VIRTUAL BALINT GROUPS; THE LATEST AND MOST EFFECTIVE WAY TO PREVENT BURN OUT IN RURAL CLINICIANS
Dr Emma Boulton, Dr Jenny Presser
RVTS

Balint groups have been around for over 50yrs and in some parts of the world are a mandatory component of GP Training. They are usually held in a face to face format, though now technology has enabled us to hold effective meetings in a virtual space. For the RVTS that is an essential modality. Most of our education is delivered by teletutorial, where members join in small groups from across the whole country.

Rural clinicians face unique challenges in terms of professional and social isolation, making it even more desirable to provide peer friendship and support through a virtual group. Rural clinicians often are faced with challenging and distressing medical problems to deal with, and having the opportunity to debrief and discuss emotions and personal responses to clinical experience is highly desirable.

Evidence suggests that membership of Balint groups, improves job satisfaction and prevents burn out in doctors. The RVTS has provided an opportunity for GP registrars to participate in face to face and teleBalint groups, as part of their structured education, with the hope that as they progress through their medical career, they will feel confident of participating in Balint groups in the future.
MEASURING AND IMPROVING CULTURAL SAFETY IN A RURAL CLINICAL SCHOOL
Mr Justin Gladman 1, Ms Courtney Ryder 2, Associate Professor Lucie Walters 3, D McDermott 2, D Sjoberg 2, H Burton 3
1 Flinders University, Mount Gambier, 2 Flinders University, 3 Flinders University Rural Clinical School

Background
Flinders University as a partner of the Committee of Deans of Australian Medical schools (CDAMS) has agreed to delivery Indigenous health content in the core medical education. Attitudes of all teaching, clinical and administration staff create the cultural climate of an organisation and influence the effectiveness of learning.

Australian Rural Clinical Schools are charged with the responsibility to enhance and maintain the number of Aboriginal and Torres Strait Islander medical student graduates. In order to achieve this staff must develop and maintain community linkages; and actively create a culturally safe work and study environment through a comprehensive understanding of Aboriginal and Torres Strait Islander health issues and culture.

The aim of the research is to evaluate the knowledge, attitudes and skills in cultural safety of Flinders University Rural Clinical School (FURCS) staff, students and clinicians using a validated survey tool.

Methods
An email was sent out all FURCS associates inviting them to complete an online survey consisting of 31 likert scale questions. The responses to the survey will be analysed and compared with published results from previous studies using the validated tool, using a Cronbach’s alpha coefficient and a student t-test.

Results
The survey results will be presented at the conference

Conclusion
In order for staff and clinicians to deliver the Indigenous health curriculum it is important that they have assessed they own cultural knowledge and attitudes and address any personal barriers that may inhibit the delivery of Indigenous health content and teaching from a positive strength based model rather than a deficiency model.
MAKING THINKING AUDIBLE - THE LEARNING EXPERIENCES OF REMOTELY SUPERVISED
GP REGISTRARS
Dr Susan Wearne 1, Prof Tim Dornan 2, Prof Timothy Skinner 3, Dr Pim Teunissen 2,4
1 General Practice Education and Training, 2 Maastricht University, Netherlands, 3 Rural Clinical School, University of Tasmania, 4 VUmc, Amsterdam, Netherlands

Introduction
Remote supervision of GP registrars is shifting from being a novel to an accepted model of medical education in Australia. Registrars found remote supervision could be a supportive educational experience equivalent to on-site supervision (Hays and Peterson, 1996) and produce favourable outcomes in examination results (Wearne et al., 2010).

The standards set for onsite supervision have been implemented for remote supervision but with adaptations to overcome physical separation. This presumes that learning occurs in the same way as with on-site supervision. We explored whether this presumption is true and asked how do remotely supervised GP registrars learn?

Methods
GP registrars from Australia and Canadian, who had been supervised remotely were interviewed in-depth using a topic guide informed by socio-cultural (Lave and Wenger, 1991, Wenger, 1998) and work-based learning theories (Billett, 2002). Participants were asked to describe their experience, give examples of how and why this method of supervision worked or not, and its impact on their learning and clinical practice. Ten interviews were transcribed, coded openly and inductively analysed into themes by constant comparison. Further interviews will be conducted to test our initial analysis. Flinders University Social and Behavioural Research Ethics Committee approved the study.

Results
Our initial analysis is that remote supervision has several specific affordances for registrars learning. Registrars value learning via the ‘virtual autonomy’ provided by remote supervision. They learn by seeing the impact of their continuing care on a small discrete population. Registrars are free to seek assistance from the most appropriate person when it most suits their learning needs. Registrars create a network of professional and personal supports and learn through a cognitive apprenticeship of ‘making thinking audible’.

The disadvantages of remote supervision include difficulty in registrars knowing if they are making progress, identifying their blind spots, their emotional well-being and learning procedural skills.

Discussion
Remote supervision has some specific educational affordances and disadvantages for experienced GP registrars. Understanding these may lead to adjustments in the remote education model that can maximise the learning opportunities and partially ameliorate the disadvantages.

Workshop Format
As well as seeking to inform and promote discussion, the presenter will draw on the workshop discussion to test the trustworthiness of her research findings and to further inform her research.
Participants will be advised of this at the start of the workshop and will be asked to give written consent for their anonymised contributions to be used in the research.

**Workshop Format - This workshop will be recorded**

1. Presentation of research results

2. Facilitated small group discussion about salient results. Do these ‘fit’ with participants’ experience of remote supervision?

3. How should remote supervision be organised to maximise the affordances and limit the disadvantages to registrars’ learning?


HELPING TO ‘CLOSE THE GAP’ THROUGH CHRONIC DISEASE PREVENTION, IDENTIFICATION AND MANAGEMENT

Mrs Christine Potter
Australian Indigenous HealthInfoNet

Remote Medical Education in the Indigenous Health Context

The Australian Indigenous ClinicalInfoNet (www.clinicalinfonet.net.au) is a new Internet resource for primary health care workers. It presents, in a single comprehensive resource, existing tools, guides and online information to promote best practice in the prevention, identification and management of chronic disease in Indigenous people.

Indigenous people experience a burden of disease two-and-a-half times greater than that of other Australians. Their average life expectancy is, on average, 11 years less than that of non-Indigenous people and about 70% of this gap in life expectancy is due to avoidable and treatable chronic diseases. The gap can be reduced by prevention, early identification and improved management of these diseases.

Chronic disease management in the primary health care workplace requires access to a range of materials such as patient education information, management tools, guidelines and references. While extensive clinical resources are already available online, key barriers to use in practice include a lack of awareness by health professionals and limited access to these resources. A website that brings together all these resources in one place will assist general practitioners, nurses and Aboriginal Health Workers in their decision-making, and inform options relating to chronic disease management among Indigenous people. It will enable the primary health practitioners to access relevant, evidence-based, current and culturally appropriate information.

This web resource is the Australian Indigenous ClinicalInfoNet (ClinicalInfoNet) (www.clinicalinfonet.net.au). It covers the key chronic diseases contributing to the burden of disease in Indigenous people:

- cardiovascular disease
- diabetes
- chronic respiratory disease
- chronic kidney disease
- cancer.

It provides access to:

- patient education materials
- clinical guidelines and references
- clinical tools
- administrative information,

and covers all stages of the disease pathway:


• prevention
• diagnosis
• treatment
• drug therapy.

The integration of the web resource into patient management systems via the PrimaryCare Sidebar® (free software that connects the clinicians’ desktop to valuable resources and clinical tools) provides access to information in ‘real time’, enabling immediate returns during the patient consultation.

The ClinicalInfoNet is funded by the Commonwealth Department of Health and Ageing, and developed and managed by the Australian Indigenous HealthInfoNet (AIH). AIH is well-recognised for delivering a high standard of quality, evidence-based material to inform practice and policy in Indigenous health through the Australian Indigenous HealthInfoNet website (www.healthinfonet.ecu.edu.au).
This workshop will showcase the reflective case presentation – a unique remote education model developed by Northern Territory General Practice Education (NTGPE) to deal with the challenge of Prevocational General Practice Placements Program (PGPPP) doctors needing to be more reflective in their work environment, particularly when working with Indigenous patients in remote settings.

A number of doctors in NTGPEs PGPPP programme come from interstate. For many of them, a 13 week placement is their first encounter with Indigenous patients.

NTGPE has developed a unique remote teaching model which allows PGPPP doctors to:
reflect on their challenging patients;
enhance their understanding of cross-cultural issues;
obtain peer support;
debrief where appropriate;
deal with culture shock.

Reflective case presentations involve learners, medical educators and cultural educators working together in regular teleconferences.

At the end of the workshop participants will have:

1) Observed a mock cross-cultural reflective case presentation using teleconferencing;
2) Learnt from the experience of NTGPE in establishing a unique cross-cultural reflective space for PGPPP doctors using teleconferencing
3) Examined the experience of NTGPE cultural educators, medical educators and PGPPP doctors of being immersed in the cross-cultural teleconferencing reflective space
4) Examined the elements of the three-way conversation between cultural educators, medical educators and PGPPP doctors
5) Appreciated the context of a cross-cultural reflective space in terms of the broader roles, training and place of cultural educators within NTGPE
6) Have considered the issues of trust and relationships within the teleconferencing reflective space
NEXTGENU.ORG AND THE GLOBAL FAMILY MEDICINE RESIDENCY: USING INFORMATION TECHNOLOGY IN MEDICAL EDUCATION TO ADDRESS THE GLOBAL HEALTH WORKFORCE SHORTAGE

Dr Ainsley McCaskill 1, Dr Erica Frank 1234

1 NextGenU.org, 2 School of Population and Public Health, Faculty of Medicine, University of British Columbia, 3 Canada Research Chair in Preventive Medicine and Population Health, 4 Research Director, Annenberg Physician Training Program

NextGenU.org is the world's first portal to free, accredited higher education. Starting with a focus in Health Sciences, NextGenU courses are competency-based and include an online global peer community of practice and a local, skills-based mentorship. NextGenU partners with leading universities, professional societies and government organizations, including the U.S. CDC, Grand Challenges Canada, World Bank and the World Health Organization. Our accredited partners give learners credit for this training and institutions can adopt NextGenU courses to use with their students; all cost-free, advertisement-free, barrier-free, and carbon-free.

Founded in 2001, NextGenU launched its first full course (Emergency Medicine for Senior Medical Students) in March 2012. Initial data shows that NextGenU's training performs comparably to traditional American medical schooling. An international collaborative effort to develop the Global Family Medicine Residency (GFMR) was established in late 2012. The GFMR will be piloted in partnership with the Sudanese Ministry of Health and the University of Gezira.

NextGenU expects to educate millions of trainees at a time. This method is about to produce an educational and global health revolution and we would like the opportunity to share this with those attending the Remote Medical Education Conference.

A few examples of trainings (and our partners on each) are:

- Introduction to Emergency Medicine - launched in March 2012, in partnership with the Society of Academic Emergency Medicine, the International Federation of EM, and Emory University's Center for Injury Control (with users registered from over 40 countries);
- Global Family Medicine Residency - piloting in July 2013, in partnership with the Sudanese Ministry of Health and the University of Gezira;
- Environmental Health - launched early in 2013, partnered with Simon Fraser University and International Society of Doctors for the Environment;
- Climate Change and Health - to launch in February 2013 with 350.org, Physicians for Social Responsibility and the University of British Columbia;
- Prevention and Treatment of Domestic Violence - to launch in March 2013, in partnership with the International Federation of Ob/Gyns and Medical Women's International Association;
- Clerkships, Residencies, Fellowships, and Continuing Medical Education in Adolescent Health, Family Medicine, Pediatrics, and Preventive Medicine, in partnership with the American College of Preventive Medicine, International Federation of Gynecologists and Obstetricians, Latin American Pediatric Association, the University of British Columbia, and others;
- Certificates in multiple and diverse topics including Exercise and Health (U.S. CDC and the American College of Sports Medicine), Head and Neck anatomy (University of Pittsburgh), the Prevention and Treatment of Tobacco Use (International Primary Care Respiratory Group) and of Alcohol Use Disorders (Annenberg Foundation, University of Florida), and
Environmental Health (Simon Fraser University and the International Society of Doctors for the Environment);

- A Pre-Medical Curriculum - in partnership with the International Federation of Medical Student Associations and the World Medical Association.
WHAT FACTORS AFFECT MEDICAL STUDENTS’ PREPAREDNESS FOR PRACTICE DURING EXTENDED PLACEMENTS IN RURAL AND REMOTE SETTINGS?

Dr Malcolm Moore ¹, Ass. Prof David Perkins ¹, Ass. Prof. Chris Roberts ¹, Michele Daly ², Koshila Kumar ²

¹ University Department of Rural Health, USyd, Broken Hill, ² Faculty of Medicine, University of Sydney

Background
As community-based rural education opportunities expand in Australia, more medical students are being placed in rural and remote settings.

Aim
To identify the factors in an integrated, community engaged rural placement that may impact on perceptions of preparedness for practice, from a student and supervisor/clinician perspective.

Methods
42 semi-structured interviews with medical students, supervisors and health clinicians were thematically analysed.

Results
Students and clinicians identified three key factors affecting their perceptions of preparedness for practice: active clinical involvement; personal and professional development; and becoming culturally aware. Potential barriers associated with extended placements in rural and remote settings included geographical/academic isolation, students’ perception of educational risk and students’ differing engagement with informal learning opportunities.

Conclusions
An immersive, longitudinal clinical placement in a rural setting can enable development of competencies and identity which lead to preparedness for practice and, ultimately, ‘membership of the tribe’. A rural learning environment can help provide a unique experience through hands-on learning, enhanced personal and professional development opportunities and observation of how social determinants of health affect people’s lives.
INTEGRATING SMART PHONES INTO SKILLS ACQUISITION – STUDENTS TEACHING AND LEARNING IN A RURAL CLINICAL SCHOOL
Dr Alan Pedersen
University of Newcastle

Background
In Australia, Rural Clinical Schools face significant challenges in training medical students, such as sparse teaching staff and campuses that are distant from major teaching centres. The use of video conferencing, on-line teaching and learning platforms, and distance education, combined with adult learning principles, are some of the technological means to address these challenges. Given the high level of personal connectivity of students, the aim of this paper is to explore the use of short videos for collaborative learning amongst students at rural sites. The success of short videos as a learning tool has been amply demonstrated by online organisations such as the Khan Academy and Technology, Entertainment, Design (TED) Talks.

Methodology of current project
Medical students learn in a social context but as Rural Clinical Schools have relatively small student numbers this can be isolating. At the Rural Clinical School (RCS) of the Joint Medical Program of the University of Newcastle and University of New England, innovative programs are being run as a series of week-long ‘camps’, where medical students from all the rural sites meet for collaborative learning and social interaction. They problem solve clinical cases in small groups and then present their approach to the wider group. Opportunities therefore exist to utilize students who have learnt a skill or behavior to share this with their peers in ways other than in small groups. Students are asked to break into small groups and produce short videos to address a skill, topic or case. Filming can be performed on their smart phones, or whichever video cameras they possess. These videos are edited and then posted to the RCS secure web site, from which they can be downloaded and viewed by other students in their cohort. Students can detail their experience and tips and demonstrate the skill and the context in which it has been learnt. They take responsibility for collating feedback and for an iterative process of improvement of the video as a teaching aid for others.

Satisfaction with the teaching and learning is assessed at the end of a semester using both quantitative and qualitative elements.

Discussion and relevance
Given the ubiquitous nature of smart phone technology and the capacity for students to effectively engage online with social media, the possibility of using student experiences to teach others is an exciting extension of current teaching platforms. The need for university moderation and monitoring of sites is important, as is the clear roles and responsibilities for students in this process. Students may comment online on the videos, thereby generating discussion and ideas for further videos.
The Fellowship in Advanced Rural General Practice (FARGP) is the qualification awarded by the RACGP beyond the vocational Fellowship in addition to the FRACGP.

The FARGP recognises advanced rural skills training undertaken to develop extended general practice skills and broaden options for safe, accessible and comprehensive care for Australia’s rural, remote and very remote communities.

In October 2012 the FARGP online learning platform was launched. This new development allows medical educators, general practice registrars, and practising GPs access to the FARGP learning resources, enabling them to complete the course work and submit completed work for review and assessment via the College’s gplearning website.

This presentation will provided information on the FARGP program and a demonstration of the FARGP online learning platform and functionality.

Over 400 general practice registrars and practising GPs living and working in rural, remote and remote Australia are current enrolled in the FARGP program.

**Sub Theme**  
E-learning and New Technologies

**Presentation Type**  
15 min paper presentation
UPSKILLING HEALTH PROFESSIONALS AS EDUCATORS IN DISTRIBUTED TEACHING SITES IN RURAL AND REMOTE AUSTRALIA

Associate Professor Louise Young
School of Medicine, James Cook University

Introduction
A pilot investigation sponsored by Health Workforce Australia as part of their National Clinical Supervision Support Fellowship Initiative was undertaken to increase educator skills in health professionals supervising students on clinical placements in rural and remote Australia. Increasing numbers of students in all health professions are being sent further from tertiary institutions for their clinical placements. Combined with numbers of students and distance from capital cities, is the fact that most supervising preceptors are junior staff and only newly qualified themselves. Usually it is not possible for supervising coordinators from the universities to visit these clinical sites on a regular basis or to assist with issues related to their role as educator. This project aimed to investigate the impact of enhanced educator skills in a core set of best practice teaching and learning skills for rural clinical preceptors.

The project had an interprofessional focus as all health profession educators were learning the same information and skills related to teaching and learning which means there would be consistency for students when they were being taught by staff from different health professions at their clinical location. Lack of consistency in teaching approach between the health professions has been highlighted in a recent literature review (Young et al, 2012). Educators from the same clinical location would use the same approaches incorporating best practice educational techniques. This provided opportunity for clinical staff to teach students from several health professions using a consistent approach and further develop interprofessional concepts by students.

Methods
Skills were developed in a two hour face to face workshop introducing an overview of basic concepts related to teaching and learning in a clinical setting. A series of digital modules were developed which provided opportunity for further refinement and practise. The modules were trialled, feedback collected and skill development evaluated. Professions supported included Medicine, Nursing, Dentistry, Pharmacy, Aboriginal Health Workers, Physiotherapy, Occupational Therapy, Social Work and Psychology ie any health professional who had a role supervising health students in rural and remote locations.

Results
Quantitative and qualitative data was collected about educator skills and perceptions of teaching and learning from multiple perspectives on completion of the workshops. Participants completed a pre- and post- test of knowledge and skills and a survey covering their learning and changes in approaches and confidence about teaching. Results will be presented outlining the core teaching skills participants found beneficial in improving their confidence and competence in teaching students.

Discussion
The project resulted in teaching support for mainly junior health staff and provided basic but essential skills for supervising students in distributed teaching sites in rural and remote Australia.
Increased confidence and competence with teaching and supervising students may result in these new graduates feeling more comfortable in their role as clinical teacher which may contribute to increased job satisfaction. This increased confidence, competence and enjoyment in the teaching role may contribute to the willingness of these health professionals to remain working in rural and remote locations. Only time will tell.

References
International SOS, the world’s largest medical assistance company, provides its members with 24-hour access to medical care, wherever they are located.

Registered nurses and doctors provide over the phone medical advice, diagnosis, and referrals from 27 global assistance centres. During critical incidents, medical resources are deployed to provide on-the-ground assistance to members.

To ensure the seamless management of new or ongoing medical cases, International SOS coordinates its services across time zones, utilising the follow-the-sun principle. The Australian assistance centre provides after hours medical care for the Johannesburg, Moscow, Dubai and London assistance centres.

This results in complex challenges in providing on-call doctors and nurses with appropriate knowledge and specific information surrounding the medical capabilities, evacuation options, logistical issues and cultural considerations in each region.

Webinars and office communicator software are the primary tools utilised to facilitate remote education of medical professionals. In this session International SOS Deputy Medical Director, Dr Stewart Condon and Medical Trainer, Emma Gibson will explore the benefits and challenges associated with remote learning and fostering learner engagement.
LAUNCHING THE ROCCT-SHIP: REMOTE OPPORTUNITIES FOR CONSULTATION, CLINICAL TRAINING AND SUPPORT FOR HEALTH IN THE PACIFIC

Dr Lachlan McIver
World Health Organization

The Australian College of Rural and Remote Medicine (ACRRM), in collaboration with the Remote Vocational Training Scheme (RVTS), is the leading provider of specialized postgraduate medical training in the field of rural and remote primary health care in the Asia-Pacific region.

A core element of training towards Fellowship of ACRRM is the provision of high-quality medical care in isolated, challenging and often resource-poor environments while undertaking a specialized program of postgraduate study and clinical practice, with remote supervision and online learning support tools (including virtual classrooms and video consultations) key parts of this process.

As ACRRM continues to provide increasing numbers of Australian medical graduates with the skills and expertise they require to practice as “rural generalists”, providing vital services to communities across Australia, the spectrum of this training may begin to expand to include Australia’s neighbours – most of which are small island developing states (SIDS) with strong ties to Australian and New Zealand.

The ACRRM model of clinical training is uniquely placed to benefit health professionals in the Pacific region, most of whom practice in contexts which would be considered “isolated, challenging and resource-poor” from an Australian perspective.

Tuvalu, a Pacific atoll nation of approximately 10 000 people, over half of whom live on the capital atoll of Funafuti, is one of those SIDS.

With careful planning and in close consultation with senior counterparts in Tuvalu, ACRRM may be in a position to extend some aspects of its postgraduate medical education, clinical training and specialist support services to a small number of Tuvaluan health professionals.

Initial discussions with the Tuvalu Director of Health and Chief Public Health Officer suggest that a pilot program involving remote vocational training (to a Diploma- or Masters-equivalent level) for one of the current Tuvaluan interns in Fiji and/or one of the “GP’s” in Tuvalu along with a small suite of tele-health/remote specialist support services would be warmly welcomed.

A project, still at the conceptual stage, has been provisionally entitled “ROCCT-SHIP” – Remote Opportunities for Consultation, Clinical Training and Support for Health in the Pacific.

This presentation provides an overview of the key components of ROCCT-SHIP and invites discussion from the audience of experts and stakeholders regarding opportunities to refine this concept at its inception stage, and contribute to it as it develops.
LEARNING STYLES
Mr Luke Burgess
Community Mental Health

There are some questions around education and learning styles, is it the individual’s delivery of the health service?

Maybe the inappropriate manner of service delivery, that creates poor engagement?

I will admit there will be a considerable number of factors involved in this debate, although if I could attempt to extinguish one element of a debate. By suggesting some elements of the mainstream/western health models of care and education are out of date?

In its configuration/style of educational and therapeutic options, could this explain and or be directly related to the indigenous over representation, and under representations of individuals to health facilities, correctional facilities and health services, not to mention an under representations through secondary educational opportunities.

Meaning the methodology of the abstract content held within the above cultural existing traditions. With the reliance of psychology, and the abstract communicational techniques utilised, within, psychology, alongside the number of physical health and mental health, correctional and educational practises. This is inclusive of C.B.T, D.B.T and E.C.T alternately Mindfulness; these therapies are based on abstracts, of an individual’s feelings/mood. Alongside the time these Therapies consume, is the fact that most Australian indigenous peoples/client’s style of learning is not considered in the continual missed appointments.

Meaning this communicational style/therapy is not culturally appropriate, with an inability in emphasizing the repercussions and severity behind situations as a whole.

Then the minimal implementation of alternate learning styles that could be seen as tokenism, which in turn impacts on family, community and lifestyle, and the future of the community as a whole, not as an abstract of the communities as a whole.

So I would like to put to you all some helpful practices that maybe useful, and create a discussions regarding these responses. Though a power point presentation, of these styles and how the styles can help us with improving poor engagement and the overrepresentations of others.
Introduction
With almost 500 staff providing multi-disciplinary healthcare across some 24 geographically-dispersed sites, International Health and Medical Services (IHMS) is tasked with providing extended primary and mental healthcare for people in immigration detention. The services we provide take into account the health needs of a culturally-diverse client population at a standard of healthcare equivalent to that available to the wider Australian community.

But how can you prepare doctors to work in an environment which encompasses these challenges?

- remote and geographically-dispersed locations, from Christmas Island to Tasmania to Nauru;
- a custodial setting;
- isolated locations where external medical facilities and supplies are not readily accessible;
- patients presenting with medical conditions that are uncommon in Australia;
- high prevalence of communicable diseases, and torture and trauma;
- diverse cultural and linguistic backgrounds, with varying levels of literacy; and
- a high degree of public scrutiny.

This paper will provide an overview of how IHMS prepares and supports doctors being deployed to work in immigration detention facilities.

This process commences with a stringent selection process with our Recruitment team and Medical Directors, assessing appropriateness and resilience to work in this environment. Our medical staff then undertake an induction programme to prepare them for their roles at sites, including the regulatory environment, clinical governance arrangements, specialised processes, reporting requirements and cross-cultural sensitivities. Ongoing supervision and collaboration is crucial to ensure staff development, as well as the sharing of best practice across the 24 sites.

The Regional Medical Director for IHMS, Dr Mark Parrish, will outline the ways in which our medical staff are equipped to manage these issues and supported in their continuing medical education in this unique environment.
WHAT WE HAVE LEARNT, PROCEDURAL WORKSHOPS USING SYSTEMS AND TECHNOLOGY
IN THE CONTEXT OF RURAL LIFE

Dr Lorri Hopkins
Remote Vocational Training Scheme

Background
Procedural training provides challenges especially when general practice registrars work in rural and remote location. Some of the challenges are specific to isolation others to the community served. The Remote Vocational Training Scheme workshop team have developed procedural workshops that have provided remote registrars with a broad range of skills. The six week-long workshops are spread over three years. The development and organisation of these workshops is labour intensive.

Methods
The workshop team have developed systems to provide an intergraded procedural workshop that reflects the content in the teletutorials and supervisors training. This prepares the registrars for life as a remote and/or rural doctor. The systems enable the organisation of learning using technology and allow good communications in planning the workshops.

Results
The systems that have been developed over thirteen years of procedural workshops will be demonstrated and are available for application by other medical educators. Internet technology for interactive programing and collaborating has ensured document control. The educational sessions at of the workshops are rotated to cover our syllabus and correspondingly integrated into the RACGP and ACCRM curriculum. This has lead to a high level of registrar’s satisfaction, excellent rural work force retention and a high fellowship rate.

Conclusion
The Remote Vocational team will continue to provide procedural workshops to assist rural registrars learning. The workshop systems we have developed can be adapted for both procedural and nonprocedural workshops in other organisations.
Introduction
The aim of interprofessional learning (IPL) is to provide the opportunity to develop knowledge, skills and behaviours that enable health professionals to work as part of a patient/client-centred multidisciplinary team in providing safe and effective healthcare.

The aim of this project was to design and evaluate an interprofessional learning (IPL) unit for students from multiple disciplines while on rural placement rotations. The objective of the 2 week IPL course is to introduce students to multidisciplinary patient care and improve their confidence in skills in communicating with other health professionals.

Methods
Case study, pre-and post-evaluation including six month follow-up.

Participating students were divided into small multi-disciplinary (medicine, nursing, allied health) groups of 3 to 4 people. Each group was allocated a patient for whom they had to develop a holistic management plan over a 2 week period. At the end of this period each group had to present their patient’s case. Case presentations included developing and describing holistic care plans for management of their complex patient.

Results
Data collected from case presentations clearly demonstrated that students shifted from a theoretical endorsement of patient-centred care to a more practical and robust engagement with IP practice. Integral to this change was their observation that it was important to include the patient in the care planning process.

Discussion and conclusion
The effectiveness of this unit was enhanced by: the use of actual patients rather than case scenarios; the mixture of structured classroom and ward-based activities; the requirement that students reflect on the patient’s subjective experience as well as their group processes; the inclusion of practicing clinicians at case presentations; and the intentional inclusion of “fun” to enhance engagement in learning and professional behaviour.