipline at that site.

Figure 1: Ukwanda Rural Clinical School teaching sites.

This article shifts the spotlight from the student to the specialist clinicians as the description of their experience as key role-players in the inauguration of a rural clinical school is explored.

Methods

As part of an evaluative study referred to previously, semi-structured interviews had been conducted by one of the authors (SvS), an educational advisor tasked with implementing a longitudinal evaluative research project on the impact of the RCS. The 11 lead clinicians responsible for teaching the students in each discipline were invited to

participate – surgery (2), internal medicine (1), obstetrics and gynaecology (1), paediatrics (2), psychiatry (2), orthopaedics (1) and family medicine (2). Ten were able to participate in the interviews (one was not available at the time). None refused to be interviewed. Most of the clinicians had been in practice at the sites of this study for 5–15 years prior to their incorporation into the RCS.

The interviews were generally about an hour long and were conducted and audio-recorded at the Ukwanda RCS. They were anonymised during the process of transcription.

For the purpose of this article the interview data were revisited, after having been previously analysed in light of the



student experiences, this time with the specialist physician as the subject of investigation. Following an interpretive approach and using open-coding, three of the authors (JB, JB and MdV) conducted thematic content analysis to obtain a clearer understanding of how these practising physicians had experienced their first year as clinical teachers in the RCS. This second round of coding was undertaken by researchers who had not been involved in the coding for the earlier study. The coding was initially done independently and then discussed to reach consensus. Another researcher, the Director of the Rural Clinical School (HC) checked the findings in relation to his knowledge of the participants and the hospital community and confirmed the consensus coding. The participants had the opportunity to comment on the research findings when a report on the research was presented to them.

Ethics approval

Ethics approval had been obtained from Stellenbosch University's Health Research Ethics Committee (N11/07/245). All the specialists who were approached to participate in interviews about their experiences during the implementation of the RCS gave consent.

Results

Four overarching themes were identified from the interviews with the specialist physicians. These are presented as they emerged chronologically from the data (Fig2), depicting, in part, the journey travelled during the first year of implementation. (For the following quotes, the number in brackets refers to respondent and 'T' indicates that the quote had been translated from the original Afrikaans.)

Attitudes towards implementation of the new medical education model (RCS)

Some of the practising specialists felt that the new model was imposed on them. Yet, while they had limited choice in their

participation in the model, and the teaching increased the scope of their original appointment, they were not averse to the implementation of the RCS. Evidence about similar educational initiatives implemented in other parts of the world presented to them influenced their willingness to participate in a positive way. Over time their attitudes shifted towards taking pride and ownership in successfully implementing the new model.

I felt slightly colonised actually, by it, by the way that the thing was organised. I mean, I enjoy students, I think that the idea of a rural clinical school is very good. I like the way in which it sort of breaks down the traditional third world/first world divide that has characterised South African medicine. I was actually uncomfortable with the way the thing was communicated and the way that Stellenbosch assumed that we would do it before we'd said we would, and it sort of passed the point of no return. [6]

I listened to the outcomes that were presented by the others, you know about what is happening internationally, for example in Australia and America and so forth, and I thought it made sense. I thought that we are competent to do this. [5,T]

Important influences were those of the RCS director, a practising rural and academic family physician with longstanding links with the university, and certain departments at the main tertiary teaching hospital.

Most definitely Prof XX was basically the middle man and if there were any questions or problems, we spoke to him. At (the tertiary teaching hospital), of course, some departments are much better than others. They were prepared to bend over backwards to help us. So, I think very, very good support. I mean, we would not have been able to do it on our own here on this side. Or even if only Prof XX and I had to sort of do it, it would not have worked out. So, yes, I think academically the University really took responsibility⁴.

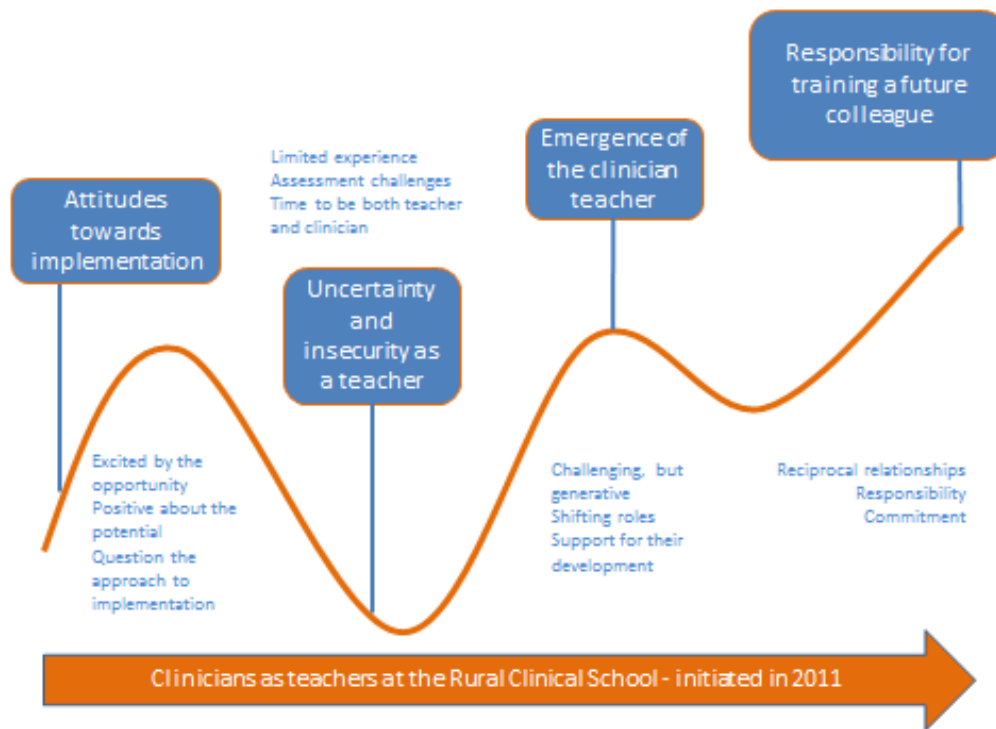


Figure 2: Illustration of the journey of the evolving clinical teacher.

Uncertainty and insecurity as a teacher

The specialists described differing levels of prior teaching experience and some perceived themselves as somewhat underprepared for the implementation of the RCS, although their self-confidence in teaching the students grew over time. They questioned whether they were ‘good enough’ and at the same time wanted to ‘show the (tertiary teaching) hospital’ that they could do it. Despite having had a role in the development of the new tools such as the student portfolio¹¹, they were uncertain about their role in the implementation of these new tools and their preparation of the students for the summative clinical examinations. They valued the leadership of the RCS director in this regard. As practising specialists they also expressed concerns about the impact that teaching would have on their time and their service delivery.

I think we were excited about it, but I think we were also cautious because we were unsure about the extra work involved and whether we were ready to do this. [9,T]

Yes, there were uncertainties, because as I said, you did not prepare yourself, and I think the uncertainties were there just because we did not have all the information right from the beginning. We did not know what our role would be. [9,T]

I was uneasy about the portfolio because it was a totally new thing. It is always difficult to learn something new. So it was a difficult concept to me, but once they were under way and they were writing, what was nice was that [one of the GP consultants] was there for the evaluation of the portfolio. [9,T]



We did not know what it would involve, time wise, and how it would work in practice and then of course the students' fears. Our biggest fear with this project was that we were offering them a different way of training, a way that was different to what was experienced at [the tertiary teaching hospital], and we were assessing them differently and everything else and this made them anxious and I am not exactly sure whether we are addressing this appropriately. [5,T]

Emergence of the clinician teacher

About half of the practising specialists had not been involved in undergraduate (pre-service) training in the past. The way they described their teaching approaches could be seen as case-based, practical and interactive. They intuitively embraced student-centred learning by addressing the students' learning needs, stimulating independent learning and allowing the students to 'lead' the curriculum. The process led to the specialists spending more effort and time in keeping up to date themselves and preparing for teaching. Most importantly they felt that they enjoyed the teaching experience.

For me, I enjoyed it. It's not a role that comes, or in the past it didn't come to me naturally, to teach. I was just a guy, don't speak to me, I just do the work, that kind of thing, and if I was left alone and nobody bothered me, so much the better ... I don't chase numbers to see how much or how fast an operation I can do, anymore. I used to do that when I first started here. It now gives me a kick to see a young guy, me being able to train him. It almost gives me as much satisfaction as doing the operation myself, seeing somebody else progressing ... Now they stand at the back with a cell phone and Google. You can't just tell them any old story anymore. They actually check if it's the truth. [6]

What was interesting was that I sometimes had an idea about what I wanted us to discuss and then they perhaps came with a different patient. Sometimes it was a surprise what we actually discussed in the end. [9,T]

I think to me it was actually valuable, because I realised again that you should refresh your own academic knowledge and on the most recent, you know, it motivates one to go and read and the students ask interesting questions, and one does not always know. It also activates questions in yourself, and how they see things. So I think from that point of view it was very valuable to me to work with the students to keep up to date with my own academic knowledge and also to think about things in different ways, that they contribute. [2,T]

Responsibility for students' success

The students rapidly became integrated into the clinical service teams and worked as fully fledged members of the team alongside the rest of the staff. The clinicians felt that the students worked long hours in delivering patient care and showed commitment towards patient care. This resulted in the teachers feeling invested in the students and created a much richer and more reciprocal teacher–pupil relationship.

Over time, working together in clinical teams and during the dedicated weekly 'academic days', the specialists got to know the students well and developed a relationship with the students as a group and as individuals. They expressed a sense of responsibility for the students, wanting the students to succeed not only in their summative examinations, but also as future colleagues. This resulted in them taking a personal interest in students, including specific mentoring.

I must say, if I look back, it was quite a difficult year for me in the sense that I felt very responsible for the students. It was sort of, I want to say, if they struggled, it would almost reflect on me. So it was difficult to me in that respect, I felt very responsible for them, but at the same time it is the first time that I am formally a family physician at the hospital. [4,T]

You feel a great responsibility towards these students, and because you soon get to know their names, you know soon, you know where they come from, they become part of the team, so there's this advantage, but you are also responsible. [5,T]



Discussion

In the process of inaugurating new clinical teaching sites there seems to be a focus on the student experience. As a result, the clinicians at these sites may be sidelined, with less attention paid to their experience.

The physicians at the rural regional hospital in this study were well-established clinicians who had initially been employed predominantly to deliver clinical services. They worked in a well-functioning context delivering health care to a rural community. They functioned as members of a supportive community of clinicians – most of them had worked and lived alongside each other for more than 5 years.

With the inauguration of the Ukwanda RCS, their community was disrupted by the university who was seen as imposing an innovative educational model onto their clinical environment, expecting them to take on additional teaching and assessment tasks. It is interesting to note that it was neither the presence of students, nor the role of teacher, that were perceived as the source of the disruption.

The clinicians were uncertain about living up to these new expectations – fitting teaching into their service delivery time, how to teach, whether their teaching would be good enough to enable the students to pass the examinations conducted by the university. They anticipated the challenge of balancing the clinical realities of patient care with having to ‘teach’ the student.

This dissonance between their previous known, confident clinical practice and the practice of teaching about which they felt less confident created the opportunity for a transformative learning experience for these practising specialists.

Instead of keeping the students in a separate student community, the clinicians responded by inviting the students to participate in their world (ie their clinical teams), embracing them and their potential (and future) role within

the team. This resulted in long-term relationships and continuity of supervision. The incorporation of new members into their community resulted in a sense of responsibility for the students, their growth and their success.

As a result, the specialists recognised the need to look at their own clinical practice – to be (and to remain) up to date with developments in their fields, to consider the evidence base of their practice, to develop new skills in teaching and assessment, and to see that they could make a significant contribution to the preparation of these students to take on their future roles in the clinical community.

This approach enabled them to embrace the role of clinical teacher without having to leave their clinical community, transforming their own social identity. It seems that as a result of their responses to the expectation of taking on the role of teacher (both incorporating the students into their environment and a willingness to take on some of these new roles) these clinicians started on a journey from clinician to clinical teacher. Their learning through social participation enabled them to become better clinical teachers for the sake of their students’ success.

They took ownership of teaching, taking responsibility for their students – their learning and their development towards being independent practitioners. They took a long-term view of the value of improving their own teaching practices with a view to the contribution that their students would make to the healthcare system in the future.

These findings seem to be consistent with other reports in the literature regarding initial discomfort with change; continuity of supervision which provides dialogue grounded in practice about values, professionalism, and lifelong learning¹²; and working with students to apply knowledge for patient care¹³.

A golden thread running through all interviews was the commitment expressed by the specialists and their genuine concern for the students. The commitment was such that, even when circumstances were not ideal and presented challenges, the specialists sought to address these challenges.



Their sense of responsibility for the students stretched beyond academic success and it was evident that on the whole the relationships were reciprocal and positive¹¹.

The data was collected with a focus on the students' experience, but the reported effects on the clinicians emerged, which strengthens its validity. Despite the small study population, this research does express the voice of the vast majority of the cohort of lead clinicians involved in teaching. Interviews with other members of the clinical teams, who might also have been involved in (although not responsible for) teaching, were not included. It could be seen as a limitation that this data emerges from a slice in time during the early implementation phase of the first rural clinical school in South Africa. It is possible that this early stage was a 'honeymoon' phase after which the clinicians' enthusiasm might dissipate. However, the researchers believe these are potentially valuable lessons for others to consider when initiating new clinical teaching sites.

Conclusion

There is little in the literature that describes the transition required of clinicians to become practising clinical teachers when clinical teaching expands to new sites such as this rural clinical school. This article presents findings that may be helpful to others who want to consider ways of facilitating the journey of practising clinicians to becoming clinical teachers. Understanding the change from a sense of being pushed by the university, and then embracing the role of clinical teacher with the accompanying sense of responsibility for the welfare and success of their students and the program, may be a valuable addition to faculty development initiatives. The practising clinicians in a particular clinical environment have the knowledge of the health system and its resources to be able to use these optimally for the incorporation of student. They have the potential to be powerful agents of the development of interdependence in education¹⁴, harmonising the educational institution and the healthcare facility by developing supportive and enabling social participation where constructive relationships between students and teachers

develop with a mutual sense of responsibility for improvement in clinical practice – instructional reform resulting in institutional reform.

This research does not explore whether this effect is unique to a rural environment, or the inauguration of a new clinical teaching site, or whether this understanding might also be of use in faculty development initiatives in established, traditional teaching environments. Further research in this area is indicated.

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