Education for Health

Volume 27, Issue 2 (August 2014)

CONTENTS

Brief Communications

Practical Advice Paper

Letters to the Editor

Editorial

Special Issue on Rendez-Vous 2012 Conference, Thunder Bay, Canada, October 9-14, 2012

Community Participation in Health Professional Education, Research and Service

Roger Strasser[1], Sue Berry[1]

[1]*Integrated Clinical Learning, Northern Ontario School of Medicine, Ontario, Canada*

Rendez-Vous 2012

Rendez-Vous 2012, five world conferences in one, brought together The Network: Towards Unity for Health (TUFH) annual conference and the Wonca World Rural Health Conference, as well as the Northern Ontario School of Medicine (NOSM)/Flinders Conference on Community Engaged Medical Education (CEME), the Consortium of Longitudinal Integrated Clerkships (CLIC) and the Training for Health Equity Network (THEnet). For six days (October 9-14, 2012), NOSM played host to over 850 participants from 50 countries including 150 health professional schools. There were over 400 presentations including an inspirational keynote address, plenary and parallel sessions, student-run workshops, Francophone Symposium, NOSM all residents retreat, community site visits in Thunder Bay and Conference on the Move involving other communities across Northern Ontario.[1]

This was a conference like no other because of the cross fertilization between The Network: TUFH focus on integrating individual and population health approaches to community-oriented education and service; the Wonca rural focus on improving the health of remote rural people; the NOSM/Flinders focus on community engagement through CEME; the CLIC focus on continuity through longitudinal learning; and THEnet's focus on socially accountable health professional education. For many, the momentum generated by Rendez-Vous 2012 continues through new initiatives and relationships, which began in Thunder Bay. This special edition of *Education for Health* contributes to that momentum with papers of works and programs originally presented at the conference.

Access this article online	
Quick Response Code:	Website: www.educationforhealth.net
	DOI: 10.4103/1357-6283.143726

Community Engagement

"Loosely defined, community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs and practices."[2]

This notion of community engagement from the Centers for Disease Control and Prevention (CDC) emphasizes the potential importance of active community involvement in improving health at the community or whole population level. Community engagement is of importance also in health professional education, particularly when the focus is on producing health professionals with the skills and desire to

Address for correspondence:
Dr. Roger Strasser, Northern Ontario School of Medicine, 935 Ramsey Lake Road, Sudbury, Ontario, P3E2C6, Canada.
E-mail: roger.strasser@nosm.ca

provide care, which is responsive to the community's health needs.[3]

CEME has evolved over the past 15 years and may be seen as a development from community-oriented medical education (COME) of the 1960s and 1970s, and community-based medical education (CBME) of the 1980s and 1990s. The Network: TUFH began in 1979 at the instigation of the World Health Organization (WHO) with a group of 19 medical schools, which implemented COME.[4] COME described students as learning about community contexts and their impact on the care of patients from different cultural and social backgrounds.[5]

Subsequently, CBME aimed to enhance students' learning by placing them in communities rather than learning about communities from the classroom. CBME extended the range of potential clinical learning environments to include mental health services, long-term care facilities and medical clinics as well as hospitals and health services in remote, rural and urban communities.[6] CBME also explored the extent to which students could benefit from prolonged community-based learning, typically in family practice. This approach was developed in the urban setting at Cambridge University in England,[7] and became part of the "rural tracks" established by a number of US medical schools in the 1970s.[8,9] In the 1980s, community-based education and service (COBES) developed in Africa to produce students "with a strong inclination to broad community care and preventive medicine".[10] In Australia, Flinders University developed the Parallel Rural Community Curriculum (PRCC) where students spend a whole year based in family practice in a single rural community.[11]

CEME stresses the importance of interdependent and reciprocally beneficial partnerships between education institutions and the communities they serve. Active community participation is a fundamental part of setting a schools' education, research and community development mission. CEME seeks to address power inequities between academies and their community partners, supporting the alignment of communities' healthcare needs with student learning objectives and activities, and encouraging students to develop the skills and motivation to practice in specific community settings. CEME requires that communities directly contribute to students' learning of local social determinants of health. The CEME agenda is consistent with the WHO model of social accountability in medical education.[12]

Longitudinal Learning

Since the Flexner report in 1910, the standard model for learning core clinical medicine has involved students in teaching hospitals undertaking block rotations (clerkships) in various medical specialty and subspecialty disciplines. Longitudinal Integrated Clerkships (LIC) developed as an alternative to this model. The first LIC, the Rural Physician Associate Program (RPAP) was introduced by the University of Minnesota in 1971 as a rural workforce initiative. Despite the success of the RPAP, it took more than 20 years for other institutions to develop the next generation of LICs in the 1990s including the Flinders University PRCC, which started in 1997.[11] Subsequently, these initiatives were shown to be successful in terms of recruitment into primary care and rural practice. The reliance of LICs on educational continuity provides many advantages. Research over the past 15 years has shown educational advantages of LICs undertaken in both rural and urban clinical settings. Compared with students who undertake teaching hospital clerkship blocks, students who complete LICs have improved academic results, enhanced patient-centeredness, greater exposure to common conditions and more meaningful learning relationships with patients and academic mentors.[13]

NOSM in Canada was the first medical school in which all students undertake LIC clinical education within a program known as the Comprehensive Community Clerkship (CCC). In preparation for the first CCC, NOSM hosted a think tank in 2006 that brought together representatives of six medical schools in the USA, Canada and Australia to share their experiences of LICs. As well as assisting NOSM, the success of these deliberations led to the establishment of the international CLIC. CLIC is a group of faculty members from medical schools around the world who have or are considering developing, implementing and studying the LIC model of core clinical training for undergraduate medical education.[14]

Although there are various models of LIC, the key common features are: Comprehensive patient care over time; continuity of learning relationships for students with patients, clinicians and curriculum; and achieving competencies across multiple disciplines simultaneously. More generally, longitudinal learning has the advantage of providing a breadth of exposure to clinical problems over time, continuity of relationships with patients and clinical teachers, and graded responsibility, which supports growing autonomy and counters learned helplessness.

Building on the success of the PRCC, Flinders University in Australia has moved to implement a LIC model in the teaching hospital environment. In this special issue, Heddle *et al*.[15] outline the challenges and opportunities in developing the Longitudinal Integrated Flinders Training (LIFT) model at Flinders Medical Centre in Adelaide and Alice Springs Hospital, transitioning from traditional block rotations to LIC.

Social Accountability

For the World Bank, social accountability is achieved through a broad range of actions and mechanisms geared toward

public expenditure management processes. These mechanisms seek to "directly involve ordinary citizens in processes of allocating, disbursing, monitoring and evaluating the use of public resources."[16] The WHO describes the social accountability of medical schools as the obligation to direct their education, research and service toward addressing the priority health concerns of the community, region and/or nation that they have the mandate to serve. The priority health concerns are identified jointly by governments, healthcare organizations, health professionals and the community members themselves.[12]

Social accountability is the guiding principle for the health professional schools who are members of the THEnet. THEnet schools are located in underserved and rural regions where they partner with others seeking to transform health professional education, build institutional capacity, and shape policy so as to encourage health systems around the world to be more equitable.[17]

NOSM, a founding member of THEnet, is the first Canadian medical school established with a social accountability mandate to contribute to improving the health of the people and communities of Northern Ontario. Northern Ontario, a geographically vast region (>800,000 km^2), is known for its volatile resource-based economy and its socio-economic characteristics that differ markedly from the rest of Ontario province. Forty percent of the population of Northern Ontario live in rural and remote areas in diverse communities and cultural groups, most notably involving Aboriginal and Francophone peoples. The overall health status of Northern Ontario communities is below that of the province as a whole, exacerbated by a chronic shortage of trained health professionals.

In this context, NOSM developed Distributed Community Engaged Learning (DCEL) as its distinctive model of medical education and health research. DCEL relies heavily on electronic communications and interdependent partnerships between NOSM and the communities of Northern Ontario. In the classroom and in clinical settings, students explore cases from the perspective of physicians practicing in Northern Ontario. There is a strong emphasis on the interprofessional education and integrated clinical learning (ICL) that takes place in over 90 communities and many different health service settings, so that the students have personal experience of the diversity of the region's communities and cultures.

The success of this approach is reflected in many ways. NOSM students have performed consistently above the national average in Canadian licensing exams and almost all graduating classes have matched to residency programs in the first round of the national residency match. Between 2009 and 2013, 62% of NOSM graduates chose family medicine (predominantly rural) training, almost double the Canadian average, and 70% of NOSM residents choose to practice in Northern Ontario after completing their training. After seven years of recruiting applicants from its underserved health workforce region, there are signs that NOSM's model of socially accountable distributed education is successful in graduating health professionals who have the skills and the desire to provide healthcare in remote rural communities.[18]

Ross *et al*. report a pilot study using THEnet Evaluation Framework.[19] This framework provides criteria for schools to assess their level of social accountabilityfrom multiple views: within their organization and planning; education, research and service delivery; and the direct and indirect impacts of the schooland its graduates on the community and health system. In South Africa, the Collaboration for Health Equity in Education and Research (CHEER) involvesall the Faculties of Health Sciences. Using the THEnet Evaluation Framework, CHEER undertooka pilot peer review of Social Accountability in Health Sciences in South Africa. The paper by Michaels *et al*. shares lessons learned and insights from the pilot process.[20]

Ritz, Beatty and Ellaway[21] explore social accountability at the conceptual level, challenging the reader to undertake a critical analysis and reflexivity. They contend that social accountability in medical education will not fulfil its potential for transformative social change unless "we are willing to become accountable, not only for our actions, but also for the ideologies and discourses through which they are articulated".

The article by Mahoney *et al*.[22] reports a Flinders University initiative which aims to incorporate social accountability in the curriculum for students undertaking acommunity-based LIC in suburban Adelaide. Through engagement with community agencies, medical students participate in a Wellbeing Centre at the local high school.

International Collaboration

The Wonca Working Party on Rural Practice (WWPRP) was formed in 1992 in response to the realization that rural health care faced many serious and similar challenges around the world. Despite the obvious differences between developing and developed countries, access is the major issue in rural health globally. Even in countries where the majority of the population live in rural areas, the resources are concentrated in the cities. All countries have difficulties with transport and communication between rural and urban communities, and they all face the challenge of shortages of doctors and other health professionals in rural and remote areas.[23]

The Working Party developed a series of Wonca rural policies beginning in 1995 with the Wonca Policy on Training for Rural Practice. In 1996, the first Wonca World Rural Health Conference

was held in China, bringing together over 300 rural practitioners from 30 different countries. One of the remarkable features of Wonca World Rural Health World Conferences has been the high level of common interest and strong sense of fellowship coupled with a willingness to discuss even the most difficult issues. The Wonca rural policy documents and conference consensus statements have been important in shaping rural health care in a number of different contexts, and have led to issues of rural health care rising to prominence on the world stage.

International perspectives on health have changed with the development of rapid transportation worldwide, associated movement of people and diseases, and a growing awareness of health disparities between and within countries. In this context, the notion of Global Health has developed building on the previous population health/primary health care movement of the 1970s and 1980s, international health exchanges of the 1980s and 1990s and Network: TUFH integration of individual and population health perspectives of the 1990s and 2000s. In 2009, Global Health was defined as "an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide".[24] The emphasis on achieving health equity connects with the growing focus on social accountability.

The article by Morin *et al*.[25] describes an initiative of the University of Sherbrooke in Canada which aims at achieving social accountability through international collaboration with a partner medical school in Uruguay. Their experience is described as mutually rewarding with benefits outweighing the challenges. Wallace and Webb[26] address the issue of preparing medical students for international elective experiences through pre-departure training (PDT). They suggest that PDT alone is insufficient, emphasizing that a socially accountableprogram should actively involve community partners in the process. Dickson, Manalo and Plater[27] report a postgraduate international public health initiative "Beyond Borders" which connects international public health with Indigenous health promotion as a means of achieving knowledge and skill exchange of value to developing health professionals.

For many participants, the momentum generated by Rendez-Vous 2012 continues through new initiatives and relationships, which began in Thunder Bay. For example, Dr. Bill Ventres, a US family physician educator, currently working at the University of El Salvador MPH program, commented: "For me, the conference was a wonderful exploration of many themes related to rural health, family medicine (and primary care in general) and medical education, in the US and around the world. It was big enough to get some great ideas, yet small enough to meet with people individually". He connected with other Rendez-Vous 2012 participants resulting in the several publications.[28-30] Another example is The Network: TUFH Task Force on "Implementation of transformative health professional education guidelines", which had been the Rendez-Vous 2012 International Advisory Committee. After the conference, the group was joined by Dr. Erica Wheeler of the WHO. Sue Berry acts as convener of the group, which has continued to meet regularly by Skype. The Task Force contributed to:Finalizing the WHO *Guidelines for transforming and scaling up health professionals' education and training*;[31] a workshop at the 2013 The Network: TUFH conference in Thailand; and leadership in planning and implementing the WHO contribution to the Prince Mahidol Award Conference 2014 "Transformative Learning for Health Equity" in Thailand.[32]

Thunder Bay Communiqué

Rendez-Vous 2012 concluded with adoption of the conference declaration, the Thunder Bay Communiqué, *New Ways of Thinking* about the conference theme of Community Participation in Health Professional Education, Research and Service.[1] This document grew out of discussions during and after conference sessions. Recognizing that an important factor in health inequity is a lack of access to skilled health practitioners, the statement supports World Health Assembly resolutions targeted at training and retaining adequate numbers of health workers, implementing integrated primary health care and strengthening health systems through universal health coverage.

Conference participants in universities and academic institutions resolved to: have communities guide them in implementation of health professional education that addresses the communities' needs; develop programs and new methods of education that maximize the immersion of students in communities throughout their training; work together internationally to share education resources and research tools openly; and provide transformational educational opportunities that maximize the length and strength of relationships with patients, supervisors and communities and create authentic workplace learning and identity formation.

References

1. Available from: http://www.rendez-vous2012.ca [Last accessed 2014 Jul 31].
2. Centers for Disease Control and Prevention (CDC). Available from: http://www.cdc.gov/phppo/pce/part 1.htm [Last accessed on 2014 Jul 31].
3. Strasser RP. Community engagement: A key to successful rural clinical education. Rural and Remote Health 2010;10:1543.
4. Schmidt HG, Neufeld VR, Nooman ZM, Ogunbode T. Network of community oriented education institutions for the health sciences. Acad Med 1991;66:259-63.
5. Hamad B. Community-oriented medical education: What is it? Med Educ 1991;25:16-22.
6. Magzoub ME, Schmidt HG. A taxonomy of community-based medical education. Acad Med 2000;75:699-707.
7. Oswald N, Alderson T, Jones S. Evaluating primary care as a base for medical education: The report of the Cambridge Community-based Clinical Course. Med Educ 2001;35:782-8.

8. Ramsey PG, Coombs JB, Hunt DD, Marshall SG, Wenrich MD. From Concept to Culture: The WWAMI Program at the University of Washington School of Medicine. Acad Med 2001;76:765-75.
9. Verby JE. The Minnesota Rural Physician Associate Program for Medical Students. J Med Educ 1988;63:427-37.
10. University of Ilorin College of Health Sciences. Community Based Experience and Services: An Innovative Medical Education of University of Ilorin, Nigeria. College of Health Sciences. University of Ilorin, Nigeria. Available from: http://www.cohs.unilorin.edu.ng/index.php/cobes/about-cobes [Last accessed on 2014 Jul 13].
11. Worley P, Silagy C, Prideaux D, Newble D, Jones A. The Parallel Rural Community Curriculum: An integrated clinical curriculum based in rural general practice. Med Educ 2000;34:558-65.
12. Boelen C, Heck JE. Defining and Measuring the Social Accountability of Medical Schools. Division of Development of Human Resources for Health, World Health Organization, Geneva; 1995.
13. Strasser R, Hirsh D. Longitudinal integrated clerkships: Transforming medical education worldwide? Med Educ 2011;45:436-7.
14. Norris TE, Schaad DC, DeWitt D, Ogur B, Hunt DD; Consortium of Longitudinal Integrated Clerkships. Longitudinal Integrated Clerkships for Medical Students: An Innovation Adopted by Medical Schools in Australia, Canada, South Africa, and the United States. Acad Med 2009;84:902-7.
15. Heddle W, Roberton G, Mahoney S, Walters L, Strasser S, Worley P. Challenges in transformation of the "traditional block rotation" medical student clinical education into a longitudinal integrated clerkship model. Educ Health 2014;27.
16. Agarwal S, Heltberg R, Diachok M. Scaling up social accountability in World Bank operations. Washington: World Bank; 2009.
17. Palsdottir B, Neusy AJ, Reed G. Building the Evidence Base: Networking innovative socially accountable medical education programs. Educ Health 2008;21:177.
18. Strasser R, Hogenbirk JC, Minore B, Marsh DC, Berry S, McCready WG, *et al*. Transforming health professional education through social accountability: Canada's Northern Ontario School of Medicine. Med Teach 2013;35:490-6.
19. Ross SJ, Preston R, Lindemann IC, Matte MC, Samson R, Tandinco FD, *et al*. The training for health equity network evaluation framework: A pilot study at five health professional schools. Educ Health 2014;27.
20. Michaels DC, Reid SJ, Naidu CS. Peer review for social accountability of health sciences education: A model from South Africa. Educ Health 2014;27.
21. Ritz SA, Beatty K, Ellaway RH. Accounting for social accountability: Developing critiques of social accountability within medical education. Educ Health 2014;27.
22. Mahoney S, Boileau L, Floridis J, Abi-Abdallah C, Lee B. How social accountability can be incorporated into an urban community-based medical education program: An Australian initiative. Educ Health 2014;27.
23. Strasser R. Rural health around the World: Challenges and solutions. Fam Pract 2003;20:457-63.
24. Koplan JP, Bond TC, Merson MH, Reddy KS, Rodriguez MH, Sewankambo NK, *et al*.; Consortium of Universities for Global Health Executive Board. Towards a common definition of global health. Lancet 2009;373:1993-5.
25. Morin M, Maison PG, Henderson E, Vignolo J. Sherbrooke-Montevideo: A socially responsible international collaboration to foster family medicine. Educ Health 2014;27.
26. Wallace LJ, Webb A. Pre-departure training and the social accountability of international medical electives. Educ Health 2014;27.
27. Dickson M, Manalo G, Plater S. The beyond borders initiative: Aboriginal, Torres strait islander and international public health students: Engaging partners in cross-cultural learning. Educ Health 2014;27.
28. Ventres W, Dharamsi S. Beyond religion and spirituality: Faith in the study and practice of medicine. Perspect Biol Med 2013;56:352-61.
29. Ventres W, Dharamsi S. AM last page: Socially Accountable medical education--the REVOLUTIONS framework. Acad Med[In Press].
30. Ventres W. Ethical considerations for health-related service-learning programs. Acad Med 2014;89:529.
31. Available from: http://www.who.int/hrh/resources/transf_scaling_hpet [Last accessed on 2014 Aug 30].
32. Transformative Learning for Health Equity: Report of Prince Mahidol Award Conference 27-31 January 2014, Pattaya, Thailand. Available from: http://www.pmaconference.mahidol.ac.th [Last accessed on 2014 Aug 30].

How to cite this article: Strasser R, Berry S. Special issue on Rendez-Vous 2012 conference, Thunder Bay, Canada, October 9-14, 2012: Community participation in health professional education, research and service. Educ Health 2014;27:111-5.