The 2014 Muster
Global Community Engaged Medical Education
ULURU, NORTHERN TERRITORY, AUSTRALIA

Sessions and Presentations
Keynote and Master Class Presentations
PLENARY

Collaborative Leadership Conversation

Author(s) and Affiliations: Donna Ah Chee, CEO Central Australian Aboriginal Congress | Pat Miller, CEO Central Australian Aboriginal Legal Aid Service Inc. (CAALAS) | Agnes Soucat, Director for Human Development, African Development Bank

Donna Ah Chee is the CEO of the Central Australian Aboriginal Congress, an Aboriginal community controlled primary health care service in Alice Springs. Congress employs up to 300 staff delivering services ranging from antenatal and postnatal care, early childhood development, chronic disease, social and emotional wellbeing, women’s and men’s health and a 55 place childcare centre. This includes auspicing five Aboriginal health services in the central Australia, helping them achieve community control of their own services while at the same time providing much needed primary health care services.

Dr Patricia Ann Miller AO was born in Alice Springs and is a member of the Liddle family which has both traditional and pioneering ties in Central Australia. Her mother Polly Liddle was a traditional Alyuwarre woman and her father Milton Liddle was of Arrerre and Scottish heritage. Through her parents, Dr Miller is a native title holder and as such she plays a role within the Lhere Artepe Aboriginal Corporation which represents native title holders within the municipality of Alice Springs. Dr Miller is currently the Director of the Central Australian Aboriginal Legal Aid Service, an organisation for which she has worked for since 1978. Prior to this she worked for wholesale/retail distribution companies in Alice Springs for 10 years. Dr Miller was appointed as Deputy of the Administrator of the Northern Territory on 30 June 2002. She is the first female Indigenous Australian to hold such a position and as a member of the Arrerre people she is also the first Northern Territory native title holder to do so.

Doctor Agnes Soucat is the Director for Human Development for the African Development Bank, where she is responsible for health, education, and social protection for Africa, including 53 countries in sub-Saharan Africa and the Maghreb. Previously she worked at the World Bank where she variously served as Lead Economist and Advisor to the Director for Human Development for Africa, and Advisor to the Director for Health the World Bank. She has been leading the Health Systems for Outcomes (HSO) program of the Africa Region, a program which helps countries strengthen their national health systems in Africa to achieve better health for poor people —making sure that poor people get the health services they need to lead healthy lives, when they need them. The program places a strong emphasis on Results-Based-Financing (RBF), which in a nutshell finances health programs only when service providers can show verifiable results.

Learning Objectives:
1. Define the benefits and barriers of collaborative leadership.
2. Be able to take some initial steps towards collaborative leadership in their own clinical teaching or research practice.

Abstract:
The Muster Conference has invited three senior women leaders: Agnes Soucat, Donna AhChe and Patricia Miller to discuss their experience of collaborative leadership, optimal strategies to establish collaborative leadership and what this might mean for our collective future in terms of Social Accountability, Aboriginal Health, Community Engagement and Longitudinal Learning. This session will be chaired by Professor Paul Worley, Dean of the Flinders University School of Medicine. Paul will no doubt reflect on his own experiences of collaborative leadership in directing the Q and A conversation after an initial short presentation from each speaker. This session is very interactive so please be prepared to let us all know your ideas & questions.
KEYNOTE

Exploring the intersections of medical schools and communities

Author(s) and Affiliations: Rachel Ellaway, Northern Ontario School of Medicine

Dr. Rachel Ellaway is the Assistant Dean for Curriculum and Planning and an Associate Professor at the Northern Ontario School of Medicine in Sudbury, Ontario. Following her PhD in Medical Education from the University of Edinburgh her academic work concentrated on online learning, simulation and the use of new technologies for teaching and assessment in and around health professional education. More recently she has been exploring the many connections between medical education activities and medical education systems. Dr. Ellaway was the instigator and continues to act as the Maîtresse des Ceremonies for the AMEE Fringe and she is the author of the eMedical Teacher column in the journal Medical Teacher.

Learning Objectives:
1. Describe issues in community-engaged medical education research literature.
2. Describe the essential dimensions of realist review.

Abstract:
Medical schools and communities interact in many different ways. Some schools have very little contact with communities while others define their mission in terms of their community relationships. Although there has been a growing interest in building relationships between medical schools and communities there has been little consistency in the way this has been reported in the literature. Developing from discussions at the 2010 Muster meeting, a realist review of the literature on the relationships between medical schools and communities was undertaken. Dr. Ellaway will present findings from this review and she will explore their implications for our understanding of community-engaged medical education and the social accountability of medical schools. She will also consider the design and use of systematic reviews and the use of realist methods in the context of community-engaged medical education.
KEYNOTE

Programmatic assessment for learning

Author(s) and Affiliations: Lambert Schuwirth, Flinders University, Maastricht University

Lambert Schuwirth graduated from Maastricht Medical School as an MD. He became involved in medical education and medical education research since 1990. His main interest is in assessment of medical competence and performance, both in undergraduate and postgraduate training settings. He has worked at Maastricht University for almost 20 years as assistant, associate and full professor in the department of educational development and research, before coming to Flinders in August 2011.

Lambert is currently Professor of Medical Education at the Flinders University School of Medicine's Health Professional Education Unit. The unit’s main activities are in the domains of curriculum development, assessment, admissions/selection, program evaluation and faculty development.

Learning Objectives:
1. Understand the limitations of a testing-only approach to assessment.
2. Understand the fundamentals of assessment-for-learning.
3. Understand the fundamentals of programmatic assessment.

Abstract:
Is there something wrong with most current approaches to assessment in medical education? An increasing number of people would say there is. Education and learning are generally known to be most effective if it is an active process. It requires the learners to be self-regulated and agentic in their self-reflection so that they can formulate their own meaningful learning goals. This view is widely underpinned by research mainly in the cognitive sciences domain. But assessment, especially in the form of structured and standardised testing, is largely based on behaviourist principles and therefore does not allow for the learner to be in control over their assessment. In programmatic assessment for learning approaches have been developed to better constructively align the educational processes and goals with the assessment processes and goals with the intent to better equip student for a future of lifelong learning. In this presentation I will explain the fundamentals of assessment for learning and programmatic assessment.
KEYNOTE

Health for More, Health Disparity and Health Education Training: An on-going Tension?

Author(s) and Affiliations: Fortunato L Cristobal, (“Khryss”) M.D., Professor of Pediatric Gastroenterology. Currently Dean of the School of Medicine of the Ateneo de Zamboanga University (ADZU-SOM), Chairman of ADZU’s Board of Trustees.

Fortunato L Cristobal MD is the founding Dean of the Ateneo de Zamboanga University School of Medicine (ADZU-SOM) in Zamboanga City Mindanao Philippines. He is Professor for the Masters in Public Health Program and Masters in Health Professions Education Program at ADZU-SOM.

He trained in medicine at the University of the Philippines, Manila (1973-1977), and underwent paediatric residency training at the University of the Philippines-PHP General Hospital. He took his post graduate training in gastroenterology at Westminster Children’s Hospital London in 1985; Community Paediatrics at King’s College London in 1993 and also took advanced studies in Medical Education under the mentorship of Dr. Charles Engel. He finished both his Masters in Medical Education and Masters in Public Health degree at the Ateneo de Zamboanga University in 1998 and 2001 respectively.

Dean Cristobal developed in 1993 a new medical school in the region with a radical vision and innovative teaching and learning processes. These innovations are now being shared with other countries especially in Southeast Asia at the National University of Laos and Patan Academy of Health Sciences in Kathmandu.

Learning Objectives:
1. To present a viable medical education curriculum reform model that incorporates a Health Development Community Engaged Medical Education program with a Social Accountability mandate.
2. To discuss the Biological and Social Models of health care and training and their implicit implications for current tension for medical education/training reforms.
3. To present the impact of a 20 year old innovative medical education reform experience in the context of a developing country.

Abstract:
Health is a social enterprise with a social construct. Unfortunately, not too many in medicine believe and accept this valuation. In the Philippines, health is mostly available to only a privileged few. Health inequality has become a glaring reality, making it an “accepted norm in life” across social groupings. In this paper, we posit and critically challenge the way how our health workers, particularly the doctors, are trained. Controlled and determined by the medical curriculum adapted from Western perspectives predominantly individual health care focused, hospital based, specialists and technology dependent, our graduates upon graduation are easily recruited for western placement while, those who remain to serve locally, are with inappropriate competencies, where mostly the underlying causes of ill health and disparity are socially and environmentally determined and controlled. This predetermined helplessness of doctors, (“the settled way things are”), has become the complacent surface norm. However, it need not necessarily be. We report here, how a small medical school in southern Philippines, strove to go against the power structures to train appropriate future doctors who have reversed the health trend indicators for the region.
Developing professional competence through the integration of experiences in practice and educational settings

Author(s) and Affiliations: Stephen Billett, Griffith University, Australia

Dr Stephen Billett is Professor of Adult and Vocational Education in the School of Education and Professional Studies at Griffith University, Brisbane, Australia and also an Australian Research Council Future Fellow. Stephen has worked as a vocational educator, educational administrator, teacher educator, professional development practitioner and policy developer within the Australian vocational education system and as a teacher and researcher at Griffith University. Since 1992, he has researched learning through and for work and has published widely in the fields of vocational learning, workplace learning and conceptual accounts of learning for vocational purposes. He was a Fulbright Professional Scholar in 1999. His sole authored books include Learning through work: Strategies for effective practice (Allen and Unwin 2001); Work, change and workers (Springer 2006) Vocational Education (Springer 2011) and edited books Work, Subjectivity and Learning (Springer, 2006) Emerging Perspectives of Work and Learning (Sense 2008), Learning through practice (Springer 2010), Promoting professional learning (Springer 2011) and Experiences of school transitions: Policies, practice and participants (Springer 2012). He is currently preparing a manuscript entitled the Integration of Practice-based Learning in Higher Education Programs. He is the founding and Editor in Chief of Vocations and learning: Studies in vocational and professional education (Springer) and lead editor of the book series Professional and practice-based learning (Springer) and lead editor for the forthcoming International Handbook of Research in Professional and Practice-based Learning with colleagues from Germany. He was awarded a 2009-2010 Australian Learning and Teaching Council (ALTC) National Teaching Fellowship that identified principles and practices to effectively integrate learning experiences in practice and academic settings. In June 2011, he commenced a four-year Australian Research Council Future Fellowship on learning through practice, which aims to develop a curriculum and pedagogy of practice. In August 2013 he was awarded an honorary doctorate by Jyvaskyla University (Finland) for his contributions to educational science.

Learning Objectives:
1. Develop further their understanding about learning experiences and how these might be integrated to secure particular learning outcomes.
2. Understand, be able to organise and enact the curriculum to support students’ learning in clinical settings, and select appropriate pedagogic strategies to assist students’ learning prior to, during and after clinical experiences.
3. Understand and appraise processes focused on promoting students as agentic learners.

Abstract:
This presentation identifies ways in which the provision of experiences in both practice and educational settings, and their integration, can be enacted to initially develop and extend professional competence across working life. What is proposed is that both of these settings provides afford experiences that assist the development of occupational competence, but issues associated with the ordering of these experience, their integration and support both within the practice and educational setting can be addressed to maximise the learning potential of these experiences. In addition, a key consideration is the active approach taken by those who are learning. Learning in both of these settings is held to be a process founded on interdependence between those who are learning and what is afforded by each of these settings. Hence, learners’ actions will be essential in shaping the outcomes as the provision of experiences in both settings. Although much consideration has been given to the provision of practice-based experiences for the initial occupational preparation, here it is proposed that such arrangements are also helpful in supporting ongoing professional development across working life albeit in securing new specialisations or maintaining sustainable practice. The presentation will progress as follows. Firstly, some key premises and conceptions for understanding utilisation of practice-based experiences and their integration will be elaborated. Then, consideration is given to the kinds of goals for learning to which the provision and integration of these experiences might be directed. These include initial development of skills, the formation of identity as a medical practitioner, identifying and securing the capacities required for specialisation and ongoing development associated with currency of practice. Thirdly, and outlining of what constitutes the integration of experiences and the legacies of such integrations are briefly elaborated. Then, some suggestions are made pertaining to what kind of curriculum considerations, pedagogies practices and positioning of and engagement by learners are likely to be helpful for securing productive learning for and across professional working lives.
Lambert Schuwirth graduated from Maastricht Medical School as an MD. He became involved in medical education and medical education research since 1990. His main interest is in assessment of medical competence and performance, both in undergraduate and postgraduate training settings. He has worked at Maastricht University for almost 20 years as assistant, associate and full professor in the department of educational development and research, before coming to Flinders in August 2011.

Lambert is currently Professor of Medical Education at the Flinders University School of Medicine’s Health Professional Education Unit. The unit’s main activities are in the domains of curriculum development, assessment, admissions/selection, program evaluation and faculty development.

Abstract:
Assessment never runs as planned, and often solutions for unexpected, ad hoc problems need to be found quickly, because generally the stakes are high. Rarely do we have the luxury of exploring the whole relevant literature or if we do, we find it difficult to translate the described solutions into our own education practice. In this master class we want to explore your own concrete experiences with such assessment problems and your local solutions. The purpose is to consider the relevant literature, alternative solutions or alternative way to translate solution to your context. For this we ask you to prepare a short description of such a problem, your chosen solution and its rationale and share this with the other group members to allow for discussion. We do not expect fancy presentations but rather that you think about this and are able to tell it to the rest of the group in a short time.
**MASTER CLASS II**

**Using realist methods to explore the relationships between medical schools and communities**

**Author(s) and Affiliations: Rachel Ellaway, Northern Ontario School of Medicine**

Dr. Rachel Ellaway is the Assistant Dean for Curriculum and Planning and an Associate Professor at the Northern Ontario School of Medicine in Sudbury, Ontario. Following her PhD in Medical Education from the University of Edinburgh her academic work concentrated on online learning, simulation and the use of new technologies for teaching and assessment in and around health professional education. More recently she has been exploring the many connections between medical education activities and medical education systems. Dr. Ellaway was the instigator and continues to act as the Maîtresse des Ceremonies for the AMEE Fringe and she is the author of the eMedical Teacher column in the journal Medical Teacher.

**Learning Objectives:**
1. Describe the principles and practices of realist inquiry.
2. Situate realism within the context of other modes of inquiry.
3. Apply principles of realist inquiry to their own practices.

**Abstract:**
Developed by Ray Pawson and colleagues, realist methods provide an eclectic and pragmatic way of explaining how complex socially created situations work by investigating the contexts, mechanisms and outcomes within a social phenomenon. Community-engaged medical education is both socially constructed and complex and as such it is a particularly good fit with realist methods for research, evaluation and program development. Drawing on her keynote address, Dr. Ellaway will lead a master class on realist methods of inquiry and their use in medical educational scholarship.
MASTER CLASS III

Curriculum and pedagogic practices for work-integrated learning

Author(s) and Affiliations: Stephen Billett, Griffith University, Australia

Dr Stephen Billett is Professor of Adult and Vocational Education in the School of Education and Professional Studies at Griffith University, Brisbane, Australia and also an Australian Research Council Future Fellow. Stephen has worked as a vocational educator, educational administrator, teacher educator, professional development practitioner and policy developer within the Australian vocational education system and as a teacher and researcher at Griffith University. Since 1992, he has researched learning through and for work and has published widely in the fields of vocational learning, workplace learning and conceptual accounts of learning for vocational purposes. He was a Fulbright Professional Scholar in 1999. His sole authored books include Learning through work: Strategies for effective practice (Allen and Unwin 2001); Work, change and workers (Springer 2006) Vocational Education (Springer 2011) and edited books Work, Subjectivity and Learning (Springer, 2006) Emerging Perspectives of Work and Learning (Sense 2008), Learning through practice (Springer 2010), Promoting professional learning (Springer 2011) and Experiences of school transitions; Policies, practice and participants (Springer 2012). He is currently preparing a manuscript entitled the Integration of Practice-based Learning in Higher Education Programs. He is the founding and Editor in Chief of Vocations and learning: Studies in vocational and professional education (Springer) and lead editor of the book series Professional and practice-based learning (Springer) and lead editor for the forthcoming International Handbook of Research in Professional and Practice-based Learning with colleagues from Germany. He was awarded a 2009-2010 Australian Learning and Teaching Council (ALTC) National Teaching Fellowship that identified principles and practices to effectively integrate learning experiences in practice and academic settings. In June 2011, he commenced a four-year Australian Research Council Future Fellowship on learning through practice, which aims to develop a curriculum and pedagogy of practice. In August 2013 he was awarded an honorary doctorate by Jyvaskyla University (Finland) for his contributions to educational science.

Learning Objectives:
1. Develop further their understanding of and procedures for enacting and integrating experiences for promoting particular learning outcomes.
2. Be able to organise and enact the curriculum to support students’ learning in clinical settings, and select appropriate pedagogic strategies to assist students’ learning prior to, during and after clinical experiences.
3. Enact processes focused on promoting students as agentic learners.

Abstract:
This master class comprises a structured activity focusing on what curriculum and pedagogic practices can best secure effective work-integrated learning for healthcare students. It draws directly from the findings of a recently finalised ALTC National Teaching Fellowship - Curriculum and pedagogic bases for effectively integrating practice-based experiences within higher education that comprised 20 work integrated learning projects across a diverse range of teaching areas in 6 Australian universities. From these projects, a series of findings pertaining to curriculum (i.e. intended, enacted and experienced) and pedagogic practices that can be used before, during and after students’ practice experiences have been identified that are intended as practical advice to assist the teaching practice of busy academic staff members. The key concern for this master class is to identify the ways in which these practices are helpful in informing how the experiences for the participants’ students might be enhanced by these findings and discussions.
Full Abstracts for the Parallel and Poster Sessions
1 Factors related to medical students’ engagement in LIC’s: A longitudinal study

Author(s) and Affiliations: Doug Myhre, MD | Tyrone Donnon, PhD | Paul Adamiak, MSc | Wayne Woloschuk, PhD

Doug Myhre continues to practiced family medicine after 30 years but is also the Associate Dean Distributed Learning and Rural Initiatives at the University of Calgary. He has successfully designed and implemented rural based medical education programs, undergrad and postgrad since 2000, most recently leading a three fold expansion of rural rotations in specialty postgrad programs. He is passionate about learning and even more so about supporting the well-being of learners.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. The audience will recognize of the change of learners’ perception about LIC’s over time in one medical school.
2. The audience will understand the changing impact of learner demographics and career interest of the learner in considering the LIC.
3. The audience will understand what factors remain to be a student obstacle to committing early to an LIC.

Background:
The University of Calgary (UC) LIC program (UCLIC) consists of a 52 week integrated curriculum with 32 weeks at a rural teaching site. As the LIC experience appears to be increasingly sought by learners, the reasons for this interest, and how it may have changed over time, is of importance to administrators and funders.

Aims:
To investigate the perceptions of first year medical students about a rural-based LIC over time.

Methods:
UC first year medical students were surveyed regarding their background demographics, interest in and attitudes towards pursuing UCLIC. The investigation was conducted longitudinally with the same 35 item instrument applied to students from the Classes of 2009, 2010, and 2015.

Results:
Response rate was 68%. Overall, 134 students (42%) indicated they would consider the UCLIC, 42 (13%) reported that they would not, and 142 (45%) stated they were undecided. The proportion of those not considering UCLIC decreased significantly between 2009 (25%) and 2010 (8%) and thereafter remained consistent. Tables provide detailed breakdown of analyses for demographics and aggregated scores for each item and factor for each of the three class cohorts.

Discussion:
Results suggest that there has been an overall increase in the willingness of students to consider LICs. Career plans and demographics appear to have a substantial influence on student perceptions about specific items.

Conclusions:
UC students report an ongoing positive attitude towards the LIC with specialty-focused students increasingly interested. These results suggest that there has been an overall increase in the willingness of students to consider LICs.
2 Preliminary validation of a problem gambling assessment tool for Aboriginal people...implications for GP and allied health practice

Author(s) and Affiliations: Peter Harvey, To be presented by Sue Bertossa (Flinders University)

From 1996 to 2000 I led the rural component of the South Australian Council of Australian Governments (COAG) national coordinated care trial. My PhD, completed in the School of Medicine, faculty of public Health at University of Western Australia, was based on this COAG Trial and explored the health benefits and systems change processes of South Australia's rural sector trial.

From 2001 to 2004 I led the Sharing Health Care SA chronic disease self-management demonstration project in rural South Australia and from 2003 to 2008 I was a chief investigator with the Centre of Clinical Research Excellence (CCRE) in Aboriginal and Torres Strait Islander health in South Australia; a National Health and Medical Research Council (NH&MRC) funded collaborative project between the Aboriginal Health Council of South Australia (AHCSA) and Flinders University.

Currently I am Director of the Flinders Centre for Gambling Research in South Australia

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. DSM5 and the diagnosis of problematic gambling.
2. The process of adapting an existing assessment tool to suit Aboriginal people.
3. The implications of problem gambling diagnoses for GP and allied health professionals.

Mode:
Group to experience the AIPGI first hand, score and feedback following presentation of data.

This preliminary study looked at adapting the Canadian Problem Gambling Index (CPGI) to suit Aboriginal people and to create a more effective and culturally inclusive assessment process that would more accurately reflect problems in Aboriginal communities and facilitate effective treatment (3). We present information on the context and process of a project to re-design the 9 item Problem Gambling Severity Index component of the CPGI to suit the needs of Aboriginal people in South Australian communities. Early results with a small cohort (n=301) show the new Australian Indigenous Problem Gambling Index (AIPGI) to be an acceptable and effective tool for assessing problem gambling in Aboriginal communities (Cronbach's Alpha – 0.89).

We are improving the effectiveness of our assessment techniques in relation to the diagnosis and treatment of problematic gambling, but still only a very small proportion of those affected adversely by gambling actually have access to appropriate treatment. By involving GPs and allied health professionals in the screening and assessment processes and informing them about low level interventions, referral pathways and higher level treatment options, we anticipate that more people who need support for their gambling problems will be able to gain access to such help in the process of overcoming their gambling problems and improving their health and wellbeing.

Harvey PW. The provision of integrated care for people with gambling disorders and co-occurring mental health conditions. ANZJPH. 2013;on line(October).

12
Interviewing third-year medical students in situ: Employing guided walks during a longitudinal integrated clerkship in rural and northern communities

Author(s) and Affiliations: Tim Dubé, PhD, Northern Ontario School of Medicine

My research interest relates to the sociology of medical education, particularly the social worlds created by medical students from their vantage points. For my doctoral research, I explored the lived experiences of third-year students undertaking the longitudinal integrated clerkship at the Northern Ontario School of Medicine (NOSM). As a Senior Instructional Designer at NOSM, I have extensive knowledge of the distributed community-engaged learning model. I also have a background in sport psychology with an interest in the contextual challenges and sources of social support in elite hockey.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Describe the “mobilities paradigm”.
2. Demonstrate the use of a mobile research method, the guided walk, to elicit situated understandings from medical students undertaking a longitudinal integrated clerkship in Northern Ontario.
3. Propose recommendations regarding the suitability of mobile methods for research in distributed medical education.

Background:
The Northern Ontario School of Medicine's (NOSM) clinical clerkship year, the Comprehensive Community Clerkship (CCC), consists of a mandatory eight-months of residence and learning in rural and northern communities throughout Northern Ontario, Canada, and studying clinical medicine in the context of rural family practice.

Aims:
The purpose of this presentation is to explain why employing a mobile research method, the guided walk, elicited situated understandings from medical students undertaking a longitudinal integrated clerkship in a way which could not have been attained by other qualitative or quantitative approaches.

Methods:
Informed by a social constructivist research paradigm, 12 participants were recruited from the NOSM's 2011-2012 CCC cohort to answer the research question: how do third-year medical students at the NOSM describe their clerkship experience as encountered in their placement and living context?

Results:
Participants provided their views of the methodological approach, related to ease of participation, contextual relevance, and serendipitous encounters. The participants also found that the methods used evoked a richness in their experiences they felt would be otherwise difficult to convey.

Conclusions:
The guided walk method is promising for medical education, particularly for researchers seeking to gain the participants' stories in context. Recommendations will be proposed regarding the suitability of this authentic method in medical education research.

School based service learning for medical students: Design, implementation and reflections

Author(s) and Affiliations: Suzanne McKenzie, James Cook University, School of Medicine and Dentistry, Townsville | Sophia Couzos, James Cook University, School of Medicine and Dentistry, Townsville | Karen Loto, The Smith Family, Communities for Children – Townsville West, Townsville | Christie Schmid, Vincent State School, Townsville | Nicole Mohajer, Townsville Health Professionals, General Practice, Townsville

Dr Suzanne McKenzie is an Associate Professor and Head of the Discipline of General Practice and Rural Medicine at James Cook University’s School of Medicine and Dentistry, Townsville Queensland; and a conjoint Associate Professor with the School of Public Health and Community Medicine at the University of New South Wales. She has experience in all aspects of undergraduate medical education including curriculum development, implementation, delivery, assessment and evaluation; and extensive teaching and curriculum development experience in vocational training for general practice including provision of regular train the trainer activities for community based medical teachers.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. To describe a method of community engagement through service learning in medical school.
2. To discuss the evaluation outcomes of service learning in a primary school.
3. To discuss the key aspects of developing and maintaining community partnerships.

Background:
Service learning is increasingly being recognized as an important part of medical curricula and contributes to the community engagement of medical schools. As part of their general practice rotation, medical students from James Cook University, Australia provide health assessments for children and families within a primary school which services disadvantaged families, and assist with referrals to community and health services.

Aim:
To describe key factors in the planning, design and implementation of this program and evaluate outcomes from the perspective of students and staff.

Methods:
Descriptive case study

Results:
This grass roots program was developed in response to an identified need. A strong and dynamic partnership has been developed between a university, primary school, non-government organization and local general practitioner. Families are now engaging with the health service and children with previously unaddressed medical problems are being attended to. All members of the partnership contribute time, equipment and other resources without external funding. Medical students improve their understanding of program design that facilitates community engagement.

Conclusion:
A service learning model can be used in a primary school setting to benefit communities and provide valuable learning opportunities for medical students. The key elements of success are the strong commitment from the services and people involved and the ongoing engagement by families. The program contributes to the health promoting environment in the school and the model could be used in other primary schools.
The public and private good benefits in addressing the chronic disease pandemic among Indigenous peoples

Author(s) and Affiliations: David Campbell, Centre for Remote Health, Flinders University

David Campbell is a Flinders University PhD candidate, Centre for Remote Health, Alice Springs. His PhD research relates to the health policy issues surrounding the behaviour of Aboriginal and Torres Strait Islander people in their choosing between good and bad health choices.

From 2007 to 2011, he was the Senior Economist, Centre for Remote Health, Alice Springs; coordinating the post-graduate course in Health Economics, and undertaking economic research on the health and economic benefits of Aboriginal engagement in traditional land management. Prior to 2007 he was with the Flinders University Centre for Applied Social and Survey Research, Northern Territory Fisheries, the Australian Bureau of Agricultural and Resource Economics and, following his first retirement, running his own consultancy, in which he contracted to Aboriginal organisations, state and commonwealth government departments and overseas. He has lectured at the Australian National University Crawford School of Economics and Government, and the Australian Maritime College.

Abstract Stream(s): Aboriginal health

Learning Objectives:
1. That the selection of bad health choices can be rational, especially in highly stressful circumstances.
2. There is evidence that cultural engagement through traditional caring for country, and living in small family groups on country, provide environmental engagement and personal mastery and control.
3. That such actions complement medical responses to chronic disease.

Abstract:
Current health policies for Australia’s Indigenous peoples are based on a medical response to addressing chronic disease and proximate variables encapsulated in the term ‘bad health choices’. It is shown that the selection of bad health choices can be rational, especially in highly stressful circumstances. It is in this context that the importance of distal psychosocial life stressors including cultural disenfranchisement, and the loss of personal control or mastery and the importance of empowerment, exist. There is evidence that cultural engagement through traditional caring for country, and living in small family groups on country, provide environmental engagement and personal mastery and control. Such outcomes result in an expansion of health outcomes within a given budget and a range of private good and public good benefits for Australia’s Aboriginal and Torres Strait Islander peoples and Australia as a whole. These include the maintenance of environmental heterogeneity and biosequestration, and the mitigation of disease bearing dust storms. It has been argued that such actions complement medical responses to chronic disease. These observations are of particular relevance for Indigenous peoples in general and world-wide mitigation of the chronic disease pandemic.

The quantitative results are based on existing data and mathematical modeling, while the argument is developed and demonstrated using a multidisciplinary approach within an economic framework.

9 extending the explanatory power of subjective wellbeing in relation to health through the integration of the psychosocial determinants

Author(s) and Affiliations: David Campbell, Centre for Remote Health, Flinders University

David Campbell is a Flinders University PhD candidate, Centre for Remote Health, Alice Springs. His PhD research relates to the health policy issues surrounding the behaviour of Aboriginal and Torres Strait Islander people in their choosing between good and bad health choices.

From 2007 to 2011, he was the Senior Economist, Centre for Remote Health, Alice Springs; coordinating the post-graduate course in Health Economics, and undertaking economic research on the health and economic benefits of Aboriginal engagement in traditional land management. Prior to 2007 he was with the Flinders University Centre for Applied Social and Survey Research, Northern Territory Fisheries, the Australian Bureau of Agricultural and Resource Economics and, following his first retirement, running his own consultancy, in which he contracted to Aboriginal organisations, state and commonwealth government departments and overseas. He has lectured at the Australian National University Crawford School of Economics and Government, and the Australian Maritime College.

Abstract Stream(s): Social accountability

Learning Objectives:
1. Subjective wellbeing (SWB) is shown to be a reasonable indicator of future health outcomes and life longevity, it is only partly integrated with those explanatory variables affecting health related quality of life.
2. The integration of the psychosocial determinants (PSD) of health literature with the SWB literature is proposed as going some way to meeting this shortfall.
3. That is, the cognitive response to stress results in a cognitive/psychological link between the PSD stressors and SWB status.

Abstract

While subjective wellbeing (SWB) is shown to be a reasonable indicator of future health outcomes and life longevity, it is only partly integrated with those explanatory variables affecting health related quality of life. This limits the use of SWB in the development of health policy. It is important, therefore, to identify those causative agents having a joint influence on health outcomes and variation in SWB status. The integration of the psychosocial determinants (PSD) of health literature with the SWB literature is proposed as going some way to meeting this shortfall. Stress plays an important role in such integration. This is because the PSD of health make-up a range of stressors triggering adaptive responses directed to maintaining homeostasis. Excessive stress and inappropriate adaptive responses can disrupt homeostasis – thereby increasing chronic disease risk. At the same time stress levels are an important factor affecting the cognitive assessment of SWB status. That is, the cognitive response to stress results in a cognitive/psychological link between the PSD stressors and SWB status.

Development of the paper content is primarily directed at the general SWB/PSD literature. Consideration is also provided in relation to how this might relate to the assessment and monitoring of Aboriginal and Torres Strait Islander people.

10 Pre-med summer institute – promoting & preparing Aboriginal students to apply to medical school in Canada

Author(s) and Affiliations: Michael Jong, Memorial University

Michael Jong is rural family physician in remote community of Happy Valley-Goose Bay in Labrador, Canada. He is a professor of family medicine at Memorial University of Newfoundland and Vice President of Medical Services for Labrador Grenfell Health. His interests are in rural and aboriginal health, health education and research. He developed the Northern Family Medicine (NorFam) program to train medical students and residents for rural and remote practice. He is a member of the working group to introduce aboriginal health into the medical school curriculum in Canada.

Abstract Stream(s): Social Accountability, Aboriginal Health

Learning Objectives:
1. Learn about the design of a pre-med institute for aboriginal students.
2. Learn about which components were of greatest interest to students.
3. Learn about the outcomes.

Background:
A pre-med summer institute was developed by Memorial University under the direction of the Aboriginal health advisory committee. It is as one of the strategies to increase the number of Indigenous physicians in Canada.

Aims:
The objectives of the summer institute are to:
• Allow students to discover life as a medical student, resident and as a physician
• Provide encouragement to become a physician
• Provide mentorship with physician/medical resident/medical student
• Facilitate reflection on health, health care, indigenous health and the needs in rural communities
• Learn how to improve their chances for acceptance into a medical school

Methods:
The program includes:
• Orientation with medical staff/trainees and the health facilities
• First Aid
• History taking, charting and patient confidentiality
• Ethics in medicine
• A personal journey in application to medical school
• Shadowing of medical students/residents/medical staff
• Participation in aeromedical evacuation
• Visitation to remote clinics with medical trainees/staff
• Discovering traditional medicine
• Implementing and administering a health lifestyle program
• Mental fitness
• Medical and socio-cultural models of healthcare
• Reflection exercise - the role of industry and government in population health
• Land-based program in the ‘country’
• Workshop on how to apply for admission to medical school
• Cross-cultural training
• Unpacking determinants of health

Results:
Nine of the ten students decided to choose medicine as a career. Two completed MPH and Masters in Nutrition. Three are in medical school. Five are completing their undergrad education.

Conclusion:
The five Aboriginal organizations considered the program as a success and are funding the institute.

11 The struggling rural LIC learner: remediation challenges

Author(s) and Affiliations: Kathleen D. Brooks MD, MBA, MPA Director Rural Physician Associate Program (RPAP) University of Minnesota Medical School

Dr. Kathleen Brooks serves as the Director of the Rural Physician Associate Program at the University of Minnesota Medical School and Assistant Professor in Department of Family Medicine and Community Health. Her work focuses on medical education and physician workforce issues. She chairs her school's education steering committee charged with oversight review of the curriculum and consults nationally on longitudinal integrated clerkship development. She received her undergraduate and medical degrees and completed her family medicine residency at the University of Minnesota. After a number of years in private practice, she transitioned into administrative medicine, health policy and teaching. She completed a MBA at the University of St. Thomas, St. Paul, MN and a MPA degree at Harvard University Kennedy School of Government. She has done administrative consulting for health systems, health policy work for Minnesota state programs and served as the Minnesota Carrier Medical Director for the federal Medicare program.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Analyze the complexity of relationships involved when engaging in remediation of a student in a rural LIC program.
2. Identify the challenges for a community preceptor serving as role model, mentor and providing student assessment.
3. Debate the pros and cons of selecting students into rural LIC programs whose background suggests likely future rural practice but who have some academic challenges.

Abstract:
Rural longitudinal integrated clerkship programs are designed to nurture medical student interest in future rural and primary care practice, and thus serve as pipeline programs for future workforce. Students with profiles suggesting likely future rural practice are recruited to such programs. Rural LICs typically require student learning styles including comfort with ambiguity and expectations for self-direction. Rural community preceptors serve as mentors, role models, teachers and student evaluators. Typically the collaborative implicit agreement between medical schools and rural community practices does not include responsibility for remediating student academic performance and professionalism issues.

Our 43-year-old rural distributed model LIC places between 35 and 40 students per year in sites across Minnesota. We encounter challenges when a student struggles during the program. Typical student evaluation forms often provide insufficient opportunities for community preceptors to identify concerns. Role conflict can occur when preceptors are asked to serve as mentors and as gatekeepers to the profession in providing negative assessments. Resources to address newly unmasked learning disorders, mental health issues, and family crises are often more limited for students in rural sites. Engaging the academic institution involves multiple parties: clerkship directors, faculty advisors, dean of students, and scholastic standing committees.

Discussion questions:
a. What is the role of community preceptors in assessment and remediation?
b. How to manage working with all involved parties to decide whether a student stays in the community or returns to campus?
c. How should such potential remediation challenges help inform selection criteria for rural LICs?

Community health assessment project curriculum in rural LIC; A program evaluation

Author(s) and Affiliations: Kathleen D. Brooks, MD, MBA, MPA Director of Rural Physician Associate Program Assistant Professor Department of Family Medicine and Community Health University of Minnesota Medical School | Nancy Baker, MD Faculty Rural Physician Associate Program Assistant Professor Department of Family Medicine and Community Health University of Minnesota Medical School

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. Define the components of a successful community health assessment (CHA) curriculum within a distributed model longitudinal integrated clerkship.
2. Recognize the distinct and differing roles of faculty, community preceptors and stakeholders, as well as 3rd year medical students in CHA project development and implementation.
3. Appreciate the challenges created by engaging multiple parties with differing end objectives in such work.

Background:
Longitudinal integrated clerkship (LIC) curricula offer the opportunity for students as members of the healthcare team to provide quality medical care to patients in the context of their community. For over a decade the Rural Physician Associate Program at the University of MN has required its annual cohort of 35 to 40 third year medical students to complete a community health assessment (CHA) project during their 9 month LIC. The longitudinal CHA projects promote scholarship and authentic community engagement and collaboration.

Aims:
This session will present this curriculum, and discuss its placement in our LIC. We will share our program evaluation including its impact on student engagement in the community. We will discuss conundrums we identified in this community engagement curriculum.

Methods:
The CHA curriculum will be reviewed, and our last 2 years of summary data on projects, our assessment tool, and a student survey on community impact will be presented. The program evaluation will be presented, including impact on student engagement in the community and student sense of contribution to the healthcare team.

Results:
The CHA curriculum enhances student engagement with the community in authentic roles, allows for leadership development, and broadens learner focus on improving health of individuals and communities. Managing expectations of the community, the students and the faculty regarding scope, stakeholder engagement, research possibilities and value to the community are conundrums to be discussed in this session.

Conclusions:
CHA curricula in LICs allow another avenue for authentic workplace learning through broadened student community engagement.
“Have I jumped the gun?” – Assisting students’ transition towards clinical reasoning competency in a longitudinal integrated clerkship

Author(s) and Affiliations: Professor Daryl Pedler - Director of Rural General Practice; Director of Clinical Studies, IMMERSe (Deakin University) | Ms Nancy Tran - Research Assistant, Department of Rural General Practice (Deakin University)

Graduating in Adelaide in 1972, Professor Pedler has spent all but ten years of his medical career in rural practice. Initially working in a rurally-based procedural general practice, he returned to Adelaide as Medical Educator and then State Director of general practice training for South Australia and the Northern Territory. In 1987, he moved to the regional city of Warrnambool, Victoria, as Emergency Department Director.

In 2003 he became Director of Monash University’s Gippsland Regional Clinical School, returning to Warrnambool in 2012 as Professor of Rural General Practice for Deakin University and to lead the development of a new general practice in Warrnambool. In late 2013 he also became Director Clinical Studies of Deakin University’s longitudinal integrated clerkship program, IMMERSe.

Daryl’s research interests focus on those population health and health professional education issues of particular relevance to general practice.

Abstract Stream(s): Longitudinal Learning
Comparative clinical ethics education: LIC v TBR

Author(s) and Affiliations: Katharine R Meacham, PhD: Mars Hill University, University of North Carolina School of Medicine-Asheville, University of North Carolina Department of Social Medicine | Shelley L Galvin, MD: Mountain Area Health Education Center (MAHEC), Asheville, NC | Deborah J Love, JD, MBA, MA: UNC Center for Bioethics, Novant Health Systems | Robyn A Latessa, MD: UNC School of Medicine-Asheville and Chapel Hill; MAHEC | Arlene M Davis, RN, JD: UNC Center for Bioethics, UNC School of Medicine Department of Social Medicine, Memorial Hospital, Chapel Hill, NC

Katharine R. Meacham, Ph.D., is professor at Mars Hill University, where she has taught philosophy and religion for almost twenty five years. She is also an adjunct professor in the Department of Social Medicine at the UNC School of Medicine, through which she has developed and teaches an integrated ethics curriculum to third year medical students who come to Asheville for their clinical training. She serves on the Mission Hospitals Ethics Committee and has spoken widely on ethics, philosophy, religion, interfaith dialogue, and feminist thought.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To explore whether ethical knowledge and skills learned in MS1 and MS2 transfer to MS3.
2. To compare LIC students with integrated ethics curriculum with TBR students who shared MS1 and MS2 ethics and social medicine curriculum, with regard to ability to identify ethical issues and to imagine morally reasonable alternative responses.
3. To compare LIC and TBR students who shared MS1 and MS2 curriculum with regard to moral distress experienced during clerkships.

Background:
Does ethical knowledge from the first two years of medical school transfer to the third year? Research shows need for guided, interdisciplinary ethical reflection in clerkships. UNC School of Medicine-Asheville's longitudinal integrated clerkship (LIC) has integrated ethics curriculum. UNC SOM-Chapel Hill's traditional rotation-based clerkship teaches ethics in some rotations.

Aims:
To compare the frequency of identification of ethical issues and corresponding moral distress measures between longitudinal clerkship students and traditional, rotation-based clerkship students who share a common social medicine curriculum in their first two years.

Methods:
- Study design: cohort study (June 2013)
- Participants: University of North Carolina School of Medicine at Asheville, n = 10 (100%) and the University of North Carolina School of Medicine at Chapel Hill, n = 10 (30.3%)
- Data Sources: Self-ratings of abilities post-then-pre (not well- very well: 0-5)
  - To identify ethical issues
  - To imagine alternative responses
  - Wiggleton Moral Distress Inventory (2010)
  - 52 ethical dilemmas (5 categories)
  - Frequency: never - very frequently (0-4)
  - Not well at all - very well (0-3)
- Statistics: Descriptive statistics & Mann-Whitney analyses (p < 0.05; SPSS V.21)

Results:
In retrospect, longitudinal clerkship students saw their initial abilities to identify ethical issues and to imagine morally reasonable alternative responses as much less developed initially but more developed at the end of the clerkship than their counterparts in the traditional, rotation-based clerkship. Longitudinal clerkship students saw more ethical dilemmas and experienced more moral distress than the cohort in the traditional rotation-based program.

Conclusions:
Clerkship students in the traditional rotation-based program were less aware of ethical issues and experienced less moral distress than longitudinal integrated clerkship (LIC) students. Longitudinal integrated clerkship students were possibly more aware of ethical issues because of the ethics curriculum but further study would be needed to assess that. Both LIC design and ethics curriculum could influence LIC students' ethical awareness.

Wiggleton, C.M. (2010). Medical Students' Experience of Moral Distress. Academic Medicine, 85 (1), 44-49. The UNC SOM study described on this poster uses Dr. Wiggleton's study published in Academic Medicine with permission.
Comparison of models of curriculum delivery for the Monash MBBS Yr4C curriculum

Author(s) and Affiliations: Loy Perryman - Monash University Academic Coordinator/lecturer - PhD student | Assistant Professor David Campbell | Dr Eleanor Mitchell

My name is Loy Perryman and I am a Lecturer/Clinical Educator at the School of Rural Health- East Gippsland, Sale. In 2010, I was the lead in the establishment of the Year 4C MBBS Gippsland Rural Integrated Community Curriculum (GRICC) program in Sale. I am responsible for the coordination and implementation of the Year 4C MBBS and maintain a clinical teaching role within the program. Prior to joining Monash in 2010 in my current role, I spent many years as a clinical educator with the MBBS program. I have a Bachelor in Nursing, Masters in Nursing (Education) and commenced a PhD in Medical Education in 2013 looking at the "Comparison of models of Curriculum delivery for the Monash MBBS Year 4C curriculum". I currently serve on many MBBS committees within the University and work part-time as an Associate Nurse Unit Manager in a Rural Emergency Department.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Evaluate the three different models of curriculum delivery within the year 4C MBBS program at Monash University.
2. To examine the differing students' perspective and experience.
3. Explore the readiness to becoming a doctor and strength and weaknesses between the traditional delivery of the MBBS curriculum and Longitudinal Integrated Curriculums (LIC).

Background:
Literature suggests a need to transform the traditional delivery of the MBBS curriculum. It is widely argued within the literature that student experience of longitudinal relationships with patients, clinicians and environments provide “substantial opportunities to sequence and advance learners competence” (Teherani et al, 2013).

Aims:
The aim of this research is to evaluate the three different models of curriculum delivery (Longitudinal Integrated Curriculum, the Hybrid and Block) within the year 4C MBBS Monash University program, to examine the differing students’ perspective and experience, their readiness to become doctors and to explore the strengths and weaknesses between the traditional delivery of the MBBS curriculum and the emerging Longitudinal Integrated Curriculums Curricula. It is envisaged the results from this research will assist in the future transformation of MBBS curriculums.

Methods:
Students were invited to undertake (3) one hour semi structured interviews over a twelve month period. A questionnaire pertaining to clinical presentations was undertaken at the second interview. Audio- recordings were transcribed and thematically analysed using NVIVO (10). Ethics approval was obtained.

Results:
Students were interviewed on themes related to Interprofessional relationships, Student/Supervisor relationships, professional identity, Teaching methods/Educational environments, Self-directed learning and Community Engagement.

Conclusion:
This research is on-going and further analysis of the data is necessary. It is anticipated that this study will contribute to the expanding body of literature related to the graduate outcomes of a Longitudinal Integrated Curriculum.

Can you Track the Long Term outcomes of your Graduates?

Author(s) and Affiliations: John Steeves and Silvane Paixao, Dalhousie Medicine New Brunswick (DMNB) | Tim Fedak, Peggy Alexiads Brown, Gregory Power, Preston Smith, Evelyn Sutton, and Kathleen MacPherson, Dalhousie University; Raafey Mohammed, University of New Brunswick

Following completion of his Medical Degree (M.D.) at Dalhousie University, Dr. Steeves practiced rural family medicine for five years. He returned to Dalhousie University for his residency training in orthopedic surgery, followed by an orthopedic fellowship at Saint Michael’s Hospital at the University of Toronto. He practiced community Orthopedics in Moncton for 20 years before undertaking a Master Degree in Education in Curriculum Studies with a concentration in Medical Education. He also completed a Certificate in Education Health Professionals for Interprofessional Care at University of Toronto.

In 2012 DMNB opened its first Longitudinal Integrated clerkship offering the entire 48 week clinical clerkship experience at a clinical teaching site. Another site was added in 2014 with a 3rd site awaiting approval for 2015.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Identify a method of tracking MD students’ career choice and practice location.
2. Discuss challenges in identifying and capturing system data to evaluate students’ long term outcomes.
3. Participate in a demonstration of the LOCATED Application.

Abstract:
Distributed Medical Education (DME) programs are presumed to affect the distribution of graduating physicians and practice choice. Do you know:
1. What disciplines your learners have chosen and where they are located?
2. If the educational placement of your learners affected career choice and practice location?
3. What characteristics of your learners affected their career choices?

A tracking system was developed that allows the Dalhousie University Faculty of Medicine (FoM) to answer these questions and more. The FoM has a long history of undergraduate/postgraduate DME programs. In 2010, a regional campus, Dalhousie Medicine New Brunswick Program (DMNB) was established to provide undergraduate medical training for New Brunswick residents. By contract, the program is required to evaluate the human resource impact of its graduates.

Dalhousie University has adopted a framework, based on a program designed by Memorial University, to track learners’ education activities and practice location of MD graduates. The Location of Clinicians and Trainee Education Dalhousie (LOCATED) Project aims to enhance the ability to evaluate and plan medical education at Dalhousie by developing a longitudinal database composed of administrative data and national databases such as Canadian Post-MD Education Registry linked with a mapping system.

Analysis has been conducted of possible relationships of educational experience (e.g., time spent in a rural community), demographic data (e.g., gender, age, place of residence), career choice and practice location for Dalhousie MD Classes of 2006 to 2009. This will be presented with results of the first cohort of MD graduates from the DMNB program.
The international evidence base for LICs: Where is the MISSILE heading?

Author(s) and Affiliations: Paul Worley, Flinders University, Australia Ian Couper, University of Witwatersrand, South Africa | Roger Strasser, Northern Ontario School of Medicine, Canada | David Hirsh, Harvard University, USA

Professor Paul Worley is the Dean of the School of Medicine at Flinders University. A practicing rural doctor, he has a passion for increasing the profile, impact and social accountability of medical schools and their students through creating mutually beneficial partnerships with clinicians, health services, government and community agencies, the wider research community, and professional bodies. He is recognised internationally as a leader in community-based medical education and research.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Understanding of the work to date by the MISSILE collaboration.
2. Understanding of the current and future projects proposed by the MISSILE collaboration.
3. Understanding of the opportunities and processes for schools and individuals to participate in current and future MISSILE research.

Abstract:
The Multi-institutional International Simultaneous Study for Integrated Longitudinal Education (MISSILE) collaborative was first proposed at the Yankton CLIC conference in 2011. At the 2012 Rendezvous in Thunder Bay, it was agreed to undertake an initial typology study, and draft results were presented at the Big Sky meeting in 2013.

The typology study enabled the collaborative to work through many of the logistic issues inherent in conducting international multi-institutional medical education research. With this experience, it is now time to move to more focused studies that explore the outcomes, mechanisms of effect, and transferable theoretical implications of LICs.

This workshop will explore the next steps for the MISSILE collaborative with the intent to produce a consensus on:
1. The work to date by the MISSILE collaboration.
2. The current and future projects proposed by the MISSILE collaboration.
3. The opportunities and processes for schools and individuals to participate in current and future MISSILE research.
Approaches to distributed, socially accountable, and community-engaged medical education research

Author(s) and Affiliations: Rachel Ellaway, Northern Ontario School of Medicine; Jennene Greenhill, Flinders University

Abstract Stream(s): Longitudinal Learning, Community Engagement, Social Accountability

Learning Objectives:
1. Situate their research questions within a range of different research traditions.
2. Develop research projects and programs that draw upon these research traditions.
3. Critique orthodoxies within medical education research that do not serve the needs of distributed, socially accountable, and community-engaged medical education.

Abstract:
Mainstream medical education research reinforces and self-perpetuates positivist and experimental approaches with little consideration of context or culture. Whatever the merits of this dominant tradition, it has limited applicability to distributed, socially accountable, and community-engaged medical education research, not least because so much of what we do is profoundly contextualized and socially constructed. We seek alternative perspectives and methods that can capture the social realities of medical education and challenge the traditions or orthodoxies that underpin inequity.

This workshop will explore the role of different theories and methods for researching socially accountable, community-engaged medical education, including realist research and evaluation, critical theory, activity theory, complexity theory, and social capital theory. By providing a mixture of didactic and hands-on interactive activities we will introduce a range of theoretical and methodological perspectives, work through a series of examples, and develop outline research programs that meet participants’ needs.

Our goal is to build a more courageous and confident research distributed, socially accountable, and community-engaged medical education community.

“Fear of losing power corrupts those who wield it and fear of the scourge of power corrupts those who are subject to it”
Aung San Suo Kyi
Planning and developing a global community-engaged learning experience for undergraduate medical students

Author(s) and Affiliations: Dr. Basia Siedlecki, Northern Ontario School of Medicine, Georgian Bay General Hospital | Dr. Phil McGuire, Northern Ontario School of Medicine, Georgian Bay General Hospital | Dr. Basia Siedlecki, Global Health Coordinator, Chief of Hospitalist Medicine

Dr. J Basia Siedlecki obtained her PhD in Health Research at the University of Calgary school of Medicine, department of Community Health Sciences. Her doctoral thesis focused on using technology for health care delivery in rural and remote northern communities in the Yukon in Canada. She went on to do an MD degree in Calgary and to finish her Family Medicine Residency there.

She currently holds the posts of Global Health Coordinator at Northern Ontario School of Medicine and Chief of Hospitalist Medicine at Georgian Bay General Hospital. She also works as an ER physician part time. She has volunteered internationally and is active in clinical medical education at the undergrad and postgrad level.

She is also an avid runner, cyclist, snow-shoer and skier, as well as an opera and film buff.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. To understand distributed education as a facilitator of community engagement.
2. To identify curricular tools that help teach social accountability.
3. To consider how curricula and pedagogy can be revised to foster professional values.

Background:
NOSM (Northern Ontario School of Medicine) in Canada and Walter Sisulu University in South Africa are linked through THENet, and also through a common commitment to quality, distributed, community-engaged undergraduate medical education. Both struggle with the obstacles of distance, lack of resources in the communities (medical, diagnostic, treatment), and finding curricular models to teach the ideal of social accountability and community engagement.

Methods:
Much work has recently gone into developing exchange programs to facilitate a closer relationship between the two institutions. The focus from NOSM's perspective for our students involves community engagement and cross-cultural interactions: clinical, social and mundane. Service-learning has been identified as a tool to develop community engagement among students and to help foster a community approach to international electives in the course of undergraduate education.

Results:
This presentation will document the planning of a clerkship exchange program and the challenges of “curricularizing” the ideals of community engagement, cultural safety and social accountability. It will examine how these curricular components are operationalized in the curricula of the two schools currently, and discuss plans for future collaborations and exchanges that teach and model the behavior we wish to instill in our students.

Conclusions:
Through careful planning and adaptability, it is possible to teach and model community values in medical students. This presentation is of interest to faculty of undergraduate medical and paramedical programs who struggle with the need to educate idealistic, responsible, competent global citizens who will be leaders in their professions in the future.

http://www.nosm.ca/uploadedFiles/Education/UME/MD_Program/Overview/CurriculumOverview.pdf
http://www.nosm.ca/globalhealth/
How to Communicate the Facts about Medical Radiation Risks to Patients, Families, Peers, and the Community.

Author(s) and Affiliations: Douglas Boreham, Northern Ontario School of Medicine

Dr. Douglas Boreham currently holds positions as Professor and Head of the Medical Sciences Division at the Northern Ontario School of Medicine (NOSM) and is Principal Scientist at Bruce Power. He is the Bruce Power Chair in Radiation and Health at NOSM. Dr. Boreham has published research on a variety of topics including health effects and anti-carcinogenic processes induced by low doses of medical diagnostic radiation (CT and PET), radioprotective dietary supplements that prevent free radical age related cognitive decline, radiation therapy predictive assays to identify radiosensitive patients, and he developed cytogenetic assays to detect DNA damage and assist in emergency biological dosimetry. He was the 2012 Canadian expert delegate for the United Nations Scientific Committee on the Effects of Atomic Radiation. From 1995-2005 Dr. Boreham owned, managed, and operated a 50 acre vineyard and winery on the Beamsville Bench in the Niagara wine region of Ontario, Canada.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Understand the different types of medical exposures and the relative dose levels of each exposure.
2. Learn about the types of risk from high versus low dose exposures.
3. Become knowledgeable about current research and in low dose medical radiation risk.

Abstract:
Medical diagnostic radiation exposures have increased significantly in recent history. Exposure of patients to low-dose ionizing radiation has attracted attention and raised considerable concern in both the scientific and medical communities over the potential health risks. Surveys in the literature identify that many physicians have perceived risks of the consequences of medical exposure that are not supported scientifically and would recommend intervention that would be harmful when the exposure is not. This workshop will appeal to all participants with an interest in learning how to better communicate the facts about medical radiation exposure. The participants will be introduced to natural and man-made radiation sources. The types of radiation exposures in the clinic (mammography X-rays, CT scans, PET scans, SPECT, DXA, etc.) will be compared to other natural sources of exposure such as eating food containing natural radioisotopes or cosmic radiation exposure from air travel. The health consequences of radiation accidents like Fukushima will be discussed and related to other low dose exposures. The talk will begin with the basics and end with leading edge research on the biological effects of CT and PET scans. There will be hands on demonstrations on measuring radiation in food and in the air. The overall purpose is to educate participants so that they can communicate simply and effectively to dispel myths and alleviate fear of medical radiation exposure.
Global health and health equity: developing a global medical curriculum

Author(s) and Affiliations: Dr. Basia Siedlecki, Northern Ontario School of Medicine

Abstract Stream(s): Social Accountability

Learning Objectives:
1. To identify the components of a comprehensive global health curriculum in undergraduate medical education.
2. To explore how a global health curriculum can foster social accountability in undergraduate medical learners.
3. To consider Northern Ontario School of Medicine's global health thread as a vehicle for teaching social accountability.

Abstract:
This is a curricular development case presentation. The context is Northern Ontario School of Medicine's undergraduate medical education program.

A cross-disciplinary team of faculty and students collaborated on the development of a global health curricular thread at NOSM. One of the goals of the team was to use global health to foster social accountability and global citizenship among future physicians. The curriculum incorporates the CanMEDS competencies with focus on clinical, epidemiological, ethical, historical and cultural aspects of global health. A key component of the global health curriculum is service-learning. Through service learning we encourage students to engage with host communities and approach their international experiences as opportunities to develop global citizenship and altruism as well as clinical skills. This not only prepares them for practice in Canada, where cross-cultural delivery of health care is a skill all practitioners, particularly those in rural and remote communities must employ, but also for a practice that may include global health in Canada or abroad.

This presentation will be useful to faculty at institutions hoping to foster social accountability among their students through their formal curriculum and to medical educators wishing to include global health in their curricula.

Social networking in the student, professional and wider community in longitudinal integrated placements - Is it associated with better preparedness for practice opportunities?

Author(s) and Affiliations: Michele Daly, Sydney University | Chris Roberts, Sydney University | Fabian Held, Sydney University

Michele is a Research Fellow with the Sydney Medical School and Broken Hill Department of Rural Health, Sydney University. She has worked in the area of physician well-being and support over the past 15 years, in particular with medical students and new medical graduates. Research interests have included work-life balance, burnout and the affects of medico legal matters on doctors and how practice is affected. Current interests revolve around rural and remote education, in particular social learning systems and rural career intention. The impacts of longitudinal integrated placements on future preparedness for practice, and how social connectedness, relating to work based learning and team work, are of particular interest.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Medical educators and university curriculum developers to actively promote connectivity opportunities particularly at the start of longitudinal integrated placements.
2. Medical students to become more aware of the importance of being proactive in seeking out informal as well as formal learning opportunities.
3. Medical educators and longitudinal integrated placement administrators to engage more with professional and local community groups so that more opportunities for supportive relationships and interactions, providing additional informal learning opportunities, can be identified.

Background:
We have undertaken previous qualitative research looking at medical student and clinician experiences of community-engaged extended rural placements, through the lens of social learning system theory(2013a) and of preparedness for practice(2013b). This then led us to further question what factors are associated with future preparedness for practice, in this setting. Research aim/question: To see if connectedness and supportive relationships in the community is associated with better prepared for practice opportunities using a mixed methods methodology. We were testing an emergent hypothesis and building on deductively built frameworks.

Methods:
In this sequential study, two key elements, ‘connectivity’ and ‘preparedness for practice’, previously identified looking at the data through the two theoretical lens’(2013a and 2013b) were singled out. Subsequent to this a cross-over analysis was undertaken. An independent researcher revisited transcripts (n=18) and recoded them based on the two elements and associated themes. Association between the frequency of coding segments relating specifically to these two elements was then investigated. Results: The relationship between connectivity and preparedness was investigated using parametric and non-parametric techniques. There was a strong significant correlation with high levels of connectivity associated with high levels of preparedness for practice.

Conclusion and Implications:
Our results suggest that enhanced connectedness in the student, professional and wider community is associated with increased opportunities for becoming better prepared for future practice. The importance of community connection and sense of belonging can be promoted in the wider educational program, by highlighting strategies to enhance connectivity opportunities, during orientation week. This could include providing training for student support staff to high light opportunities to students for membership of clubs and extracurricular activities in the wider community, making the most of informal learning opportunities, and being proactive in interacting with professional, nursing and allied health staff, to source additional learning opportunities.

Effectively Addressing Challenges Presented by Multi-Cultural Medical Learners

Author(s) and Affiliations: Kimberly T. Krohn, MD, MPH, FAAFP, University of North Dakota School of Medicine and Health Sciences

Kimberly T. Krohn, MD has been a family medicine residency program director in Minot, ND since 2006. She completed her medical school and family medicine residency at the University of North Dakota School of Medicine and Health Sciences in 1996 and 1999, respectively. She has an MPH in Health Services Administration from the University of Minnesota, and a BS in dietetics from Michigan State University. She is an associate professor of family and community medicine and previous president of the North Dakota Medical Association. She practices full scope family medicine.

Abstract Stream(s): Longitudinal Learning, Social Accountability

Learning Objectives:
1. Identify culturally-based concepts which impact learning regarding care of the elderly in the community in which the learner is being taught.
2. Identify culturally-influenced barriers to participation in preventive health care of importance to health care professionals and students.
3. Identify culturally-influenced norms of communications with patients and family members.
4. Use these concepts regarding cultural norms to more effectively educate students and residents in the communities in which they work and train.

Abstract:
This presentation is based on review of the medical, anthropological, and business literature and observations from a decade of experience with the education of multi-cultural teams in medical settings. It is about adjusting teaching methods to accommodate to medical learners being educated in a different setting than the one in which they were raised, with other learners from variable cultural backgrounds. The presentation should be of appeal to medical educators working with multi-cultural learners.

The background is that physicians and other health professionals being trained in settings different than their origins and with patients and colleagues with varying backgrounds are not prepared to effectively learn communication skills and patient care skills until their own cultural beliefs and attitudes are explored and contrasted with those of their fellow medical learners, their attending, and their patients. The presentation will explore data regarding basic cultural differences that impact appropriate patient care skills and communications and educational strategies to enhance the function of multi-cultural teams. It will further relate this data to specific issues related to elder care, preventive health care, and the communication of adverse events to patients and their families.

Using Distance Technology to Facilitate a Student Balint Group

Author(s) and Affiliations: Jay S. Erickson M.D. University of Washington School of Medicine | Suzanne Allen M.D. MPH University of Washington School of Medicine

Dr. Erickson is the Assistant Dean for the Montana WWAMI/ Clinical Phase at the University of Washington School of Medicine and a Clinical Professor in the Department of Family Medicine at the University of Washington School of Medicine. He oversees the clinical teaching opportunities for WWAMI students in Montana. This includes 32 required clerkship opportunities in 11 communities in Montana. He co-chairs the WRITE program in the WWAMI region a 5 month third year rural immersion experience in thirty rural communities in the 5 state region. In 2008 he developed and helped initiate Montana TRUST (Targeted Rural Underserved Track), a comprehensive 4 year medical school curriculum for a group of Montana WWAMI students. Since 1990 he has been a part of a 10 person primary care group in Whitefish Montana (pop. 6,000) where he still maintains an active part time clinical practice as a rural family physician.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Demonstrate the use of distance technology to connect rural LIC students, in 5 states and across 3 time zones.
2. Demonstrate the use of Balint groups in WRITE using distance technology.
3. Explore student perceptions of Balint group use in the WRITE program.

Abstract:
The University of Washington School of Medicine’s (UWSOM) WRITE (WWAMI Rural Integrated Training Experience) program is a 5 month rural longitudinal integrated clerkship experience in the first clinical year of training. This program started in 1996 and now includes up to 28 students spending approximately 5 months of clinical training in small rural communities spread across the 5 WWAMI states. The WWAMI states are 28% of the United States landmass but only have 3.5% of the population making them mostly rural and frontier states. The WRITE program is designed to offer a rural continuity experience to UWSOM students. The relationships that develop during this experience can be very transformational in the career choices of these students, but at times can offer challenges as well. Because of the isolated locations of these WRITE communities students do not have contact with other WRITE students or with Seattle based faculty on a regular basis. The loneliness and isolation inherent in the program makes it difficult to share the joys and difficulties of this learning experience with others. This has been an inherent shortcoming of the program throughout the years.

In 2012 the WRITE program started a Balint program for these WRITE students using webinar technology and hosted by a faculty member at the UWSOM. Balint groups started in the 1950’s in England and are leader facilitated groups that help clinicians and trainees present and discuss clinical cases in order to better understand and utilize the clinician-patient relationship in a therapeutic and professional way. These groups help the students realize they are not alone in having challenging interactions with patients and preceptors. The groups help the students develop an increased understanding and empathy for their patients and to explore how their feelings and thoughts affect the clinician-patient relationship. The WRITE Balint groups take place for 1-2 hours every other week utilizing Adobe Connect webinar technology.

Community cultural mentoring program

Author(s) and Affiliations: Leanne Pena, Northern Territory General Practice education and Aboriginal Medical Service Alliance of the Northern Territory. (NTGPE and AMSANT)

I have a Master of Indigenous Social Policy and a GradDipEd (secondary). Predominantly my experience relates to Indigenous education and I am passionate about the obvious links between education and health, consequently I have always used the opportunity and platform as an educator to deliver material on the concepts of health promotion and preventative care for Indigenous people. I am enthusiastic about my current opportunity to work as a Project Officer between AMSANT and NTGPE in developing a more productive relationship and a model for future engagement for supporting the expansion of Indigenous Health Training for GP Registrars in the NT.

Abstract Stream(s): Community Engagement, Aboriginal Health

Learning Objectives:
1. Better health outcomes for Aboriginal people.
2. Effective community engagement.
3. Using a ground up approach a a development tool.

Aim:
The aim of this presentation is to showcase a Community Cultural Mentoring Pilot Program (CCMP) at Galiwinku, Elcho Island in the NT and the progress to date including the methodology, lessons learnt and projected outcomes. This will be followed by an analysis of the program on completion. The pilot program will commence in April for a period of 22 weeks, therefore the pilot will be completed at the time of the General Practitioners Education and Training (GPET) conference. This presentation will demonstrate best practice within Aboriginal Community Controlled Health Organisations, affiliates and key stakeholders that reflect the theme of mentoring programs under health reform and workforce.

Objectives:
The ultimate objective of the Community Cultural Mentoring Program is to improve the health of Indigenous people in the NT by:
- Assisting GP registrars and junior doctors to better understand and value the culture of the Indigenous communities in which they work
- Contribute to the education of GPRs and junior doctors in the area of Indigenous health
- Training and support of cultural mentors so that they can assist GPRs to achieve these aims
- Provide personal experience and motivation to work in Indigenous health long term
- Assist GPRs and junior doctors to understand community protocols that apply to workers in Indigenous health

Methodology:
The methodology for the Community Cultural Mentoring Pilot Program has a ground-up approach which incorporates consultation with key stakeholders and traditional owners, where the work takes place, its history, and begins by working with the senior cultural authorities, and their knowledge and vision for their people. This way of working is participatory, reciprocal, rigorous, satisfying, generative, transformative and inspiring.

The CCMP comprises three stages of development with the three main interrelated strands that run through all stages. The stages and strands emerge out of and build on each other as the process unfolds.
27 How do contextual issues influence socially accountable medical schools?

Author(s) and Affiliations: Robyn Preston, General Practice and Rural Medicine, College of Medicine and Dentistry and Anton Breinl Research Centre for Health Systems Strengthening, James Cook University | Assistant Professor Sarah Larkins, General Practice and Rural Medicine, College of Medicine and Dentistry and Anton Breinl Research Centre for Health Systems Strengthening, James Cook University | Assistant Professor Judy Taylor, Adjunct, General Practice and Rural Medicine, College of Medicine and Dentistry and Anton Breinl Research Centre for Health Systems Strengthening, James Cook University | Dr Jenni Judd, Medicine, Division of Tropical Health and Medicine, Anton Breinl Research Centre for Health Systems Strengthening

Robyn Preston is a lecturer at the College of Medicine and Dentistry, James Cook University in Townsville, northern Queensland. Robyn's research interests include socially accountable health professional schools and community engagement and partnerships in the health sector. Prior to commencing her role at JCU in 2005, Robyn worked for the Australian government and NGOs in Australia, South-East Asia and the UK.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Discuss how the three contextual factors of local workforce, nature of linkages with the health system and nature of partnership with the community have influenced socially accountable medical schools.
2. Discuss other contextual factors that have influenced socially accountable medical schools.
3. Analyse how a conceptual framework developed from this research could be applicable to other settings.

Abstract:
Since the early 1990s the World Health Organization has developed conceptual frameworks around social accountability and individual schools have described their own experiences. However, little is known about how contextual factors, or external and internal issues, have influenced the development of these schools. Using a multiple embedded case study approach I explored how contextual issues have influenced social accountability at four medical schools in Australia and the Philippines. I theorised that workforce, health sector partnerships and communities would be strong contextual influences. I interviewed 75 participants including staff, students, health sector representatives and community members. I undertook fieldwork and verified findings through the literature. There were internal and external factors that overlapped and influenced socially accountable medical schools. The strongest contextual factor was the local workforce situation which led to innovative educational programs established with or without government support. The values and professional experiences of leaders, staff and health sector representatives, influenced whether a school's organisational culture was conducive to social accountability. The wider institutional environment and policies of their universities affected this culture and the resourcing of programs. Membership of a coalition of socially accountable medical schools created a community of learning and legitimised local practice. Communities may not have recognised their own importance but they were fundamental for socially accountable practices including governance and research and curriculum foci. This research will assist the medical education community to learn from these institutions' experiences; and contribute to the development of the theory and practice of socially accountable medical schools.
28 Exploring the journey to Cultural Safety

Author(s) and Affiliations: Samia Goudie Senior Lecturer in Aboriginal and Torres Strait Islander health within the post Grad ANU Medical degree | Mrs Gaye Doolan : Co-ordinator of Aboriginal and Torres strait Islander Health and Student Engagement

Samia Goudie is a Bundjalung woman and now works as the Senior Lecturer in Aboriginal and Torres Strait Islander health within the post graduate ANU Medical School degree. Previous to this she lived in Northern New Mexico working with native American communities and then as an Aboriginal Health Worker in the Illawarra. She has also taught for 15 years in Indigenous health and received a Fullbright Fellowship to further her studies.

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. To explore what if any, are the differences between ‘cultural education’, ‘cultural sensitivity’, ‘cultural awareness’, and ‘cultural safety’. Are we lost in a world of definitions?
2. Form a deeper understanding of how we assess someone as being ‘culturally safe’ both from the student perspective and the community.
3. Discuss what the advantage or disadvantage would there be in having a ‘cultural mentor’ paid by a retainer in each community the students visit.

Abstract:
We will facilitate a conversation about what ‘Cultural safety. We would like to tackle the hard questions and hear from people from diverse backgrounds. We envisage this as being done within yarning circles (Dawn Besarab 2012). This session will be of interest to anyone working with and/or for Aboriginal and Torres Strait Islander peoples and their non Indigenous allies.

We will be to engage with critical questions relating to questions around the use of and terminology of ‘cultural safety’ and what it means on the ground and what it means to be embedded within curriculums and/or other organisational structures. We locate Aboriginal and Torres Strait Islander health as a whole life approach to wellbeing.

We will present four pertinent questions to open the yarning circles and then break into smaller discussion groups which will return together as a group to listen to the findings and reflections.

This workshop will be based on a critical and open listening session that explores specifically the topic based around the CDAMS core competencies for study in an embedded curriculum for Medicine as in CDAMS Indigenous Health Curriculum Framework, Gregory Phillips (August 2004).
Designing student centred and online learning approaches to develop clinical judgement: the student experience

Author(s) and Affiliations: Helen Wozniak, FlindersNT, School of Medicine Flinders University | Professor Hugh Granthan, Flinders Southern Adelaide Clinical School, School of Medicine, Flinders University | Dr Clare Harvey, Faculty of Health Sciences, Eastern Institute of Technology, New Zealand | Professor Kay Morris Matthews, Eastern Institute of Technology | Dr Elaine Papps, Faculty of Health Sciences, Eastern Institute of Technology

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Outline the design of a post-graduate online course designed to promote development of clinical judgment
2. Explore the student experiences of this online course
3. Highlight lessons learned and principles that underpin the design of online learning environments

Background:
Universally all health professions advocate for development of evidence based practice to guide their clinical judgments but how to develop this skill in a post graduate distance online course is unchartered territory. In 2013 staff from the new postgraduate intensive care paramedic’s course and an advanced nurse practitioner qualification collaborated to design online learning activities to develop this graduate quality. Students review a problem or challenges presented as a short video vignette, and then over the next week engage in a thought-provoking asynchronous discussion activity as well as a MCQ or short answer quiz. In both cases the students need to challenge their conceptions about the issues being researched, delve into the associated literature and provide evidence based decisions for each scenario.

Aims:
The aim of this presentation is to report on the student experience of these online learning strategies; that is how well does the online learning environment enable post-graduate students’ to develop graduate qualities associated with clinical practice judgments informed by evidence.

Methods:
The research is part of a larger and action research approach studying the development, implementation and consequences of a new educational approach to teaching evidence-based clinical judgments online. The component to be reported firstly involved students self-assessing their approach to making clinical judgments using a rubric with descriptors progressing from a narrow focused protocol-based approach to an autonomous evidence based judgment. Students were then interviewed to share their experiences of the online teaching methods.

Results:
A total of 14 students completed the self-assessment process. There was a wide range in their reported length of time practising in their profession and their experience with assessment of clinical judgment clustered in the mid-range of the rubric. This shifted to the higher levels of judgment at the completion of their study period (1 to 2 semesters). All six students who volunteered were then interviewed by an educator about their online learning experiences. A wide array of opinions was provided, from those who embraced the challenge to those who found the online environment frustrating and confronting.

Conclusions:
All of the students interviewed agreed that their clinical judgment had been enhanced through the experience. Whether greater scaffolding of the online learning activities would have assisted those who were less comfortable with the process needs further discussion.
30 Tracking learning in longitudinal integrated clerkships & community based medical education: the NTMP electronic logbook experience

Author(s) and Affiliations: Helen Wozniak, FlindersNT, School of Medicine, Flinders University | Narelle Campbell, FlindersNT, School of Medicine, Flinders University | Emma Kennedy, FlindersNT, School of Medicine, Flinders University

Helen Wozniak, senior lecturer and Academic Director (e-Learning), focuses on developing innovative, technology-mediated teaching and learning experiences for medical and health science professionals and students. She has 30 years experience as firstly a clinician (orthoptist), and subsequently an educator in health and higher education environments with two 'Excellence in Teaching' awards. Her research interests relate to developing active and engaging learning experiences for health science students in both face-to-face and online learning environments.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Outline the NT experience of using electronic logbooks for tracking patient encounters.
2. Share the challenges of embedding such activities in the curriculum.
3. Evaluate curriculum considerations when using electronic logbooks and consider future collaborations with fellow participants.

Abstract:
The Northern Territory Medical Program has developed two electronic logbook systems with students in their clinical year with limited uptake and success. The first logbook was an online externally hosted custom build database that captured a large spectrum of information about patient encounters including demographics, presenting symptoms and working diagnosis using the ICPC-2-Plus coding system. Introduced in 2008 this was intended as a learning tool for both students and supervisors that could track clinical learning, identify gaps in learning, and provide a reference point for personal learning material based on patient encounters. In response to student feedback numerous iterations were undertaken. The tool was retired in 2012 due to the complexity of the data entry interface and inadequate integration with the curriculum. With the commencement of the Alice Springs based longitudinal clerkship program in 2013 a simpler portfolio system was developed using the PebblePad e-portfolio allowing data entry on university provided iPad minis. Uptake was slow with students reporting a lack of time and value gained from this approach. This session will aim to discuss the challenges of integrating such activities into the learning milieu of beginning clinical practice. How can the perceived value of tracking patient encounters be improved? How can these be better integrated into the curriculum where the value of such records for longitudinal learning and reflection be promoted?
Longitudinal Integrated Clerkships – what is their long-term career impact? 10-year impact of The Rural Clinical School of Western Australia

Author(s) and Affiliations: Denese Playford, Sharon Evans, Wen Ng, Tessa Burkitt, Geoff Riley

Denese Playford, Assoc Prof, Medical Education

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Understand the need for effective recruitment strategies in rural areas.
2. Understand the impact of a rural clinical school LIC relative to urban-only discipline-based education.
3. Consider how urban background students may be converted by the LIC experience to work in rural areas.

Description/Background/Rationale:
As well as their educational value, LICs are of interest because they may also have long-term workforce impact. In Australia, the LIC model has been adopted as a strategy to redress rural workforce shortages via The Rural Clinical Schools. The Rural Clinical School of Western Australia (RCSWA) LIC has been operating since 2002, allowing a 10-year evaluation of Rural Clinical School workforce impact in Australia.

Methods:
The success of RCSWA LIC in developing rural doctors was calculated by comparing workforce locations of RCSWA with matching urban graduates from the same university. The national practitioner registration database was used to identify graduates’ rural or urban location. Univariate comparisons were made between the two groups for known correlates of rural practice. Logistic regression was used to predict the relative importance of each factor.

Results:
For 246 RCSWA graduates relative to 440 urban controls, there were significant univariate associations for rural work location (p<0.0001), rural recruitment (0.0040), gender (p=0.0117) and age categorised in 10-year intervals (0.0449). For RCSWA graduates there was no significant effect of rural background (0.9336) because urban origin graduates entered work rural indistinguishably from the rurally recruited LIC peers. Logistic regression with an inclusion p value of 0.6927 yielded odds ratios for RCSWA of 3.55, gender 1.77 and age 2.02.

Conclusions:
Participation in Rural Clinical School LIC effectively develops rural doctors. It does so with differential effects due to age and gender. Significantly, RCSWA also converts urban LIC participants to rural practice. Longitudinal integrated clerkships have significant workforce impact.
Impact of simulated emergencies in wilderness-based setting on learning interprofessional collaboration from the facilitators’ and simulated patients’ perspective

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Heather Smith is a second year medical student at the Northern Ontario School of Medicine (NOSM) with a strong interest in developing effective interprofessional education to improve patient care. She is currently researching the effects of a wilderness medicine conference on teaching collaboration. In 2013 she developed an interprofessional working group to bring a student perspective to the conversation of interprofessional curriculum and research development at NOSM and Laurentian University. Heather works diligently to represent her peers at the provincial and national as the vice president external of NOSM Student Society. She previously completed her bachelor of science in nursing at the University of Ottawa.

Abstract Stream(s): Longitudinal Learning, Community Engagement, Aboriginal Health

Learning Objectives:
1. Model an innovative approach to engage a local healthcare team and aboriginal actors in interprofessional education and assessment.
2. Demonstrate how openness to different health perspectives and world views can be created through simulated emergency scenarios in wilderness conditions.
3. Discuss how interprofessional learning occurs in a simulation exercise that does not include specific training in interprofessionalism.

Background:
Interprofessional collaboration has been shown to improve patient care. Its uptake requires a complex shift in professionals’ behaviors and attitudes that may be taught through simulated clinical cases (Fortugno et al, 2013; Hammick et al, 2007). An annual wilderness medicine conference (WildER Med) uses simulations to teach interprofessional competencies in a more subtle way. Over three days teams of health professionals and outdoor enthusiasts camp together, learn together and navigate to structured clinical scenarios performed by local aboriginal actors without training in interprofessionalism.

Aim:
As part of an ongoing research project on the impact of these simulated patient scenarios on learning collaboration, this project sought the perspective of scenario facilitators and aboriginal actors on how team function and collaboration were “taught” and learned.

Methods:
Using a phenomenological approach grounded in social constructivist theory, one-on-one semi-structured interviews were used to elicit facilitators’ and actors’ perceptions of the participants team functioning and the impact of factors such as setting, scenarios, and emergent group dynamics.

Results:
The research data suggests that clinical scenarios in a wilderness environment are an effective means of teaching collaboration and that learning can be evaluated by eliciting the perspective of facilitator and patient. Furthermore, the secluded and engaging wilderness atmosphere and authentic collaboration demonstrated by NOSM, Debajehmujig Storytellers and the WildER Med Team in running the conference enriches the learning and enhances participant collaboration.

Conclusion:
An engaging atmosphere and interprofessional role modelling generates interprofessional competency development. Such factors should be considered in interprofessional curriculum development and assessment.

Learning trajectories in longitudinal rural medical school placements

Author(s) and Affiliations: Cathy Owen, Amanda Barnard and Jill Bestic, Rural Clinical School, Australian National University Medical School, Canberra, Australia

Prof Cathy Owen is part of the rural clinical school team at the ANU working in medical education and student development. She works as a rural adult psychiatrist interested in shared care and tele-health. Her real ambition is to continue to grow garlic and raise cattle.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Existing students and supervisors on longitudinal learning placements can identify key incremental learning goals to display as a learning trajectory.
2. Variations in medical practices means that timing of learning goals for individual students may vary.
3. The developed learning trajectory is useful for student and new supervisor orientation and assists in identifying under-performing students.

Background:
Rural longitudinal placements are a key part of medical education and a strategy to enhance rural medical workforce. Learning trajectories (a map to guide student learning) have been recommended to maximise student learning and have potential to assist long term rural students and supervisors in adapting to a longitudinal clerkship.

Aims:
The aim was for current rural supervisors and students to develop a learning trajectory across the rural stream year, for implementation in future years.

Methods:
Year three students and staff in rural longitudinal clinical placements were invited at time points across the year to submit their current learning achievements under three streams: current skills development, knowledge acquisition, professional experiences and level of responsibility currently expected in patient care. The draft trajectory was then reviewed by the same students and supervisors at end of placement (who could now see their learning in a more complete context) to identify any goals that were not widely achieved by the cohort.

Results:
Students and supervisors identified incremental learning goals in keeping with models of progressive skill development. Students offered tips to future students to adjust to variations in learning experiences across rural sites. Some supervisors were reluctant to have a learning trajectory, fearing it would be seen as prescriptive and reduce student ambition for varied rich experiences.

Conclusion:
Two years on, the learning trajectory is proving useful in orienting students and new supervisors to longitudinal placements and assists in the recognition of the struggling student.
Distributed learning in occupational medicine for Family Physicians

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I am a fully qualified MD licensed by the College of Physicians and Surgeons of Ontario, certified in Occupational Medicine from the Canadian Board of Occupational Medicine, and by the American Board of Independent Medical Examiners. I am Medical Director for a number of Corporations, handling Occupational Health and Safety and accommodation/disability management issues. I am an assistant professor in. Clinical Sciences, NOSM and an adjunct professor in the School of Public Health, Lakehead University. I am research coordinator for the Family Medicine Program at the NOSM. I have carried out numerous file reviews for adjudication for the legal profession, corporations, insurance companies, and government agencies. I am committee chairman of the Special Interest Focused Practice in Occupational Medicine of the Canadian College of Family Practice.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Be aware of the difficulties faced by community based physicians in obtaining teaching in occupational medicine.
2. Appreciate the impact this has on the provision of advice both to individual patients/workers and their employers.
3. Understand how the Foundation Course in Occupational Medicine is designed to address the needs of community based physicians in this area.

Background:
The Northern Ontario School of Medicine (NOSM) has a mandate to improve the health of the people and communities of Northern Ontario. This area has a significant mining and manufacturing base but community physicians have little training in the management of occupational related injury and illness either in the undergraduate or family medicine post-graduate curriculum.

Methods:
A distance/distributed learning course in occupational medicine for community physicians has been developed at the University of Alberta and piloted in Northern Ontario in conjunction with NOSM. The course is delivered over 9 months [September to June]. A self-study module is provided each month, followed by a 2 hour interactive tele/video/face-to-face review. This is structured to engage learners, through case studies and in text questions embedded throughout the module. Once per semester an all day face-to-face meeting is held. The principles learned are reinforced using interactive teaching methods, with faculty and a guest clinician. The eight core modules provide physicians with skills that will benefit both their patients and local industry in promoting timely and safe return to work.

Results:
Feedback from course participants in both Northern Ontario and Alberta suggests that the course is instructive, enjoyable and fills a role perceived by community physicians to be a very significant gap in their training. There are long waiting lists to join the course.

Conclusion Objectives:
Distributed learning geared to physicians working far from major cities has proved practical and sustainable and can only have a positive socioeconomic impact on Northern Ontario.
Who Writes the Stories? Anishnaabeg Animators Creating Patient-Centred Simulations

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Maurianne a rural physician in Mindemoya, on Manitoulin Island, working in the ER, office and hospital ward. She is an Assistant Professor (Clinical Sciences Division) with NOSM, an occasional instructor for the Emergency Department Echo (EDE) course and the Program Director of WildER Med. In addition to being a rural preceptor she is a Board Member of the Physician Clinical Teachers Association. Her research interests are related to interprofessional education and communication. Her hobbies include making maple syrup, canoeing, hiking, skiing, snowshoeing and reading.

Abstract Stream(s): Community Engagement, Aboriginal Health

Learning Objectives:
1. Examine the process for creation of simulated patient scenarios by experienced animators.
2. Describe how respectful incorporation of indigenous and other worldviews into the western medical paradigm may require a shift in power.
3. Consider collaboration with artists and animators to enhance communication opportunities in undergraduate curriculum.

Abstract:
Practicing to full scope-of-practice is seen as a means to provide high quality and high value in healthcare organizations. The mandate of the Debajehmujig storytellers is to educate and share original creative expression with Native and Non-Native peoples and thereby vitalize Anishnaabeg culture, language and heritage. Animators at Debajehmujig have participated in many community projects including those with mental health themes.

We describe a pilot project, where medical students on rural placements on Manitoulin Island joined the Debajehmujig storytellers in Community and Interprofessional Learning sessions. The aim was to allow learners to understand how arts organizations engage in the health of their communities while experiencing opportunities to practice communication and interview skills.

Much of the time was spent in simulated patient scenarios, exploring themes of mental illness and social disadvantage. Animators constructed complex characters utilizing their culturally relevant knowledge and lived experiences, curriculum objectives from the Northern Ontario School of Medicine, and resources on cognitive error. Students worked in pairs, so that following each interview the student partner used the Situation-Background-Assessment-Recommendation tool to summarize. The animator then provided feedback from a patient-centered perspective. Students also learned about the Elders Gone AWOL project.

Authorship of simulated patient scenarios has traditionally been in the hands of the medical educator. Experienced animators may, however, be the ideal authors in some situations. Debajehmujig storytellers incorporate Anishnaabeg views as “patients” and as educators. Collaboration with artists may allow us to respectfully “inhabit others’ worlds”.

Croskerry,P. From Mindless to Mindful Practice — Cognitive Bias and Clinical Decision Making. NEJM 2013; 368;26
Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Consider incorporation of Interprofessional Education within non-traditional venues such as wilderness medicine, disaster medicine, and international medicine.
2. Recognize validated tools available for assessing interprofessional competencies.
3. Consider innovative ways of collaborating with artists and animators in healthcare education.

Abstract:
This research project examines the effects of a wilderness medicine event on the enhancement of interprofessional learner competencies. At WildER Med, in Northern Ontario, interdisciplinary teams learn medical, navigational and survival skills. During a final day “race” day activity, interdisciplinary teams navigate between geographic locations where they must assess and treat illness and disaster situations. Interprofessional competencies have been the “hidden curriculum” at WildER Med.

Our hypothesis is that learning together in non-traditional settings, employing study areas not usually forming part of the practitioners’ comfort zone will help professionals from different disciplines to enhance Interprofessional competencies.

Since “forum theatre can provide a practical, pedagogically effective approach to the teaching and learning of communication skills” (Middlewick, Y., et al 2011), a production with a context-related plot based on calamities in a remote environment was performed early in the course with the intent to humorously stimulate lateral thinking. WildER Med facilitators and animators from Debajehmujig Storytellers provide enhanced feedback to the participants on race day after the simulated patient scenarios, from the perspectives of observer and patient. Between scenarios, team members made audio diaries in response to pre-set questions posed regarding collaboration, communication and the impact of the live scenarios. Participants also completed the Interprofessional Collaborative Competencies Attainment Survey (MacDonald et al 2009).

Results:
suggest that Wilderness Medicine offers authentic learning opportunities to enhance Interprofessional Education competencies and is well situated for reinforcing learning related to “tolerance of ambiguity and uncertainty” (Bleakley, 2013) while utilizing limited resources.

The 2nd Evaluation for a Pilot study of Community Participatory Medical Education ~Possible New spectrum of Community Oriented Medical Education?~

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March in 1998 Graduated from Toyama University, School of Medicine | April in 1998 Work at Kanazawa Jouhoku Hospital, Intern | April in 2005 Work at Kanazawa Jouhoku Hospital, Paediatric Consultant | Jan in 2008 Finished Flinders University, Master of Education | Feb in 2009 Work at Flinders University, Rural Clinical School, Lecturer | June in 2010 JICA Laos Medical Education Project, Medical Specialist | Sep in 2012 Work at Mie University, School of Medicine, Senior Lecturer | Jun in 2013 JICA Tajikistan Community Health Promotion Project, Medical Specialist

Learning Objectives:
1. Consider the need of not passive but active community participation.
2. Consider the benefits of continuous fixed engagement in a community.
3. Understand the effects of Community Engagement.

Background:
Recently Community oriented medical education is being approved widely in the world. But in many cases, the participation of community people is still passive. And there are many benefits which young doctors learned from the community.

Aims:
This study examines whether community activities with people who educationally participated in could affect interns’ consciousness for community medicine. And investigated what interns learned intentionally or unintentionally in a community.

Methods:
Total 10 medical graduates who started their first clinical year have been fixed in each region for two years and given missions to activate people’s health consciousness through activities as sub-curriculum, while community people were also asked to make the interns motivated to learn community medicine. We assessed this by questionnaire and interviews.

Results:
The results of questionnaire show that community activities affect overall positively interns and community people. They learned many things which are both we intended and not intended. And the consciousness of community people is also affected. The educational participation of community people could be very beneficial.

Conclusion:
The result indicates that the active participation of community people which we call Community Participatory Medical Education could increase the level of new doctors’ positive consciousness for community medicine. In addition, people also felt they join in the nurture of good community doctors. Consequently, community activities with people should be introduced more in medical education to foster the better doctors.

Why are some General Practices more successful than others at engaging students to be future employees?

Author(s) and Affiliations: Dr Leesa Walker, GP and Senior Lecturer, FURCS | Walker L, Walters L Flinders University Rural Clinical School

I am a General Practitioner in Hamilton, in Western Victoria, where I have lived and worked for 12 years. I have special interests in family planning and sexual health and run a Well Women's Clinic at the local community centre in addition to my work my General Practice work. For the past 5 years I have also taken on the role as Clinical Educator for Flinders University. I lead a faculty of GP's who host the same medical students for the entire academic year in a longitudinal integrated curriculum known as the PRCC (Parallel Rural Community Curriculum). I am currently studying a Masters in Clinical Education with Flinders University. In my spare time I run after my 7 and 4 year old.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To identify other practices that have been successful at engaging students to be future employees.
2. To identify and understand if there are attributes that make a practice more likely to engage students as future employees.
3. To understand if any of these attributes are transferable to other practices or settings.

Abstract:
Rural Clinical Skills were developed in Australia as a workforce initiative to recruit students to work in rural areas. At Flinders University Rural Clinical School third year medical students spend the academic year based in General Practice undertaking a longitudinal integrated curriculum known as the PRCC (Parallel Rural Community Curriculum). One of the reasons some General Practices participate in this program is the hope that some students may return and work there. The PRCC has been running since 1997 and some practices are starting to see a return on their investment but not all have been successful. There are clinics that have been proportionally more successful in towns that have either stagnant or declining populations.

Questions for discussion:
• Do other programs have examples of such success?
• What are the attributes of these practices that contribute to their success?
• Are these attributes transferable to other practices or settings?
Mobile devices in the clinical setting: information overload and ethical dilemmas?

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Helen Wozniak, senior lecturer and Academic Director (e-Learning), focuses on developing innovative, technology-mediated teaching and learning experiences for medical and health science professionals and students. She has 30 years experience as firstly a clinician (orthoptist), and subsequently an educator in health and higher education environments with two ‘Excellence in Teaching’ awards. Her research interests relate to developing active and engaging learning experiences for health science students in both face-to-face and online learning environments.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Describe the iPad mini project at Alice Springs with Northern Territory Medical Program (NTMP) students, which aims to promote greater connectivity for students studying in remote locations during their first clinical year.
2. Explore their conceptions, opinions and biases about mobile devices in the clinical setting.
3. Discuss their own and other participants’ case studies that illustrate ways mobile devices are used in clinical settings.

Abstract:
Mobile devices, such as smart phones and tablet computers, are useful learning devices in health care settings due to their ability to connect to the internet, play multimedia files, their portability and price. It is less clear how they are being used in the health care setting and their potential uses. The first part of this session will briefly outline the iPad mini project being conducted in Alice Springs with 3rd year NTMP students completing longitudinal integrated clerkships and community based medical education. It will include results of a student evaluation of the project, conducted in 2013. Participants will then engage in interactive polling activities using mobile devices to examine and discuss their beliefs about the advantages and disadvantages of using these devices in health care settings. In the final part of the workshop, small groups will discuss and capture the range of uses and experiences the participants have had with mobile devices in health care settings and begin to develop a map of the pedagogical uses for such devices. This may include examples of how mobile devices enable easy access to information for medical and health students and practitioners, how they could be used for learning skills, such as history taking, how they can capture longitudinal learning experiences and foster reflective practice, and how they can be used for patient education. Ethical issues concerning the use of mobile devices in health care settings may also be discussed.

Helen Wozniak, senior lecturer and Academic Director (e-Learning), focuses on developing innovative, technology-mediated teaching and learning experiences for medical and health science professionals and students. She has 30 years experience as firstly a clinician (orthoptist), and subsequently an educator in health and higher education environments with two ‘Excellence in Teaching’ awards. Her research interests relate to developing active and engaging learning experiences for health science students in both face-to-face and online learning environments.
What influence does rural prevocational training have on future medical career choices?

Author(s) and Affiliations: Forgan J, Walters L, Kumar K, Hough D

Julie Forgan is the Medical & Health Education Program Administrator at Flinders University Rural Clinical School, Mount Gambier, South Australia. She has been involved in the Junior Doctor program supporting the education of prevocational doctors since December 2006. Julie has also administered a pilot program where health science students participate in rural longitudinal placements and learn interprofessionally.

Julie's qualifications include a Bachelor of Economics, Graduate Certificate in Public Sector Management and Graduate Certificate in Clinical Education. She has a broad and extensive background in administration, having worked in both the health industry (South East Regional Health Service and Limestone Coast Division of General Practice), and in the education sector (TafeSA and Deakin University) whilst a local resident. Julie also has sixteen years of experience as a rural representative on administrative review Boards and Tribunals in the social welfare and mental health sectors.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. To gain an understanding of what elements of rural prevocational training influence medical career choices.
2. To consider conceptual frameworks that could be applied to explore the rural training/career direction relationship.
3. To consider if resourcing for rural training justifies outcomes for rural workforce.

Topic Outline:
Junior medical officer training programs based in small rural communities are resource intensive both in terms of human and financial resource capital. This cost has been justified by expectations that these programs will result in a positive impact on rural medical workforce outcomes.

This presentation seeks to move beyond the simplistic view of “build it (the training program) and they will stay”, to understand how rural medical training programs influence an individual: professional identity, socialisation and career choice.

Preliminary data from tracking trainees who have undertaken a longitudinal rural prevocational placement will be presented as the basis for the discussion.

Questions for discussion:
What evidence exists internationally that junior doctor training programs based in rural communities have a positive impact on doctors future career decisions?

What conceptual frameworks could be used to explore the impact of rural community-engaged training programs on future career decisions?

Who the presentation appeals to:
Rural medical workforce outcomes are important outcomes for socially accountable medical training. This presentation will appeal to organisations including medical schools, medical colleges, and governments.
Expanding the boundaries of clinical skill development in undergraduate medical education: Instruction in Point of Care Ultrasound (POCUS) at the Northern Ontario School of Medicine

Author(s) and Affiliations: Siobhan Farrell, NOSM | Dr. Rachel Ellaway, NOSM | Dr. Lisa Graves, NOSM | Dr. Jacques Abourbih, NOSM

Siobhan Farrell, Director of Active Learning at the Northern Ontario School of Medicine has a Bachelors Degree in Film and Communication Studies and a Master of Science in Rural Planning and Development. She has worked at the Northern Ontario School of Medicine for seven years, and previously has worked in health planning for the provincial government as well as in private consulting. Ms. Farrell has strong interests in community planning and development, global health and experiential learning.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To describe the challenges and benefits of introducing Point of Care Ultrasound (POCUS) education to the undergraduate curriculum.
2. To discuss the specific experience at the Northern Ontario School of Medicine.
3. To examine the role of POCUS in medical education and its application in classroom and distributed clinical learning environments.

Background:
POCUS is the use of ultrasound with patients where they are located rather than within an ultrasound/radiology department/facility. Emergency Department Echo (or EDE) Course is unique and is one of the leading programs in Canada. EDE is a continuing medical education program with a unique educational philosophy. POCUS is the adaptation of EDE to match the needs of undergraduate medical students at NOSM.

Aims:
The presentation will briefly summarize the experience of NOSM, suggesting next steps as well as its application in other distributed contexts.

Methods:
The presentation will describe POCUS in the NOSM MD program, including:
- How the curriculum is delivered in small groups with a clinician instructor
- How POCUS can translate to the teaching of physiology and anatomy
- Results of preliminary evaluation of EDE-POCUS implementation

Results/Conclusions:
Evaluation results will be used to make decisions regarding future planning and implementation, and discussed in context of it will contribute to better understanding the strengths and weaknesses of EDE-POCUS, as well as supporting further development of POCUS programs in clinical and non-clinical educational contexts. It will be important to consider how its use may be extended as learners progress through UME and into distributed clerkship sites.
Developing a simulation-based education program in a distributed environment: breaking new ground and avoiding the potholes

Author(s) and Affiliations: Siobhan Farrell, NOSM | Susan Morhart, NOSM

Siobhan Farrell is the Director of Active Learning at the Northern Ontario School of Medicine in Canada. She has a Bachelor’s degree in Film and Communications Studies from Concordia University and a Master of Science in Rural Planning and Development from the University of Guelph. She has been employed by NOSM for seven years, and worked previously in health and community planning for government and in private consulting. She has a strong interest in community-based learning and community development, as well as service learning, global health and experiential education.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To recognize both the benefits and challenges of providing simulation-based learning in a distributed learning environment for medical education.
2. To gain knowledge regarding some of the current tools, logistics and mechanisms used to provide simulation-based learning in a distributed learning environment.
3. Through interactive discussion, to explore and examine specific approaches and tools to help determine which may be most useful in developing curricula.

Abstract:
The Northern Ontario School of Medicine operates in a large geographic area, and uses a model of distributed medical education throughout its undergraduate and postgraduate programs. Its simulation program however, for the most part is still primarily centralized and located at its two main campuses. Some progress has been made (e.g. use of virtual patients) While developing a plan to help guide the development of our simulation program, we discovered that there are not many examples of simulation in distributed environments to help guide us. We therefore wish to engage in discussion with experienced practitioners and teachers to explore and challenge our thinking and assumptions.

Examples of Questions:
1. What programs exist which are using distributed learning as a major component in their simulation program?
2. How are the programs managed and how do the learners interact with program?
3. What are the challenges?
4. What are the benefits to this type of learning which cannot be provided in traditional large simulation labs (e.g. working in small communities, online environments etc.)?
5. What are key lessons?
6. How might we move forward?
Service-learning: linking the local and global learning environment

Author(s) and Affiliations: Siobhan Farrell, NOSM | Dr. Basia Siedlecki, NOSM

Siobhan Farrell is the Director of Active Learning at the Northern Ontario School of Medicine in Canada. She has a Bachelor’s degree in Film and Communications Studies from Concordia University and a Master of Science in Rural Planning and Development from the University of Guelph. She has been employed by NOSM for seven years, and worked previously in health and community planning for government and in private consulting. She has a strong interest in community-based learning and community development, as well as service learning, global health and experiential education.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. To describe the service learning program at the Northern Ontario School of Medicine (NOSM) at the local and global level.
2. To understand the strong links between the service learning program and our community engagement and social accountability mandate.
3. To discuss how service learning can be an effective tool in developing healthy campus-community partnerships.

Background:
The curriculum of the Northern Ontario School of Medicine (NOSM) reflects its social accountability mandate and its commitment to serving the health care needs of Northern Ontario. Our service-learning program planning is now taking place in concert with the development of a global health curricular thread. This thread can only help to highlight the strong linkages between content from the northern context to the global community, focusing on issues like access, equity, the environment and socio-political issues.

Aims:
Learning from this session will focus on how to effectively link local and global content in a meaningful way for medical students, in service-learning and in their other learning experiences.

Methods:
This presentation will summarize the literature on service learning, community engagement and its relevance in developing ethical physicians, as well as a summary of NOSM’s, experience locally and globally, concluding with discussion of next steps.

Results and Conclusions:
The presentation will conclude with discussion and questions as to how to effectively integrate service learning in a meaningful way which challenges power imbalances and inequities in the environments in which medical learners and physicians work.
Rural longitudinal integrated placements – How do they work? : A social learning systems perspective

Author(s) and Affiliations: Michele Daly (Sydney University) | Chris Roberts (Sydney University) | Koshila Kumar (Flinders University) | David Perkins (Newcastle University)

Michele is a Research Fellow with the Sydney Medical School and Broken Hill Department of Rural Health, Sydney University. She has worked in the area of physician well-being and support over the past 15 years, in particular with medical students and new medical graduates. Research interests have included work-life balance, burnout and the affects of medico legal matters on doctors and how practice is affected. Current interests revolve around rural and remote education, in particular social learning systems and rural career intention. The impacts of longitudinal integrated placements on future preparedness for practice, and how social connectedness, relating to work based learning and team work, are of particular interest.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Medical educators to have greater insight into the design, implementation and improvement of longitudinal integrated placements.
2. Curriculum developers to actively incorporate a mix of formal and informal learning spaces in the setting up of service led learning environments, in rural and remote under-served communities.
3. Medical students to better appreciate the benefits of broader community-engaged learning opportunities available in a rural longitudinal integrated placement.

Background and Aims:
There is currently little theoretically informed exploration of community engaged longitudinal integrated placements. The operation of these placements is something of a black box and since more placements will be needed to meet the increase in students numbers it would be helpful to understand better how the placements operate. The aim of this research was to understand how medical student clinical placements, delivered in rural and remote community-engaged settings, work from a social learning system perspective.

Methods:
Data collected using semi-structured interviews, with medical students, their supervisors and other health clinicians (n=34) in a rural and remote setting were analysed using framework analysis. The data interpretation was informed by the theory of social learning systems (Wenger 2000) and examined the structure and operation of learning spaces and the nature of formal and informal curriculum.

Results:
Our findings show that within a unique geography of place, students take part in a number of distinct learning spaces characterized by different degrees of formality, membership and interactions, as well as different learning opportunities and experiences. The notion of “connectivity” helps explain how students access and cross the boundaries between these learning spaces and communities, and how they may develop a more complex sense of rural professional identity.

Conclusions:
Conceptualizing a longitudinal clinical placement program as a social learning system around a rural community is a valuable way of promoting student learning. Medical educators can encourage active student engagement and participation in the various learning spaces that make up a particular geography of place. Students can be coached to recognise the embedded communities of practice and social networks within the various spaces and then take advantage of the learning opportunities they bring.

Challenges in Developing a New Graduate Program in a Socially Accountable Medical School

Author(s) and Affiliations: David MacLean, Greg Ross and Roger Strasser, Northern Ontario School of Medicine, Sudbury and Thunder Bay Campuses, Ontario, Canada.

Dr. MacLean is a full time faculty member in the division of Medical Sciences and is also the Assistant Dean, Research at the Northern Ontario School of Medicine.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Attendees will be able to identify unique challenges that face the formation of graduate program in a socially accountable medical school.
2. Attendees will be able to describe how a graduate program can be developed utilizing a Distributed Community Engaged Learning model as its foundation.
3. Attendees will be able to identify how courses and research can be designed to focus on e health care needs.

Abstract:
The Northern Ontario School of Medicine (NOSM) is the only medical school in Canada created with a social accountability mandate, which is to be responsive to the needs of the people and communities of Northern Ontario with a focus on improving people's health. The school also utilizes a Distributed Community Engaged Learning (DCEL) model, the distinctive approach to medical education and health research that was developed specifically by NOSM. Therefore, when developing a new graduate studies program, it is critical that these two fundamental aspects be at the core of the program. It is anticipated that the courses will draw on the specific expertise of NOSM faculty members and complement the need to focus on health care needs. In addition, there will be a strong emphasis on research with the intent that the NOSM students would learn the skills which are required for an academic career pathway. Furthermore, it would be beneficial if these courses and research endeavors could reinforce, and where possible, be integrated into our existing undergraduate and postgraduate medical education curricula. In addition, it is important for NOSM to promote the uniqueness of its DCEL model, which will allow full-time and part-time students to undertake their studies at multiple locations, including across Canada and beyond. The purpose of this presentation will be to outline the blueprint for the formation of a graduate studies program in Medical Studies at NOSM and how the school is addressing the challenges guided by its social accountability mandate.
Increasing global capacity to improve diabetes care for Indigenous peoples through point-of-care testing

Author(s) and Affiliations: Lara Motta and Professor Mark Shephard | Affiliations: International POCT Programs Coordinator and Director, Flinders University | International Centre for Point-of-Care Testing, Adelaide, Australia

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. To demonstrate the applicability of POCT for diabetes management in Indigenous populations
2. To highlight the role POCT can have in building local workforce capacity and fostering community engagement
3. To demonstrate evidence for the clinical and cultural effectiveness of POCT

Background:
Rates of diabetes have reached epidemic proportions in many Indigenous populations. The Flinders University International Centre for Point-of-Care Testing has developed two point-of-care pathology testing (POCT) programs for diabetes management – the Australian-based QAAMS (Quality Assurance for Aboriginal Medical Services) Program and the international ACE (Analytical and Clinical Excellence) Program. In both, POCT is performed for key markers of diabetes management (Haemoglobin A1c and urine albumin:creatinine ratio), with results available in under 15 minutes for immediate clinical management.

Aim:
To use POCT as an innovative strategy to improve access to, and deliver better health outcomes for, Indigenous diabetes patients.

Methods:
Through continuous Government support over 15 years, QAAMS now operates in over 175 Aboriginal medical services nationally. Through partnerships with international universities, ACE has been introduced to communities in Canada, South Africa, Thailand, Papua New Guinea, Solomon Islands, East Timor and Western Samoa. Local workforce capacity has been built by training health professionals in the principles and practice of quality-assured POCT for diabetes management through workshops, videoconferences and self-directed e-learning programs.

Results:
Over 1000 health professionals have completed QAAMS and ACE training and competency programs in the past 5 years. Both programs are clinically effective (shown by reductions in HbA1c), culturally effective (through qualitative surveys) and analytically sound (meeting laboratory benchmarks for quality).

Conclusions:
Through QAAMS and ACE, Indigenous communities in Australia and internationally have been engaged and empowered with the skills and resources to manage and sustain POCT to help close the gap in health equity for diabetes care.
Moving towards a health professions school in the North West province of South Africa: possible models for a collaborative approach

Author(s) and Affiliations: Ian Couper, Centre for Rural Health, University of the Witwatersrand (Wits), Johannesburg, South Africa

Ian Couper, a family physician, is Professor of Rural Health at the University of the Witwatersrand (Wits), Johannesburg and Head: Clinical Unit (rural medicine) in the North West Provincial Department of Health. He is founding director of the Wits Centre for Rural Health, and is currently academic head of the Wits Department of Family Medicine. He chaired the International Wonca Working Party on Rural Practice from 2007 to 2013. He serves as editor of the African section of the international journal Rural and Remote Health.

He was a member of the expert panel that produced the WHO Global Policy recommendations "Increasing access to health workers in remote and rural areas through improved retention" and of the WHO Core Guidelines Group that developed the recommendations on "Transforming and Scaling up Health Professionals’ Education and Training". He is currently a member of the WHO Guidelines Review Committee.

Learning Objectives:
1. Describe collaborative models of medical student training.
2. Identify examples of community-based and distributed learning.
3. Discuss contextually appropriate solutions for medical training.

Background:
Discussions have been held in the North West Department of Health regarding the development of a health professions training school in that province. The province is mainly rural and has one of the lowest doctor-population ratios in the country. Various tasks teams established over the years to take this forward have led to no outcomes.

Aim:
To explore possible models for the development of a health professions training school in North West Province (NWP), with a particular focus on distributed and collaborative models.

Methods:
As part of a sabbatical in the latter part of 2013, the author, a Wits-NWP joint appointee, visited a number of medical schools in North America that utilise such models were visited to research their programs and a concept note was drawn up for the provincial Department of Health.

Results:
A range of models will be presented, from a limited “contracted training” approach typified by some of the programs at the Northern Ontario School of Medicine (NOSM), through a regional medical school typified by the University of Washington WWAMI program, to satellite medical school programs typified by the University of British Columbia, and a collaborative two-university distributed medical school, demonstrated by NOSM.

Conclusion:
The unifying themes include community-based teaching, distributed learning and contextually appropriate solutions. A phased approach using elements of many of these models may be an appropriate way forward for the North West if there is a serious intention to develop a medical school in the future.
Using critical incident reflection sessions to promote reflection in undergraduate medical learners: exploring elements of the hidden curriculum

Author(s) and Affiliations: Siobhan Farrell, NOSM | Marion Briggs, NOSM

Siobhan Farrell is the Director of Active Learning at the Northern Ontario School of Medicine in Canada. She has a Bachelor's degree in Film and Communications Studies from Concordia University and a Master of Science in Rural Planning and Development from the University of Guelph. She has been employed by NOSM for seven years, and worked previously in health and community planning for government and in private consulting. She has a strong interest in community-based learning and community development, as well as service learning, global health and experiential education.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To understand the benefits and challenges of small group critical incident reflection for undergraduate learners.
2. To explore the significance of facilitators being “witness” to learners’ reflections.
3. To explore how themes from critical incident reflection can inform needs assessment strategies for faculty development and reveal opportunities for curricular development.

Abstract:
Creating a “safe space” for reflection about significant experiences is important for medical learners’ professional and personal development. Critical incident report writing is a reflective learning method which focuses on learners’ formative experiences to highlight their development both as a person and as a physician. Critical incident report writing accompanied by reflection on that writing in small groups has recently been introduced as a pilot at the Northern Ontario School of Medicine to enhance skill development through reflection, focusing on community-based learning experiences.

This interactive workshop will explore the use of critical incident reflection in undergraduate medical education and consider associated challenges and opportunities. Beginning with a brief summary of popular critical reflection tools, there will be short discussion focusing on the use of critical incident reporting at NOSM. Participants will then be invited to participate in a critical incident reflection experience, followed by questions and discussion regarding their experience, differences in the nature of written vs. group critical incident reflection, as well as the wider application of the approach for faculty and curricular development.

Distributed community-engaged dietetics learning as the road to rural practice: Examining the impact of the Northern Ontario Dietetic Internship Program on recruitment and retention of Registered Dietitians in rural and underserviced areas

Author(s) and Affiliations: M Hill (1), D Raftis (2), P Wakewich (3) | Affiliations: (1) Centre for Rural and Northern Health Research, Lakehead University; (2) Northern Ontario Dietetic Internship Program and Northern Ontario School of Medicine; (3) Centre for Rural and Northern Health Research, Departments of Sociology and Women's Studies, Lakehead University and Northern Ontario School of Medicine

Denise Raftis, RD, MEd., is the Program Manager of the Northern Ontario Dietetic Internship Program, at the Northern Ontario School of Medicine. Denise obtained her Master of Education from Nipissing University. Although born in Toronto, she ventured north to start her career as a Registered Dietitian in Sault St. Marie, and never looked back.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. To explore the impact of a distributed community-engaged practicum learning model on recruitment and retention of dietitians in rural and underserviced areas.
2. To identify professional, personal and community factors affecting recruitment and retention decisions of dietetic graduates trained using a distributed community-engaged learning model.
3. To collaborate and communicate with researchers and health professionals, engaged in developing and evaluating recruitment and retention strategies for rural health practice.

Background:
There are gaps in the evidence on the effectiveness of Canadian dietetic practicum models designed to increase the number of Registered Dietitians (RDs) choosing to practice in rural and under-serviced communities. The Northern Ontario School of Medicine's (NOSM) social accountability mandate and commitment to community engaged and distributed education provides the foundation upon which the Northern Ontario Dietetic Internship Program (NODIP) delivers and evaluates its 46-week program.

Method:
NODIP graduates of the first five cohorts (2008-2012) (n=62) were invited to complete a 27- item questionnaire two years after internship to track employment experiences, employment decisions, preparation for practice, and future career plans. Data were analysed descriptively using SPSS multiple response procedures.

Results:
Pending data collection and analysis of fifth cohort in July/August and combined analysis September, 2014. Preliminary results from the four-cohort database reveals two-thirds of graduates were practising in rural and under-serviced areas. Confirming factors identified in the rural allied health literature, prior awareness of employers, prospects for full-time employment, flexible working conditions, interprofessional practice and continuing education, along with personal and community factors, influenced practice decisions.

Conclusions:
A key measure of long term success of the NODIP is the ability to attract and retain dietitians in Northern Ontario. This study provides early evidence about the effectiveness of the NODIP distributed community-engaged learning model on recruitment and retention of dietitians. Results are being used to inform curriculum design, practicum experience planning, and strategies used to recruit and retain dietitians to under-serviced areas of Ontario.

53 How to contextualize the curriculum – to wherever you and your learners happen to be located and covering the full extent of learning in medical education

Author(s) and Affiliations: Sarah Strasser, NOSM & Flinders University | Helen Wozniak, Flinders NTMP | Pascale Dettwiller, Flinders NTMP, Katherine

Professor Strasser comes from a background of over thirty years in rural general practice and medical education. She has been instrumental in establishing a number of new programs in both undergraduate and postgraduate medical education in Australia and Canada with a particular focus on community engagement and social accountability. She led faculty development at the Northern Ontario School of Medicine from 2002-2007 and then in 2009-10 as the Director of 3rd year in the MD program when the students live and work in small rural communities for a year. In Australia as director of Community Based Medical Education in the Northern Territory for Flinders University in 2007-9 she secured the funding for the NT Medical Program and was the inaugural Associate Dean from 2010 to 2013. In 2014 Professor Strasser returned to Canada and is currently the Associate Vice President, Academics and Inter-professional practice at Health Sciences North.

Abstract Stream(s): Longitudinal Learning, Community Engagement, Social Accountability

Learning Objectives:
1. Contextualize the curriculum;
2. Maximise the strengths, and develop new resources for learning in your community and practice;
3. Identify gaps in the curriculum and options on how they might be filled.

Abstract:
This workshop will take you through the basic steps of curriculum design and program implementation in the process of designing a curriculum to meet your needs (goals and learning objectives) for a locally relevant curriculum using locally available resources and maximising opportunities as they arise. This workshop will be useful for those who are wanting to change the delivery of the curriculum (for example to longitudinal placements), or for those who already have a pre-set curriculum, but want to adapt it to their own setting; or for those planning to develop a new curriculum from scratch. This will suit learning in both rural and urban settings and crosses the discipline divide (ie. useful regardless of discipline background).

This workshop is based on a previous contextualizing the curriculum workshop delivered in 2012 at the Flinders Northern Territory Medical Program. The content process and outcomes of that workshop will be shared however participants are encouraged to bring their own current curriculum, any ideas for which they might like some feedback, and although individuals will find it useful, teams from the same location are encouraged to undertake this workshop as a joint activity.

Mastery will be built into the workshop so that you will come away with a number of skills and resources to take home.
Conversion of Traditional Block Rotation education (TBR) in an Academic Medical Centre to Longitudinal Integrated Clerkship (Longitudinal Integrated Flinders Training LIFT).

Author(s) and Affiliations: W Heddle, G Roberton, M Slee, S Mahoney, P Worley. Flinders University

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Unique challenges in establishing LIC in an Academic Medical Centre
2. Reaffirming the continuity principles in LIC
3. Challenges in continuity of patient/student contact is fragmented health care system

Introduction:
Flinders University School of Medicine has used TBR as the format for the major clinical training year at the attached Academic Medical Centre (Flinders Medical Centre (FMC)) since opening in 1974, initially as a 6 year undergraduate course, and changing in 1996 to a 4 year postgraduate course. At FMC In 2013 a LIFT Pilots were run in 2013 and 2014 exploring how a successful LIFT can be run at FMC.

Methods:
Two iterations of Pilot LIFT have been run in 2013 (P1) and 2014 (P2) with 8 students each year out of 72 selecting FMC. In P1, each student had preceptors in each major discipline (medicine, surgery, paediatrics, O&G, psychiatry, family medicine) and two weekly “academic tutorials” (a total of one day), plus an Educational Supervisor. P1 was successful in terms of academic performance. P2 was a redesign of the P1 to enable transfer (if successful) of the whole class at FMC in subsequent years. Limited numbers of Consultants in Paediatrics, O&G, and Psychiatry made this model untenable for the 72 students; in P2, the major change is 40 weeks of LIFT with unit attachments (rather than to individual consultants) in Medicine and Surgery, with the responsibility devolved to the unit of working with the student to optimise learning opportunities, including inpatient, emergency, and ambulatory care. Weekly academic tutorials continue with an educational supervisor and family medicine attachments are unchanged. On completion of this time, the students then will rotate in groups through the other disciplines with 4-6 week rotations. This requires a change in assessment times with the major “hurdle” examination moved to middle of year 4 from end of year 3. (In the transition year of 2014, the rotations are only 4 weeks each, to permit the exam to remain at same time).

Questions:
Is the latter model transferable to the whole cohort of 72 students attached to the Academic Medical Centre?
What will be the major challenges?

Abstract:
In developing a longitudinal integrated clerkship (LIFT) at Flinders Medical Centre, two pilots have /are being run to explore feasibility of a full cohort LIFT; the two Pilots will be described and then the challenges of how to expand to the full cohort will be discussed.
Learning and teaching after dark-innovative techniques inspired by the Tasmanian devil

Author(s) and Affiliations: Bruce Peyser MD, FACP Duke | Joseph Jackson MD, Duke

Dr. Bruce Peyser is a co-director of the Longitudinal Teaching Program at Duke University Medical Center. He has extensive experience teaching in both the inpatient and outpatient service and currently serves as a preceptor to medical students and nurse practitioner students who rotate regularly through his office. He also currently leads three small group seminars for medical students in their first and second years of training.

Dr. Peyser is also a medical director of an outpatient medical clinic for Duke and is involved with faculty development for the teaching faculty at the medical center.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Learn about innovative teaching methods that extend learning beyond a clinic setting.
2. Explore effectiveness of self-directed learning amongst students.
3. Brainstorm ways to inspire learners to read, study, and learn after the clinic is closed

Abstract:
Busy clinic settings are rich sources for learning for longitudinal students but many constraints exist that preclude extensive periods of teaching during the day. Work volume metrics and packed schedules make it difficult for learners and teachers to sit down for long time periods to review clinical topics. This brief presentation will look at what ways exist to inspire and extend learning beyond daytime constraints, and how can this be incorporated in a way that is comfortable, easy, and effective?

Tasmanian devils are solitary animals that are mostly nocturnal in nature. This is the time when they forage for food, as they spend much of their daytime residing in logs or caves. They are voracious eaters and willingly eat most body parts of their prey, including hair and bones and organs. Our desire is to inspire a comparable vigorous appetite for learning during evening hours.

We have recently begun to experiment with the assignment of work and readings after normal work hours for our students. Faculty will anecdotally self-report successes and failures in these methodologies. When available, literature references will be presented and correlated as well.

Brainstorming and benchmarking with other clinician educators is anticipated for the final third of the presentation with open discussion and sharing of best practices. The goal of inspiring more widespread longitudinal student foraging for learning opportunities at night will be the final focus of the presentation.

References:
The New Education Frontier: Clinical Teaching at Night by Hanson et al, Academic Medicine vol 89, No 2, Feb 2014, 215-218
Patients as teachers or patients as text? Augmenting the active involvement of patients in medical education

Author(s) and Affiliations: Marion Briggs and Sue Berry, Northern Ontario School of Medicine | Kathy Brotchie, Monash University | Robyn Preston, James Cook University

Marion Briggs holds a Bachelor of Science in Physical Therapy (Alberta, Canada), an MA in Leadership from Royal Roads University (BC, Canada), and a Doctorate in Organization Development and Change from the Complexity and Management Research Institute at the University of Hertfordshire (England). Her Doctoral work focused on a deep articulate of healthcare practice from a complexity perspective. She is the Director of Health Sciences and Interprofessional Education at the Northern Ontario School of Medicine.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. Define and differentiate “Patients as Teachers” and “Patients as Text”
2. Experience both clinical learning models through role plays, and discover the unique features of each
3. Articulate the potential advantages and disadvantages of each model in their own context

Abstract:
Medical education is, at least in part, an “apprenticeship” model of learning. Learning from, with, and about patients has always been a critical component of teaching and learning at the bedside and in community-based clinical settings (Spencer et al, 2011). Bleakley et al (2011) introduce the notion of “Patients as Text” (PATxt) as a progression to the more usual Patients as Teachers (PATs) discourse. These two models of an active role for patient’s in medical education can be distinguished in terms of how the roles for and inter-relationships between the preceptor, the student, and the patient are articulated. The PATxt approach supports a more direct relationship between the patient and the learner that is not mediated by the preceptor. It also supports a robust engagement between the learner and an interprofessional preceptor team. In this workshop, participants will experience and explore differences between PATs and PATxt, and consider the potential for each model in their own clinical learning environments.

The workshop begins with a brief overview of the two models of patient involvement in medical education. Two small-group role plays will allow participants to experience these two approaches. Finally, a large group knowledge synthesis discussion will articulate strengths, weaknesses and applicability of the PATxt approach in the participants’ context. This workshop is Part 1 of 2 related workshops. The second focuses on how involving patients as teachers can support community engagement.

This workshop will be of interest to clinical medical educators, students, and anyone who has been a patient.

Feedback on the fly-an innovative approach to student assessment using a smartphone application

Author(s) and Affiliations: Bruce Peyser MD, FACP Duke

Dr. Bruce Peyser is a co-director of the Longitudinal Teaching Program at Duke University Medical Center. He has extensive experience teaching in both the inpatient and outpatient service and currently serves as a preceptor to medical students and nurse practitioner students who rotate regularly through his office. He also currently leads three small group seminars for medical students in their first and second years of training.

Dr. Peyser is also a medical director of an outpatient medical clinic for Duke and is involved with faculty development for the teaching faculty at the medical center.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Briefly provide an overview of methodologies for feedback and assessment of medical learners.
2. Explore new and innovative approaches to observational recording of learners.
3. Brainstorm ways that smartphones and tablets might facilitate and support professional development of medical learners.

Abstract:
The provision of timely and valuable feedback to learners is always a challenge. Busy clinical faculty and insufficiently trained teachers can result in delivery of ineffectual, vague, and/or superficial feedback that is far from inspiring.

How can this be changed, and what could be done differently?

Over the last 18 months, a team of clinicians and web designers at our institution worked together to design an easy-to-use application (APP) for smartphones, tablets, and computers that would allow for the easy recording and collection of observations of learners. The device essentially provides a “scaffolding” that can be used to record and save observations of learners.

After providing an overview of the challenges that relate to the provision of salient feedback, a brief overview of the APP will occur and it will be demonstrated to the group in a “live” simulation. Challenges that include difficulties changing faculty habits and behavior will be presented for discussion and review. The remaining third of the discussion will be interactive.

Faculty Development in Communication Skills Instruction: Insights from a Longitudinal Program with “Real-time Feedback” by Lang et al, Academic Medicine, Vol 75, No 12, Dec 2000 p 1222-1228
Unfulfilled Promise, Untapped Potential: Feedback at the Crossroads, by Watling, C, Medical Teacher, 2014, early online, pp 1-6
Weekly longitudinal student centered primary care seminars

Author(s) and Affiliations: Bruce Peyser, MD, FACP Duke | Joseph Jackson, MD Duke

Dr. Bruce Peyser is a co director of the Longitudinal Teaching Program at Duke University Medical Center. He has extensive experience teaching in both the inpatient and outpatient service and currently serves as a preceptor to medical students and nurse practitioner students who rotate regularly through his office. He also currently leads three small group seminars for medical students in their first and second years of training.

Dr. Peyser is also a medical director of an outpatient medical clinic for Duke and is involved with faculty development for the teaching faculty at the medical center.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Review available literature referable to small group learning process within a longitudinal learning framework.
2. Share best practices for current teaching methods within a small group setting—what works and what doesn’t?
3. Strategize new approaches and innovations to improve upon current curricular outlines and methodologies.

Abstract:
Over the last four years, we have allocated time and resources to support faculty supervision of weekly small group learning within a seminar framework specifically for students within our longitudinal program. Starting with a name change inspired by Dr. Strasser last year from our PeArLs presentation in Montana, we recently revamped our format to include more practical “high value” sessions based upon student identified needs. We added some team based learning and cut back on lecture format. We think our program is more collaborative and more useful to the students.

We would start our workshop by giving an overview of what are seminars entail. We will present details of our goals and objects, as well as our syllabus and weekly schedule.

Next, we will review of summative feedback collected from students and faculty over the past 48 months about our seminar program. We intend to straightforwardly share what has worked, and what needs revamping. We will solicit input and critique of our program by workshop participants.

The third portion of the workshop will entail breaking into smaller discussion groups in order to brainstorm ways to improve upon the small group seminar teaching method for longitudinal students. We will look for innovative ways to improve upon the seminars. Methods for measuring success will be discussed as well.

Finally, the larger group will come back together at the end to share ideas and plans. Priority setting, gain sharing, and willingness to innovate and experiment should all occur as tangible learning outcomes.

Inductive teaching method—an alternate method for small group learning by Jones et al, Medical Teacher, vol 30, 2008, e246-249
Author(s) and Affiliations: Bruce Peyser, MD, FACP Duke | Joseph Jackson, MD Duke

Dr. Bruce Peyser is a co-director of the Longitudinal Teaching Program at Duke University Medical Center. He has extensive experience teaching in both the inpatient and outpatient service and currently serves as a preceptor to medical students and nurse practitioner students who rotate regularly through his office. He also currently leads three small group seminars for medical students in their first and second years of training.

Dr. Peyser is also a medical director of an outpatient medical clinic for Duke and is involved with faculty development for the teaching faculty at the medical center.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Share challenges pertaining to attempts to change large institutions.
2. Review various incentive programs that exist to encourage clinicians to teach.
3. Strategize ways to adjust clinician workload while teaching takes place.

Abstract:
We face several fundamental dilemmas within our institution that disincentivizes teaching for some clinician educators. Despite a strongly vocalized teaching mission within our health system, work volume metrics occasionally thwart policy decisions that would support clinical faculty who teach in the outpatient setting.

At our institution, course coordinators for learners within medical fields have approached the largest 180-member primary care group in order to seek faculty preceptors for longitudinal teaching assignments. Providers had been previously polled involving preferences for teaching rewards and a clear desire for slight work volume reductions was requested in return for ongoing teaching assignments. While recent contractual negotiations resulted in nominal teaching stipends, work volume reductions were not included. As a result, many faculty don’t teach, and program directors are thwarted as they seek to expand their available teaching sites.

While nominal stipend awards are available to some faculty willing to take on longitudinal learners within their office, certain academic programs selectively refuse to allocate these funds—and the money won’t flow to the providers who have volunteered their time. This system is confusing—all divisions are challenged financially and many providers struggle to see enough patients to cover their overhead.

Our questions for the group include:
1) How best to effect change within a primary care group that historically has not embraced a teaching component within its work flow and metric system?
2) How to assist colleagues who would benefit from direct receipt of a nominal teaching stipend and how can departmental fund abduction be routinely thwarted?

Preceptor rewards: How to say thanks for mentoring the next generation of nurse practitioners, by Campbell et al, J Am Acad Nurse Prac 2007; 19:24-29
The satisfaction, motivation, and future of community preceptors: the NC experience, Academic Medicine by Latessa et al 2007; 82 (7) 698-703
How important is money as a reward for teaching? by Peters et al Academic Medicine 2009; 84:42-6
Exposure to public health – A pathway to social accountability

Author(s) and Affiliations: Carole Reeve, Centre for Remote Health, Flinders University

Dr Reeve is a public health physician and general practitioner. She has spent the past 10 years working in rural and remote northern Australia and is currently working in medical education at the Centre for Remote Health in Alice Springs.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Describe the key skills developed during a public health placement.
2. Describe the key desirable outcomes of social accountability in medical education.
3. Discuss the association between public health and social accountability in medical education.

Background:
Social accountability in graduate medical education includes creating a diverse medical workforce to address regional needs, primary care and specialty shortages and providing service to surrounding communities.

Aim:
To evaluate a prevocational public health placement in terms of its contribution to junior doctors knowledge, skills and career path as a measure of developing social accountability.

Method:
All doctors who completed a public health placement during 2001-2012 were invited to complete an online survey to determine their perception of skills and knowledge gained during the placement and the degree to which they believe this placement influenced future career pathways and their current practice.

Results:
- Sixty percent are currently working in general practice or public health medicine; of these, 43% have returned to remote practice. Over 70% reported that the placement developed their knowledge of public health and Aboriginal health to a “great” or “very great” extent. 57% of respondents currently work in Indigenous health at least one day per week, with 30% working in this field full time.
- 43% of respondents currently work in rural/remote health at least one day per week, with 30% working in this field full time
- 65% of respondents currently work with vulnerable groups excluding Indigenous people at least one day per week, with 26% working in this field full time

Conclusion:
Providing the opportunity for prevocational public health and Aboriginal health placement may be a pathway towards social accountability in medical practice and a strategy for decreasing health inequities in the long term.


Worley P, Murray R. Social accountability in medical education—an Australian rural and remote perspective.
Medical students as peer educators in rural schools

Author(s) and Affiliations: A/Prof Lizzi Shires, Rural Clinical School, University Tasmania

Dr Shires is a United Kingdom (UK) trained General Practitioner (GP) and Consultant in Public Health, with extensive experience in Primary Care education and training. She has been a GP for 25 years and has been involved in Australian Rural General Practice for 10 years. Lizzi worked as an Associate Dean in General Practice in North West Thames and then Eastern Deanery in the UK. Lizzi spent 11 years in the UK working at a strategic level developing Primary Care Education and delivering Community Based Education for GPs, Practice Nurses, Health Care staff and students. Lizzi moved to Australia 10 years ago, and now practices part-time at Patrick Street Clinic in Ulverstone.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Developing a Community engagement program with Rural schools facilitated by medical students
2. Developing Medical student leadership and social engagement through teaching school aged students.
3. Development of teaching plans for medical students to engage with primary and high school students

Background:
Students from rural and regional Australia are less likely to go on to tertiary education. Rural Clinical Schools bring young people back into Rural and Regional Areas. Medical students can act as health career advocates and role models in school programs. This presentation describes the development of a program for local schools involving medical students. The schools program develops the medical students leadership, teaching and professional skills.

Results:
In 2010 the Rural Clinical School provided two health career camps for year 9 and 10, which catered for 60 students and involved 6 medical students.

In 2013 the Rural Clinical School provided a range of school programs and visits to the School. All RCS Medical students were involved at least once and all the Colleges, most high schools and some Primary Schools had been engaged across the North West Coast engaging nearly 2000 Rural students.

Conclusions:
Structured Medical Student involvement with Rural School children enhances the medical student and the Rural students curriculum and engagement.

Interventions early in school as a means to improve higher education outcomes for disadvantaged (particularly low SES) students
Blood service fellows transfusion rounds: Engaging the transfusion community in patient blood management

Author(s) and Affiliations: Dr Cindy Flores, Dr Ben Saxon, Dr Beverleigh Quested, Dr Frank Hong, Ms Tracey Spiegel, Australian Red Cross Blood Service

Dr Cindy Flores is a Project Officer for the Transfusion Practice and Education at the Blood Service. Cindy has a background in medicine, health and international development. Her role at the Blood Service involves pursuing health and medical education for stakeholders of blood, in order to further improve blood safety and transfusion practice.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Assess the Blood Service Fellows Transfusion Rounds program as a way of engaging with the transfusion community.
2. Demonstrate technology that brings together transfusion community across Australia and its benefits to the transfusion community.
3. Share outcomes of conducting Transfusion Rounds to promote a broader understanding of patient blood management principles to improve patient outcomes.

Background:
Transfusion medicine supports different clinical specialties. The paradigm of blood transfusion has shifted to the concept of patient blood management (PBM), which recognises that transfusion is only one facet of a patient’s overall care. Health professionals involved in transfusion need a broad understanding of PBM to apply evidence-based medical and surgical concepts designed to maintain haemoglobin concentration, optimise haemostasis and minimise blood loss in an effort to improve patient outcome.(1) The paradigm shift to PBM prompted the Blood Service to form a network of health professionals with an interest in transfusion practice, the Blood Service Fellows, who promote PBM principles through local clinical practice change and community interactions in Transfusion Rounds.

Aims:
Adapted from a hospital grand round concept, the Transfusion Rounds program utilises the expertise of the Blood Service Fellows to connect with, and influence, the transfusion community, both locally and nationally. It aims to enhance engagement with health professionals across a broad range of specialty areas to promote transfusion community interaction and provide expert clinical opinion in patient blood management. Transfusion rounds provided an inter-professional learning environment.

Methods:
Four transfusion rounds were conducted in Melbourne, Brisbane, Orange NSW and Adelaide in 2013. Participants had the option to attend in-person locally or via online web technology, allowing interstate participants to join in the discussion. An online survey was available after each event to get feedback from participants.

Results:
A total of 267 participants, representing medical specialists, nurses and scientists, attended the Transfusion Rounds from across Australia and 32% provided feedback. On a five-point Likert-type scale, the invited speakers were rated on average 4.8 for their expertise in PBM, 4.6 for advancing participant’s knowledge of PBM, and 4.5 for establishing rapport with the audience and responding to individual needs. Fifty-nine percent of participants rated that the rounds entirely met their learning needs (40% partially met, <1% not met). Many participants indicated that the online technology was invaluable so they could join in the presentation and discussion. Overall, participants were either very satisfied or satisfied with Transfusion Rounds and majority (95%) found it to be a useful continuing medical education event for the transfusion community.

Conclusions:
The Transfusion Rounds program paved the way for the Blood Service and its Fellows to connect with the transfusion community. Online web technology was invaluable as it invited more participants to join in the interprofessional learning event as an alternative to attending locally in person. The Blood Service Fellows showcased their clinical expertise at the Transfusion Rounds to promote a broader understanding of PBM in an effort to influence transfusion practice that improves patient outcomes.

Interventions early in school as a means to improve higher education outcomes for disadvantaged (particularly low SES) students


Medical students as agents for social change in a rural area?

Author(s) and Affiliations: A/Prof Lizzi Shires, Rural CLinical School, University Tasmania.

Dr Shires is a United Kingdom (UK) trained General Practitioner (GP) and Consultant in Public Health, with extensive experience in Primary Care education and training. She has been a GP for 25 years and has been involved in Australian Rural General Practice for 10 years. Lizzi worked as an Associate Dean in General Practice in North West Thames and then Eastern Deanery in the UK. Lizzi spent 11 years in the UK working at a strategic level developing Primary Care Education and delivering Community Based Education for GPs, Practice Nurses, Health Care staff and students. Lizzi moved to Australia 10 years ago, and now practices part-time at Patrick Street Clinic in Ulverstone.

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Evaluating Community benefit from having a Rural Clinical School in their Community.
2. Develop an evaluation framework for student community engagement in School.
3. Students as agents of social change.

Abstract:
Rural Clinical Schools have to report on how their presence has benefited the communities in which they are placed. The Rural Clinical School in Tasmania has developed a Community Engagement program using medical students in Schools. The Rural Clinical School is situated on the NW Coast of Tasmania which has one of the highest rate of youth unemployment and failure to progress in Tasmania.

The Rural Clinical School is the only organisation that brings large numbers of young people to the NW coast to study and work. Most young people who go on to tertiary education have to leave the coast so it is hard for school aged children to see many young successful and engaged youth in higher education.

Most children at school on the North West Coast will not have parents who have been in tertiary education.

The long term goal of this program is to increase student recruitment to tertiary education and health careers in particular. Medical Students work as peer educators and (hopefully) engaged and enthusiastic young people who can inspire school children to stay on at school and aspire to tertiary education.

• Will this work?
• How will we know if we don’t measure it?
• How should we develop an evaluation framework for the benefits of having RCS engaging with schools?
• Developing measurement outcomes and/or evaluation of community engagement and developing social accountability in Rural Areas?
• What proxy measures could we look for in the short term?

Interventions early in school as a means to improve higher education outcomes for disadvantaged (particularly low SES) students
A proposed innovative model in interprofessional longitudinal learning focusing on the care of seniors and the potential role for developmental evaluation (DE)

Author(s) and Affiliations: Marion Briggs, DMan, Director of Health Sciences and Interprofessional Education, Northern Ontario School of Medicine | Janet McElhaney, MD, Northern Ontario School of Medicine (Sudbury) | Maurianne Reade, MD, Northern Ontario School of Medicine (Manitoulin Island)

Marion Briggs holds a Bachelor of Science in Physical Therapy (Alberta, Canada), an MA in Leadership (BC, Canada), and Doctorate from the Complexity and Management Research Institute at the University of Hertfordshire (England). Her research interests are in understanding healthcare practices through a social complexity lens and on the integrated development and application of knowledge derived from competing theoretical perspectives, in health professional classroom and clinical education settings. She is the Director of Health Sciences and Interprofessional Education at the Northern Ontario School of Medicine and a Fellow with the AMS Phoenix Foundation.

Abstract Stream(s): Longitudinal Learning, Community Engagement, Social Accountability

Learning Objectives:
1. Evaluate a proposed innovative model of interprofessional longitudinal learning in health professional education that supports the student experience as companion, provider and collaborator in the care of seniors.
2. Examine development evaluation and its potential application to longitudinal learning
3. Construct a framework to advance the proposed (or modified) model

Abstract:
Educators are challenged to incorporate two competing kinds of knowledge into health professional education programs. One is “best practice” characterized by objective standardization; the other is “critical practice” characterized by the improvisation needed when applying best practice principles to individual patients in specific contexts (Stepney, 2011). This challenge is particularly relevant to the highly complex issues in the care of seniors in rural and remote communities. We suggest that longitudinal interprofessional education (Preen, 2005) supported by DE (Gamble, 2008) may be one way to enhance health professional education in the complex care of seniors. Consistent with changing population demographics and medical schools’ commitment to social accountability, this approach may increase interest and competence among health care professionals in providing care for this vulnerable population. Finally, we believe that this proposed application of complexity theory will support a deep exploration of the lived experience of longitudinal collaboration between patients, students, and practitioners throughout the education experience.

The workshop begins with an overview of the proposed innovative longitudinal interprofessional learning strategy including the integration of DE. Participants will then explore the benefits and challenges of this approach and the potential application of it in their rural/remote communities. The workshop will conclude with a knowledge synthesis discussion to identify a framework for advancing this model.

This workshop will be of interest to clinical medical educators, students, and anyone who is or has been a caregiver for an older patient.

A multi-perspective evaluation of a new rural campus in England

Author(s) and Affiliations: M. H. Bartlett, Keele University School of Medicine, UK | K. Pritchard Institute of Rural Health, UK | L. Lewis Institute of Rural Health, UK | R. B. Hays University of Tasmania | R. K. McKinley Keele University School of Medicine | To be presented by Richard Hays

Maggie Bartlett is a Clinical Lecturer in Medical Education at Keele University, Staffordshire, UK. She is the lead for community education in Shropshire which includes a small rural campus for eleven undergraduate medical students. She also leads a clinical reasoning course in year 4 of the undergraduate program. She teaches on the postgraduate certificate in medical education program, and teaches pharmacists on an independent prescriber’s course. She is a trainer for the General Medical Council’s performance assessors, and a GP appraiser. Her research interests are in the quality of teaching in community based medical education, faculty development, and clinical reasoning.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. Students are not educationally disadvantaged by learning in remote and rural practices.
2. Patients unused to undergraduate learners are generally willing to have them involved in their consultations.
3. Primary Care tutors enjoy teaching despite increased workload.

Background:
Keele Medical School established a small ‘rural campus’ in a town with a population of 10,000 in 2011. Groups of eleven final year students spend fifteen weeks on placement in the associated general practices, learning generic clinical skills [1] based on the principles of longitudinal integrated clerkships [2].

Aims:
To evaluate the rural campus from the perspectives of the students, the GP tutors, the community hospital staff and the patients.

Method:
Ethical approval was granted by relevant authorities. Serial focus groups were held with students throughout their placements. Students’ examination results were compared with those of the whole year group. Semi-structured interviews were held with GP tutors and community hospital staff. A patient survey was conducted by questionnaire; three cohorts of patients were sampled; those who had never consulted with a medical student, those who had in the past, and those who had on the day.

Results:
Students reported positive learning experiences, but had concerns about travel, isolation, acceptance, and perceptions of injustice. OSCE scores suggest no educational disadvantage. GP tutors reported high levels of enjoyment but an impact on workload. Community hospital staff reported a wish to be more involved in inter-professional learning. Patients reported high levels of satisfaction with teaching consultations, and a wish to help educate future doctors.

Conclusions:
Teaching and learning in a rural community in England has had many positive impacts. The evaluation has identified some areas for development regarding students’ perceptions of isolation and injustice and the development of inter-professional education in community hospitals.

Changing perceptions of final year medical students throughout a fifteen week placement in rural primary care: a study using serial focus groups.

Author(s) and Affiliations: MH Bartlett (Keele University School of Medicine UK), RB Hays (University of Tasmania, Australia), RK McKinley (Keele University School of Medicine, UK) | To be presented by Richard Hays

Maggie Bartlett is a Clinical Lecturer in Medical Education at Keele University, Staffordshire, UK. She is the lead for community education in Shropshire which includes a small rural campus for eleven undergraduate medical students. She also leads a clinical reasoning course in year 4 of the undergraduate program. She teaches on the postgraduate certificate in medical education program, and teaches pharmacists on an independent prescriber’s course. She is a trainer for the General Medical Council’s performance assessors, and a GP appraiser. Her research interests are in the quality of teaching in community based medical education, faculty development, and clinical reasoning.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. To discuss students’ responses to being allocated to rural placements.
2. To discuss optimum lengths of community placements.
3. To consider how students’ views may change throughout a community placement.

Background:
Keele Medical School established a small ‘rural campus’ in a town with a population of 10,000 in 2011. Groups of eleven final year students spend fifteen weeks on placement in the associated general practices, learning generic clinical skills [1]. The placements are based on the principles of longitudinal integrated clerkships[2].

Aims:
The study aimed to explore the expectations and perceptions of a single cohort of students before, during and at the end of their placement.

Method:
Ethical approval was granted by the school’s ethics committee in advance of the project. All students in the group allocated to the rural campus for the period August to December 2013 were invited to participate in focus groups in weeks zero, seven, and fifteen of their placements. Transcripts of the meetings were analysed thematically.

Results:
10 students participated in the first focus group, five in the second and eight in the third. Six major themes were identified. The themes of ‘isolation’ and ‘facilities’ waned through the placement, ‘travel’ and ‘injustice’ peaked in the middle, ‘teaching and learning’ and ‘personal development’ increased as time went on. In week zero some students considered fifteen weeks in primary care too long, but by week fifteen they expressed a desire to stay longer. All described a good experience overall with positive impacts on their decision making skills, confidence, career planning, and their preparedness for clinical practice.

Conclusion:
Fifteen weeks in rural general practice provided this group of students with rich experiences for learning and personal development.

Community engagement with a patient-centered approach

Author(s) and Affiliations: Sue Berry - Northern Ontario School of Medicine | Marion Briggs - Northern Ontario School of Medicine | Kathy Brotchie - Monash University, School of Rural Health | Robyn, Preston - James Cook University

Sue Berry, Associate Professor, within the Division of Clinical Sciences at the Northern Ontario School of Medicine, and Assistant Professor within the School of Rehabilitation Science at McMaster University is the Executive Director of Integrated Clinical Learning. For the past 25 years, her experience in academic administration and expertise in developing innovative approaches in health professional education has led to innovative education initiatives. Her passion for working collaboratively with communities and educational institutions resulted in four successful grants enhancing interprofessional learning and practice in Northern Ontario. Currently, Sue is also affiliated with NOSM's involvement in the Canadian Interprofessional Health Leadership Collaborative (CIHLC).

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Explore the power of PATS in their health care teaching practice from a community engagement perspective.
2. Discuss the enablers and challenges of incorporating PATs into learners' placement.
3. Apply patient-centered approaches for learners learning through and with patients.

Abstract:
Patients / clients as potential teachers (PATS) are often an unconsciously forgotten source of teachers for learners on placement or as they engage with people in non-health care settings simply as corporate citizens. Most often, patients are not encouraged to offer a deep reflection about their own experience of illness or injury or to provide constructive feedback to learners.

A PATS community-engaged approach can supplement clinical education, relieving the teaching burden and reducing preceptor burnout; providing learners with rich opportunities to learn first hand about complex illness from the patient's perspective; providing feedback that results in sustained behavior change; and engaging the student in understanding the social determinants of health. Patients also benefit from being accorded an active role in education and not just a passive recipient of disembodied health care.

Using case studies and/or simulation, this interactive small group workshop will allow participants to: explore the power of PATS in their health care teaching practice from a community engagement perspective; discuss the enablers and challenges of incorporating PATs into learners' placement; apply patient-centered approaches for learners learning through and with patients.

This 90 minute workshop will stimulate discussion through addressing the following questions – how do I build the capacity of teachers in small communities; what evidence demonstrates the effectiveness of patients as teachers in clinical education; what tools are available in fostering an engagement of patients/clients in the teaching process. This session will be of key interest to preceptors, faculty development educators, learners, volunteer simulated patients and administrative community individuals.

Joseph K. Eibl (PhD) is Research Lead for the Postgraduate Medical Education department at the Northern Ontario School of Medicine. Dr. Eibl is an active researcher in the field of health systems research. His goal is to work with learners, faculty, and researchers to develop exciting research opportunities which improve the health of the people of Northern Ontario.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. What is a health systems research platform?
2. How to leverage a health systems research platform to facilitate impactful community-based research among distributed faculty and learners.
3. Understanding the administrative capacity required to facilitate a distributed health system research platform.

Background:
Historically, research has been the domain of university campuses and teaching hospitals. More recently, training programs have shifted towards a distributed community-based model of medical education. Thus, new strategies to foster research among distributed medical students, residents, and faculty have started to evolve from traditional models. Geography poses a central challenge to aligning a research team composed of learners and mentors who share common research interests but are spatially separated. Thus, in the distributed community engaged model of medical education developed by the Northern Ontario School of Medicine (NOSM), alternative models to support research have become a necessity.

Aim:
Here we describe a strategy to support community-based interdisciplinary research by leveraging a health systems data platform across rural and urban geographies.

Methods:
In collaboration with community stakeholders across Northern Ontario, NOSM has partnered to open a network of health systems research centers which are responsive to the needs of the communities they serve. Core services are provided at the Institute for Clinical and Evaluative Sciences in Sudbury, while community-based expertise is extended across a network of remote sites.

Results:
By leveraging a community-responsive health systems research platform, we are able to link learners, faculty, and content experts across the rural and remote communities of Northern Ontario. By having access to health systems data, research questions of regional and international importance can be addressed by spatially distributed research teams.

Discussion:
NOSM has employed this strategy to promote impactful and distributed research and research training across Northern Ontario (>800,000 km2). Postgraduate learners and faculty from generalist and specialty training programs are accessing this platform to conduct meaningful community-responsive research.
The juice bar and more! Building a holistic student experience for successful collaboration, integration and development in a rural community

Author(s) and Affiliations: Dr A. Griscti (1,2), S. Lobzin (1), P.D. Mills (2), J Greenhill (1), L Walters (1)
(1)Flinders University Rural Clinical School, (2)University of Adelaide Discipline of Rural Health

I am a rural procedural General Practitioner in Angaston, South Australia, where I have lived and worked for 11 years. I have special interests in obstetrics, child health and lifestyle medicine in addition to a passion for clinical education. For the past 2 years I have also taken on the role as a Clinical Educator for both Flinders University and the University of Adelaide. I lead a faculty of GPs who host the same medical students for the entire academic year in a longitudinal integrated curriculum known as the PRCC (Parallel Rural Community Curriculum). I am currently studying a Graduate Certificate in Clinical Education with Flinders University. I am married to Jenny and have four adult sons. In my spare time I enjoy traveling, football (soccer), studying and enjoying ways to maintain vibrant health.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To explore successful strategies to allow students from diverse backgrounds to connect with each other as a cohesive and functional group.
2. To explore strategies to successfully connect students with the community in which they have been placed.
3. To understand the overarching processes of engagement are facilitated by activities such as creating and sharing fresh juice.

Abstract:
The Barossa Valley Parallel Rural Community Curriculum is a unique student adventure. Its home is in the beautiful Barossa Valley, well known for food and wine, with the added appeal of the rural lifestyle/community. This program brings medical students from two different universities with two distinct curricula together for a year of learning, in the penultimate year of their medical courses. As the students embark on this year of adventure, little do they realize it’s not only about medicine, but about life: out of their comfort zone; with a new group of people; potentially a new culture, community and lifestyle. This adventure requires a holistic view of education from an educators’ perspective with clear objectives around student collaboration, integration and development of the student group.

1. What strategies work to connect students from diverse backgrounds with each other as a cohesive and functional group?
2. How can health professional education organisations successfully connect students with the community in which they are placed?
3. How do we know that engagement processes are successful?

Who the presentation appeals to:
Successful engagement strategies can bond students to each other and to their host community so ‘I’ becomes ‘we’ and ‘them’ becomes ‘us’. This presentation will appeal to clinicians, program academics and professional staff interested in changing the personal identity and group dynamics of their students.
Longitudinal integrated clerkships – a model for facilitating medical student resilience

Author(s) and Affiliations: Janet Richards, Dr Leesa Walker, Dr Ken Fielke, Dr Lucie Walters, Professor Jennene Greenhill

Janet Richards is employed as a research assistant with the Flinders University Rural Clinical School in Renmark where she has been involved with research into Medical Education, Workplace Integrated Learning in the clinical environment and Interprofessional Education. This research has resulted in her co authoring several published papers and presenting at conferences in Australia and New Zealand. Janet has a Bachelor of Applied Science in Medical Laboratory Science from the South Australian Institute of Technology and worked as a medical scientist with the Red Cross Blood Transfusion Service in Adelaide and later managed a private pathology laboratory in Berri, before changing her career direction and joining the rural clinical school in 2009. She is currently studying part-time toward an Honours Degree in Health Science. She has an interest in rural and remote health and in improving rural health services.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To highlight the importance of developing resilience in clinical learners.
2. To challenge the simplistic notion that students only require physical and emotional support to thrive.
3. To understand a conceptual framework for integrating resilience development into clinical training.

Introduction:
It has been argued that medical students need to be prepared for the challenges of both clinical training and practice, through developing skills to address and maintain one’s mental health and wellbeing. Central to this is resilience, a culturally and contextually sensitive construct. This study aims to understand how resilience is challenged and supported in third year medical students undertaking a rural longitudinal integrated clerkship (LIC). For the purpose of this research resilience is defined as a “dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma.”

Method & Results:
Purposive recruitment was undertaken of students (past and present), administrators and clinical educators of a LIC program. Semi-structured interviews were digitally recorded and the transcripts were coded and analysed for emergent themes using a grounded theory approach.

Results:
The main themes that emerged from this qualitative research were: student distress, the safe haven, the journey within and staying on course. Despite significant challenges, student resilience was ensured when: peers, professional staff and clinicians provided a safe haven; when students were self-aware and invested in self-care; and when expert guides and the curriculum compass assisted students to stay on course.

Conclusions:
The research findings challenge the simplistic notion that students only require physical and emotional support. Whilst these are important to build resilience, the curriculum needs to provide opportunities for agentic, reflective and transformative learning. This constructivist learning process helps students navigate stressful events and shape their future professional identity.

The clinical and operational benefits of point-of-care testing for Aboriginal people from remote communities in Australia’s Northern Territory

Author(s) and Affiliations: Brooke Spaeth and Professor Mark Shephard, Flinders University International Centre for Point-of-Care Testing, Adelaide, Australia | To be presented by Prof Mark Shepherd

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. To demonstrate the practical benefits of POCT for Aboriginal patients living in remote Australia.
2. To highlight the operational efficiency of POCT in remote clinical settings.
3. To demonstrate the clinical benefits of POCT for acute care management in Indigenous remote settings.

Background:
Australia’s Northern Territory (NT) is very remote and has high disease burdens among its Aboriginal population. In 2008, the NT Department of Health partnered with the Flinders University International Centre for Point-of-Care Testing to introduce a quality-assured point-of-care testing (POCT) service in 43 remote health centres in the Territory. The device used (Abbott i-STAT) enables immediate test results for acute and chronic diseases to be used for clinical management.

Aim:
To improve access to pathology testing in remote Aboriginal communities in the NT.

Materials:
Health professionals are trained and received competency certification through flexible training programs including workshops and e-learning. A quality management program has been implemented to monitor analytical quality of POCT, and health centre managers receive regular feedback reports on management statistics. An annual evaluation report audits key performance indicators of effectiveness.

Results:
705 health professional staff have been trained as qualified POCT operators. Over 35,000 i-STAT tests have been performed across the first five years, with INR, electrolytes and troponin the most widely used. Analytical quality for POCT has met profession-based analytical goals. Clinical effectiveness of POCT for acute and chronic conditions has been demonstrated by an audit of clinical cases. Cost effectiveness has resulted from saved medical retrievals. 80% of remote staff believe POCT has assisted in the stabilisation of acutely ill patients.

Discussion:
The NT POCT Program has proven operationally effective, analytically sound, clinically and culturally effective. Challenges for sustainability include maintaining standards of training and quality in the face of high staff turnover.
Medical students being IMMERSed into a “Virtual clinical setting”

Author(s) and Affiliations: Kellie Britt, Lecturer in Medical Education - Simulation & Clinical Skills

Kellie started her health career as a nurse at Box Hill & District Hospital in the 80’s. After completing post graduate degrees in Critical Care Nursing and Education, she held a variety of roles as a clinician leading to Management & Education positions in both the Public and Private Health Sectors. Kellie’s initial role at Deakin University was to assist in the establishment of the School of Medicine’s curriculum for medical students in the delivery of clinical skills using the simulated learning environment.

Kellie is currently a Lecturer in Medical Education and provides Simulation Operations for the School of Medicine. She is a qualified Harvard Simulation Instructor and is working on the development and delivery of several collaborative simulation programs for all levels of professionals involved in healthcare and emergency service teams. Kellie has a special interest in simulation debriefing and the ability to use the simulation as a teaching modality in our rural and regional communities.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. To identify deficits in student teaching.
2. To develop strategies to provide equality of student teaching.
3. To develop strategies to promote equity in student learning.

Background:
Deakin University medical students who join the IMMERSe (Integrated Model of Medical Education in Rural Settings) Program participate in an LIC for the entirety of their clinical third year. The year’s academic teaching is based on six disciplines including Mental Health, Children’s Health, Women’s Health, General Medicine, General Surgery and Musculoskeletal Medicine undertaken in general practices in rural towns.

The IMMERSe program was reviewed in 2013 as part of the wider review of the Deakin University medical course. During this review concerns were raised regarding;

- The equality of student teaching compared to the rest of the third year cohort based at the larger hospital-based clinical schools.
- IMMERSe students believed they were disadvantaged as they did not encounter patients with ‘common conditions’ denoted by the Year 3 curriculum, when compared with larger clinical schools.
- Therefore, IMMERSe students perceived some disadvantage in their assessments.

Aim:
The aim of the “Virtual Clinical Setting” Program has been consistent in; the simulated environment allows students to demonstrate their knowledge and to practice both clinical and non-technical skills without time pressure and / or risk of causing harm to ‘real’ patients or themselves. It will also provide equality of student teaching and equity in student learning outcomes as compared to the rest of the year 3 cohort.

Method:
A “virtual clinical setting” was created to expose the IMMERSe students to a number of different patients with a variety of common medical conditions. Using the simulated learning environment (SLE), manikins and simulated patients were used to mimic clinical patient scenarios.

Results:
SLEs have been embraced as a teaching method throughout university medical schools. Our students appear to have benefited from this modality, which allows them to practice as medical professionals in a safe environment which mimics the ‘real’ workplace. The student evaluations post attendance in the “virtual clinical setting”, indicate they are confident in managing patients and they feel prepared to work in their rural clinics and hospitals.

Conclusion:
Educational literature supports that better clinical placements in the final years leads to smoother transitioning for medical students to into internship (AMA 2007; Gome, Paltridge & Inder 2008). In our experience, we have observed the “virtual clinical setting” teaching program has provided our students with a foundation to build their professional careers (Goldacre, Davidson & Lambert 2003).

AMA 2007, Position Statement Pre-Internship In Medical School.
The collaborative community engagement – “Working in health teams” education project

Author(s) and Affiliations: Kellie Britt, Lecturer in Medical Education - Simulation & Clinical Skills

Kellie started her health career as a nurse at Box Hill & District Hospital in the 80's. After completing post graduate degrees in Critical Care Nursing and Education, she held a variety of roles as a clinician leading to Management & Education positions in both the Public and Private Health Sectors. Kellie's initial role at Deakin University was to assist in the establishment of the School of Medicine's curriculum for medical students in the delivery of clinical skills using the simulated learning environment.

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Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. To identify who are the health team members of the Community.
2. To identify what are the education needs for the health team members of the Community.
3. To develop a collaborative education project this promotes excellent patient outcomes.

Background:
Deakin University medical students who join the IMMERSe Program are allocated amongst ten rural towns across Western Victoria. The IMMERSe program was reviewed in 2013 as part of the wider review of the Deakin University medical course. During this review it was identified by the IMMERSe academic team they would like to work collaboratively with their rural healthcare professionals to develop a ‘Working in Health Teams” education project to demonstrate Deakin University’s position on;
• As an education provider who was genuinely concerned about ongoing education provision to those towns who had limited resources to conduct these programs themselves.
• Providing an educational opportunity for healthcare professionals, healthcare students and emergency services staff to practice working together to enhance patient and staff safety and promote excellent patient outcomes.
• Sharing it’s educational resources and giving back to our communities who assist in the teaching of our IMMERSe medical students.

Aim:
Identify areas of educational needs in rural town communities and provide an education program where there are limited educational resources with respect to equipment, time, finances and experienced educators to ultimately promote excellent patient outcomes.

Method:
• Identify areas of both technical and non-technical education needs
• Identify who are the community team members
• Design and implementation of a one day simulation scenario program (8 scenarios) involving all the roles of the community team members
• Evaluation of the program

Results:
Our results are yet to be evaluated as the first programs will be implemented in May 2014 in two rural towns. It is anticipated the participants will benefit from this program as the program has been designed on the clinical needs of each rural town. The participant’s will have had the opportunity to experience the following;
• Be a team member
• Gain an understanding about the roles and responsibilities of leaders and followers
• Have insight into the challenges of communication and task delegation
• To have the ability to perform and practise clinical skills and clinical decision making all in an effort to promote excellent patient outcomes

Conclusion:
As discussed by both Gaba and Issenberg, learners who participate in simulation training scenarios have a greater understanding of the complexities of team work. After the opportunity to practice learners develop strategies to produce effective teamwork which results in excellent patient outcomes.

Gaba, DM 2004, ‘The future vision of simulation in healthcare’, Qual Saf Health Care, 13 (suppl) 1:2-10
75 Engaging local community members as standardised patients for clinical simulation

Author(s) and Affiliations: C Nobes, L Walters, D Abbot, L Rogers, S Lobzin, J Rutzen, L Walker, D Hough, A Griscti, P Vijayanand, J Steyn, D Rosenthal, P Michelmore, J Greenhill | To be presented by Jennene Greenhill

Chris Nobes is a Registered Nurse based in Mount Gambier, South Australia who has worked as a nurse educator for many years, and has a Masters in Clinical Education. In 2010 she was one of a group of Flinders University academics recognised for outstanding contribution to student learning in high fidelity patient simulation from the Australian Learning and Teaching Council. Chris has had a special interest in utilising standardised patients (SPs) and in April 2012 she contributed to the inaugural AusSETT Simulation Trainers Program. When she is not teaching, Chris and her husband fill their days with important grandparent duties.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To explore how community members can be engaged in meaningfully in medical student education as standardised patients.
2. To consider how best to prepare, support and debrief standardised patients.
3. To discuss challenges associated with this form of community engagement.

Abstract:
Clinical simulation scenarios using standardised patients allow students to practice and refine communication and clinical judgement skills before imposing them on potentially vulnerable patients. At the same time, people who take on the roles of standardised patients are privy to the strengths and weaknesses of the students that they may also encounter in the clinical setting. Their roles as standardised patients are often enriched by their own personal experiences of illness. However these experiences can be a two edged sword with the risk that they can identify strongly with the characters they play.

Community engagement strategies adopted by community-orientated health professional education organisations must be symbiotic, with both community and learning institution benefiting from the liaison. This workshop seeks to ask the hard questions about standardised patients as a community engagement strategy

1. What strategies work to engage community members as standardised patients in clinical simulation?
2. How can health professional education organisations successfully prepare, support and debrief community members when they are working as standardised patients? And what are the challenges we need to look out for?
3. How do we measure the success (or otherwise) of standardised patient for community member engagement?

Who the presentation appeals to:
Clinical teachers, program directors, students and community members, and all those who have been co-oped into playing the role of a standardised patient!
Effectiveness of inter-professional learning in clinical simulation scenarios using standardised patient

Author(s) and Affiliations: Nobes C, Walters L, Kumar K, Hough D | To be presented by Stefanie Lobzin

Chris Nobes is a Registered Nurse based in Mount Gambier, South Australia who has worked as a nurse educator for many years, and has a Masters in Clinical Education. In 2010 she was one of a group of Flinders University academics recognised for outstanding contribution to student learning in high fidelity patient simulation from the Australian Learning and Teaching Council. Chris has had a special interest in utilising standardised patients (SPs) and in April 2012 she contributed to the inaugural AusSETT Simulation Trainers Program. When she is not teaching, Chris and her husband fill their days with important grandparent duties.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To explore the effectiveness of inter-professional learning using standardize patients.
2. To consider if evaluation tools exist.
3. To discuss how to make best use of the experience of standardized patients in the debriefing process.

Abstract:
Clinical simulation scenarios using standardised patients (actors) provide opportunities for learners to practice communication skills in clinical scenarios particularly in inter-professional team practice scenarios such as emergency department work. Community members who volunteer as standardised patients often choose to be involved on a number of occasions, experiencing their standardised patient role as a longitudinal learning experience.

Questions for discussion:
How can we evaluate the effectiveness of inter-professional learning using standardised patients in clinical simulation scenarios? What tools exist? How are these validated? How can we make best use of the experience of standardised patients in the debriefing process of simulation training?

Who the presentation appeals to:
Simulation has an important role in teaching new skills and renewing and maintaining previously learned skills particularly for uncommon and critical conditions. This presentation will appeal to clinical educators involved in simulation training for learners of new clinical skills such as medical students and registrars; as well as for providers of continuing professional development for clinicians.
Impact of sub-quota selection on rural career

Author(s) and Affiliations: Rutzen J, Walters L, Rosenthal D, Liu S, Greenhill J, Flinders University Rural Clinical School

Since 2002, Jo Rutzen has worked as a rural GP in a group practice in Loxton, in the Riverland, South Australia. Her interest in medical education began as the GP Supervisor for 2 students undergoing a longitudinal integrated community based clerkship in general practice as part of the PRCC (Parallel Rural Community Curriculum) through Flinders University almost 10 years ago. In 2012 she took on the Clinical Educator role for the 3rd year PRCC (Parallel Rural Community Curriculum) Medical Students based in the Riverland. Jo is also the Treasurer for the Rural Doctors Association of SA. She completed her Certificate in Clinical Education in 2005 but is a newcomer to the world of research. Her limited spare time is spent with family and friends, gardening, curled up with a book or playing bridge.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To understand the impact of an affirmative selection policy for rural students into medical school.
2. To consider how community engagement in medical student selection can influence rural workforce outcomes.

Background:
Flinders University has rural Community Liaison Committee which is responsible for selecting four students into the Graduate-entry medical program[1]. This selection process which commenced in 1998 seeks to preference rural students with a commitment to rural practice to gain entry into medicine.

Recent students have demonstrated that rural clinical school exposure can increase rural medical career uptake. This alumni-tracking study seeks to explore the impact of the combine effect of sub quota selection and longitudinal integrated clerkship on rural medical workforce outcomes.

Methods:
All Flinders University Alumni completing surveys including PGY1, PGY 2 and PGY3 will be analysed to determine whether independent variables including: subquota selection, rural origin, initial rural career intent, attendance at RCS, enjoyment of and RCS experience influence dependent variables of current and future geographical location of medical practice.

Conclusion:
The Flinders University rural sub-quota is purported to be a socially accountable selection method which provides i) an affirmative selection policy for rural students; ii) community empowerment within the University iii) a rural workforce solution. The results of this report card will ensure that Flinders University is accountable to these aims.

How to make social accountability accountable

Author(s) and Affiliations: Carole Reeve, Senior Lecturer, Centre for Remote Health, Flinders University | Lucie Walters, Associate Prof, Flinders University | Prof Richard Murray, JCU and Assoc Prof Sarah Larkins JCU

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Explore how best to support students to become more socially accountable.
2. Discuss possible assessment methods for measuring social accountability.
3. Describe the desired outcomes of increased social accountability in medical education and they might be evaluated.

Abstract:
The Global Consensus for social accountability of medical schools consists of ten strategic directions for medical schools to become socially accountable, highlighting improvements to:

- Respond to current and future health needs and challenges in society
- Reorient their education, research and service priorities accordingly
- Strengthen governance and partnerships with other stakeholders
- Use evaluation and accreditation to assess performance and impact

Both James Cook University and Flinders University are founding members of THEnet, a consortium of health-professions institutions of learning committed to achieving health equity through education, research and services responsive to community priorities. In this session will focus on how to reorient medical education to respond to current and future health needs and challenges and how to evaluate the resulting performance and impact.

Questions for discussion:
How can we best inspire students to develop social accountability?
What assessment methods capture the development of social accountability in students?
How can increased social accountability in students be evaluated?
How can community participation play a role in increasing social accountability?

Who the presentation appeals to:
Social Accountability in medical education is gaining recognition as important globally. This presentation will appeal to medical educators with an interest in developing social accountability in their students and community members interested in being involved in curriculum development.

Designing ‘community’ into a distributed community-engaged curriculum

Author(s) and Affiliations: Tim Dubé, PhD, Northern Ontario School of Medicine | John Dabous, Northern Ontario School of Medicine | Christina Tremblay, Northern Ontario School of Medicine

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Describe the Northern Ontario School of Medicine’s distributed community-engaged learning model.
2. Explain instructional design strategies to extend ‘community’ in the curriculum.
3. Demonstrate the characteristics of community embedded within an online learning environment.

Abstract:
At the Northern Ontario School of Medicine (NOSM), the distributed community-engaged learning model bridges students and communities with the use of supportive technology. Faculty and preceptors located in over 75 communities across Northern Ontario are engaged in the teaching and learning across all four years of the undergraduate medical program.

Throughout the MD program at NOSM, the curriculum is interwoven across five themes delivered via a learning management system, Moodle. It is within this online learning environment where curricula for these five themes are contextualized in a case-based format representing real and fictional communities and clinical settings in Northern Ontario. NOSM’s social accountability mandate provides the “instructional fabric” through which these community and clinical contexts, as well as the patient and health care participants described in the cases, are extended in the curriculum to reflect the socio-demographic, linguistic, and cultural realities of the populations the School is meant to serve. The significant breadth of community-engaged learning, such as three four-week placements and an eight-month longitudinal clinical clerkship, is intended to ultimately prepare NOSM students for postgraduate training and eventual practice in Northern Ontario.

The presentation aims to describe the role of Instructional Designers at NOSM in relation to extending the concept of ‘community’ in a unique and complex curriculum. Recommendations will be proposed in relation to the instructional design strategies involved with maintaining the characteristics of community during curriculum development and renewal, as well as considerations to progressively innovative how community can be extended in the curriculum.


81 Evaluation of Longitudinal Integrated Flinders Training (LIFT) 2013

Author(s) and Affiliations: Dr Gayle Roberton | Professor Lambert Schuwirth | Assoc. Prof. William Heddle

Dr Gayle Roberton worked as a consultant anaesthetist in Melbourne and Adelaide for 25 years. She then became interested in medical education and worked as a Senior Lecturer in Curriculum Development at Otago University in New Zealand and at Flinders University since 2011.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Report results of a clinical reasoning test
2. Report evaluation of a LIC in a teaching hospital
3. Promote discussion of assessment of academic ability in a LIC

Background:
In 2013 Flinders University ran a pilot Longitudinal Integrated Flinders Training (LIFT) of 8 students in a tertiary teaching hospital. At the same time the remaining cohort of about 50 students did block rotations at the same hospital. In Alice Springs a group of 4 students did a similar version of LIFT.

In most reports evaluating LIC pilots, the development of student’s professional values and assessment of ethical erosion, differences were found to the advantage of LIC students1. In the knowledge domain, especially when standard in-school or national examinations were used, the results were less clear2.

Aim:
To determine whether a LIC improves clinical reasoning skills.

Method:
Our eight pilot students at Flinders Medical Centre (FMC) and a group of control students sat two equated clinical reasoning tests – one at the beginning of the year and one at the end of the year. This is in addition to, and separate from, their standard end-of-year assessments.

A description of the test and demonstration of its reliability was presented at the CLIC conference in Montana last year.

Results:
There was no significant difference between the LIFT and non-LIFT students in the clinical reasoning test but there was a significant difference in their change in class rank.

Conclusions:
We could not demonstrate an improvement in clinical reasoning skills in this small sample but there was a significant change in the class rank.

Learning to Fly in Central Australia: The Experience of Piloting a Longitudinal Integrated Clerkship for Year 3 students in Alice Springs

Author(s) and Affiliations: Dr Debbie Fearon, Flinders University and Alice Springs Hospital | Dr Carole Reeve, Flinders University | Ms Kellie Schouten, Centre for Remote Health | Dr Sheela Joseph, Flinders University | Dr Kerry Taylor, Poche Institute

Dr Debbie Fearon is a graduate of the Auckland School of Medicine. She trained in Paediatrics in New Zealand and the United Kingdom. She has a special interest in Indigenous Child Health.

In 2007, Debbie started as a Paediatric Consultant at Alice Springs Hospital. She was appointed as a Lecturer for Flinders University soon after and promoted to Senior Lecturer in Rural and Remote Medicine in 2012. Debbie has recently been appointed as the first Clinical Dean for Alice Springs Hospital. In 2013, Debbie led a team that implemented the first ever Longitudinal Integrated Clerkship in Alice Springs Hospital.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Identify the potential barriers and enablers to implementing a new LIC program in a small rural hospital.
2. Recognise the importance of modifying a LIC program to better suit local conditions, while still retaining the basic principles of all LIC programs.
3. Describe possible methods for evaluating a new LIC program.

Abstract:
Flinders University has been a pioneer in implementing Longitudinal Integrated Clerkships. In 2004, Paul Worley, Adrian Esterman and David Prideaux published a paper in the BMJ, showing that rural, community-based medical students did academically better in their Year 3 exams than their urban, tertiary hospital-based peers (5). Due to the increasing evidence of the benefits of LIC’s being described in the literature, especially for future recruitment of rural practitioners, Flinders University introduced a pilot LIC at Alice Springs Hospital (colloquially known as LIFT: Longitudinal Integrated Flinders Term) in 2013 (1, 3, 4).

Alice Springs Hospital is an 189 bed facility that serves a geographical area approximately the size of Alaska (1.6 million square kilometres). Half of the approximately 60,000 people served by ASH are Aboriginal and many live in small, isolated communities with limited access to primary health care. In addition to being based in ASH, the four Year 3 LIFT students attend weekly General Practice clinics at the Central Australian Aboriginal Congress. CAAC’s Medical Service was established in 1975. It now provides 90,000 episodes of care to local Indigenous people every year.

This short presentation will describe the initial aims, design and evaluation of the LIFT program. This has lead to changes being made in the second year of LIFT to suit the unique challenges and supports present in Central Australia.

Further evaluation of the ASH LIFT program will include:
1. Student academic results and class rankings
2. Student views on the hidden curriculum and professionalism
3. Student empathy ratings
4. Student satisfaction with the program
5. Clinician views and satisfaction with the program
6. Patient views and satisfaction with the program

Community engagement case presentation

Author(s) and Affiliations: Jill Bestic and Miriam Glennie, Rural Clinical School, Australian National University Medical School, Canberra, Australia

Dr Jill Bestic is part of the rural clinical school team at the ANU working in medical education and student development and staff support. She continues to be passionate about Palliative Care and Remote Indigenous Health. She remains perplexed by the inequities of this world but is grateful for the opportunities she has experienced in her career. She has a meditation and prayer garden in her back yard and loves hand building with clay and sharing this time of creativity with her teacher.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Understand how, as a medical educator, reflection on real experiences can contribute to student understanding of remote area medical work.
2. Understand the benefits of community engagement.
3. Understand how Art can be effective in building community engagement.

Background:
Strategies for effective engagement between remote medical practitioners and the local indigenous populations they support are poorly understood, and, as a result, often poorly practiced. This paper will present a case from my own clinical experience in Yuendumu, a Warlpiri Community 270 kilometers north west of Alice Springs that demonstrates how community engagement can be structured around Art.

Aims:
To explore the value of broader community engagement to better understand the patient’s situation within the community and to promote medical compliance; To build my relationship with the community; To foster engagement between other medical practitioners, students and the Canberra community with a remote indigenous community.

Methods:
A range of outreach, education and fund-raising activities including:
1. Medical care of patients
2. Teaching of medical students
3. Engagement with the Art community in Yuendumu
4. An exhibition and sale of Yuendumu art in my suburban Canberra garden

Results:
Through these activities I developed a personal belief in friendship within patient communities, improved my ability to support patients and other community members, expanded my understanding of remote medical practice, shared my learnings with medical students at the ANU and built connections between urban medical and remote communities. I recognize that my ongoing teaching and supervision when in Yuendumu has been influenced by establishing and maintaining community engagement over distance and time.

Conclusion:
In going beyond our defined role as medical practitioners we can be effective in community engagement, we can have unplanned experiences that we can reflect on that enhance our teaching of medical students.
Developing tools for the evaluation of Community-based Education

Author(s) and Affiliations: Ian Couper, Centre for Rural Health, University of the Witwatersrand (Wits), Johannesburg, South Africa | Abigail Dreyer, Centre for Rural Health, University of the Witwatersrand (Wits), Johannesburg, South Africa | Chris Deery, Capacity Plus, USA | Rebecca Bailey, Capacity Plus, USA

Ian Couper, a family physician, is Professor of Rural Health at the University of the Witwatersrand (Wits), Johannesburg and Head: Clinical Unit (rural medicine) in the North West Provincial Department of Health. He is founding director of the Wits Centre for Rural Health, and is currently academic head of the Wits Department of Family Medicine. He chaired the international Wonca Working Party on Rural Practice from 2007 to 2013. He serves as editor of the African section of the international journal Rural and Remote Health.

He was a member of the expert panel that produced the WHO Global Policy recommendations "Increasing access to health workers in remote and rural areas through improved retention" and of the WHO Core Guidelines Group that developed the recommendations on "Transforming and Scaling up Health Professionals’ Education and Training". He is currently a member of the WHO Guidelines Review Committee.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Describe tools available in the literature for CBE programme evaluation
2. Discuss the relevance and applicability of such tools
3. Understand the value of different approaches to CBE evaluation
4. Explore the possibility of developing common CBE evaluation tools

Background:
Schools within the Medical Education Partnership Initiative (MEPI) programme in Africa expressed a need for tools to assist them in the evaluation of their Community-based Education (CBE) programmes. As a result of this, a literature review was conducted for tools that might be useful in the African context, and a compendium of possible tools was developed, for use in a training workshop

Purpose:
To discuss and share possible tools for CBE evaluation

Process:
The results of the literature review and the compendium of tools will be presented. Discussion will focus on their usefulness and relevance in different contexts. Participants will be invited to share their experiences of evaluation and relevant tools. The value of quantitative versus qualitative methodologies will be explored. The possibility of developing common tools for sharing will be explored.
Developing personal attributes of professionalism during clinical rotations: Views of final year bachelor of clinical medical practice students

Author(s) and Affiliations: Nontsikelelo Mapukata-Sondzaba1, Ames Dhai2, Norma Tsotsi2 and Eleanor Ross2 | 1 Division of Rural Health, Faculty of Health Sciences, University of the Witwatersrand | 2 Steve Biko Centre for Bioethics, Faculty of Health Sciences, University of the Witwatersrand

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Describe the indicators for teaching medical professionalism to Bachelor of Clinical Medical Practice students.
2. Assess the role of professional health care workers in graduating critically reflective students.
3. Appraise District Education Campuses as decentralised training platforms for health sciences students to learn about medical professionalism.

Background:
Medical professionalism as a set of behaviours that transcends personal values, beliefs and attitudes to incorporate ethical and moral principles is considered a covenant between society and the practice of medicine. The uniqueness of the Bachelor of Clinical Medical Practice (BCMP) curriculum required a teaching approach that met the needs of an integrated curriculum, providing for an accelerated transition from the classroom to the patient's bedside.

Aims:
Assess the ability of the BCMP students to integrate theoretical knowledge and function as accountable, responsible and critically reflective practitioners.

Methods:
Following five week attachments in designated District Education Campuses an exploratory, retrospective and descriptive case study of 71 portfolios reflected BCMP students' end of the block experiences and the development of their personal attributes of professionalism during clinical rotations.

Results:
The majority of BCMP students reflected on the determinants of accountable and responsible practice (N=54) and the value of constantly reflecting as a skill (n=51). The commitment to the Oath became significant with personalised reference to patients 'as my patients'. Students acknowledged professional health care workers (HCWs) who demonstrated commitment to the core values of good practice. A few students reflected on feeling vulnerable in some of the settings in instances where they were pressured into 'pushing the line'.

Conclusions:
Through their portfolio narratives, BCMP students showed a willingness to shape their evolving journeys of moral growth and personal development. District Education Campuses as decentralised training platforms provided the context where students had opportunities to learn from professional HCWs and patients.

Targeted Audience: Faculty and Clinicians
Study Population Pertains to: Health Sciences Students

Tracking value formation of medical student exposed to the ADZU-SOM iterative sandwich curriculum. A cohort study

Author(s) and Affiliations: Dr Fortunato L Cristobal, Dr Rex V Samson, Dr Jejunee Rivera

Fortunato L. Cristobal MD is the founding Dean of the Ateneo de Zamboanga University School of Medicine (ADZU-SOM) in Zamboanga City, Mindanao, Philippines. He is professor of Masters in Public Health Program and Masters in Health Professions Education Program at ADZU-SOM. He trained in medicine at the University of the Philippines, Manila (1973-1977), and underwent pediatric residency training at the University of the Philippines-Philippine General Hospital. He took his postgraduate training in gastroenterology at Westminster Children's Hospital, London in 1985, Community Pediatrics at King's College London in 1993 and also took advanced studies in Medical Education under the mentorship of Dr. Charles Engel. He finished both his Masters in Medical Education and Masters in Public Health degree at the Ateneo de Zamboanga University in 1998 and 2001 respectively.

Dean Cristobal developed in 1993 a new medical school in the region with a radical vision and innovative teaching and learning processes. These innovations are now being shared with other countries especially in Southeast Asia at the National University of Laos and Patan Academy of Health Sciences in Kathmandu.

Abstract Stream(s): Longitudinal Learning, Community Engagement, Social Accountability

Learning Objectives:
1. To determine the effect of iterative sandwich curriculum of ADZU SOM on the values formation of the medical students.
2. To determine and compare the values score of students before and after hospital clerkship; mid community and after community exposure.
3. To determine and compare the life’s priority of students before and after hospital clerkship; mid and after community exposure.

Abstract:
One of the most consequential but enduring aspects of learning to be a doctor is the formation of one’s professional identity – this includes the development of a set of personal beliefs, values and role expectation that guide and eventually inform all subsequent medical and personal behavior. This identity is either developed and honed, or simply caught, while in process of learning to become a doctor.

The medical education literature suggest that this professional identity can change depending on the prevailing social environment or the “informal or hidden” curriculums embedded in training experiences that strongly influence student professional identities, values formation and future career practice choice.

The Ateneo de Zamboanga School of Medicine, a small, radical, innovative medical school in Southern Philippines is a problem based learning, community engaged and competency based medical school. We introduced a longitudinal version of an iterative learning model, mixing community based experiences with academic institution based learning alternately. Locally, we call this the “Iterative Sandwich Method”, which was used over the last 20 years, and has resulted into a high retention of graduates still practicing in the Philippines (96%), with 70% staying in our region, and 50% now based in previously doctorless areas. We are reporting how this Iterative Sandwich Model has impacted on our students values. The high graduate retention rate and on their commitment to serving the communities in need.


How do you get from here to there-LIC expansion to new sites

Author(s) and Affiliations: Dr Robert Boulay, Clerkship Site Director-Miramichi LIC, Dalhousie University

Dr. Boulay has been teaching medical students and Family Medicine residents since 1992, and is currently serving as Clerkship Site Director in Miramichi, NB, for Dalhousie University’s first LIC site, which was established in 2012. His other interests include the development and establishment of different models of Team-based and Interprofessional care, and he has served as national president of the College of Family Physicians of Canada. He resides in Miramichi, NB with his wife Bernadette McCarthy DDS and their 3 children Daniel, Emma and Samuel.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Addressing Faculty Engagement.
2. Key Indicators of success.
3. Identification of critical time lines.

Abstract:
The LICD (Longitudinal Integrated Clerkship – Dalhousie) has finished its second year in Miramichi, NB Canada. Dr. Rob Boulay, Clerkship Site Director and Dr. John Steeves, Associate Dean, Dalhousie Medicine New Brunswick (DMNB), have identified several key factors and critical steps which both assisted in the establishment of the first site for Dalhousie University's first LIC and which were also essential as plans progressed to establish a site in Woodstock NB. Plans are now underway for establishment of 2 more sites in previous block model clerkships programs, and initial conversations have begun regarding the potential for collaboration with another university (Memorial University of Newfoundland) participate in a common LIC experience that meets accreditation standards of both participating universities.

Highlights of the presentation will include addressing faculty engagement and site proposal preparation, critical time lines, barriers and how they were overcome, and key indicators for success.

Target Audience would include individuals interested in LIC establishment or expansion.

Based on experiences achieved in past 2 years in Miramichi NB
How we established community engagement projects

Author(s) and Affiliations: Dr Robert Boulay, Clerkship Site Director-Miramichi LIC, Dalhousie University

Dr. Boulay has been teaching medical students and Family Medicine residents since 1992, and is currently serving as Clerkship Site Director in Miramichi, NB, for Dalhousie University’s first LIC site, which was established in 2012. His other interests include the development and establishment of different models of Team-based and Interprofessional care, and he has served as national president of the College of Family Physicians of Canada. He resides in Miramichi, NB with his wife Bernadette McCarthy DDS and their 3 children Daniel, Emma and Samuel.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Discuss how we created community engagement projects.
2. Review how we chose the projects.
3. Review how we integrated student interests.
The Geographic Pipeline to Rural Family Medicine at Memorial University

Author(s) and Affiliations: James Rourke, MD | Mohamed Ravalia, MD | Wanda Parsons, MD | Norah Duggin, MD | Katherine Stringer, MD | Danielle O'Keefe, MD

Dr. James Rourke, (MD, CCFP(EM), M.Clin.Sci, FCFP, FRRMS, FCAHS, LLD), has served as Dean of Medicine and Professor of Family Medicine at Memorial University of Newfoundland since his appointment April 5, 2004. He has been Chair of the Board for The Association of Faculties of Medicine of Canada and a Co-Leader with Future of Medical Education in Canada projects.

Dr. Rourke grew up on a farm and attended a one room rural public school. Dr. Rourke was an active rural family physician (including obstetrics and emergency work) in Goderich, Ontario, for 25 years with his wife and partner Dr. Leslie Rourke. Dr. Rourke has a long-standing interest in rural medicine and medical education and is a recognized leader at provincial, national and international levels and has 100 published medical journal articles and textbook chapters.

Dr. Rourke has received many honours and awards, including The Canadian Academy of Health Sciences, Fellowship; The University of Western Ontario, Honorary Degree Doctor of Laws, honoris causa (LLD); Society of Rural Physicians of Canada, Rural Leadership Award; the College of Family Physicians of Canada, W. Victor Johnston Award; the College of Physicians and Surgeons of Ontario Council Award, the DJ Rice Merit Award from the College of Family Physicians of Canada; the UWO Award of Excellence in Teaching by Part-time Faculty; the UWO Martin J. Bass Recognition Award for Exceptional Contribution to Family Medicine; and the Community Teacher of the Year from the Ontario College of Family Physicians.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. This study identifies and describes a measurement strategy (the collection and collation of administrative data) to track medical students’ education locations and practice locations.
2. This study identifies an innovative (pipeline) approach to educating doctors to practice in rural areas.
3. This study describes Memorial University of Newfoundland’s experience with recruiting rural students and providing rural educational placements.

Background:
Medical schools face a difficult social accountability challenge to educate doctors to meet the needs of rural communities. This abstract uses geographic information system analysis to study Memorial University of Newfoundland’s “pipeline to rural practice.” This work will interest educators and administrators working to increase numbers of medical students entering rural practice.

Aims:
This study measures and reports on Memorial’s success in recruiting rural students and providing rural placements.

Methods:
This study uses administrative data for MUNMED graduating classes 2011 and 2012 to describe backgrounds and educational placements of these students. This study also reports on practice locations of MUNMED graduates practicing family medicine in Newfoundland and Labrador.

Results:
120 students graduated in 2011 and 2012. 32% had rural backgrounds. For graduating classes 2011-2012, 65% of Year 1 Community Health placement weeks took place in small rural communities (pop < 10,000) and 19% took place in small rural cities (pop < 25,000); 41% of Year 2 FM Community placement weeks took place in small rural communities and 14% took place in small rural cities; 88% of Year 3 FM placement weeks took place in small rural communities and 6% took place in small rural cities. Of 297 MUNMED graduates currently practicing family medicine in Newfoundland and Labrador, 64 (22%) are practicing in small rural cities and 44 (15%) are practicing in small rural communities.

Conclusions:
Memorial has had noteworthy success recruiting rural students, providing rural placements, and producing graduates who practice in rural areas.
Let’s start at the very beginning - Med Quest: A pipeline program to medical school and practice

Author(s) and Affiliations: James Rourke, MD | Fran Kirby, MEd | Jan Warren | Mary Dray | Scott Moffat, MD

Dr. James Rourke, (MD, CCFP(EM), M.Clin.Sci, FCFP, FRMS, FCAHS, LLD), has served as Dean of Medicine and Professor of Family Medicine at Memorial University of Newfoundland since his appointment April 5, 2004. He has been Chair of the Board for The Association of Faculties of Medicine of Canada and a Co-Leader with Future of Medical Education in Canada projects.

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Abstract Stream(s): Social Accountability

Learning Objectives:
1. This study identifies an innovative approach to recruiting rural students from rural areas: high school outreach and engagement.
2. This study describes Memorial University’s approach to high school outreach and engagement.
3. This study describes and maps the geographic reach of Memorial University’s high school outreach and engagement program, MedQuest.

Background:
Early engagement with secondary school students from rural communities can be an important component of a medical school’s social accountability mission to educate doctors for rural areas. In Memorial University of Newfoundland’s MedQuest program, high school students from across the province participate in weekly sessions designed to introduce students to health sciences careers. This abstract will interest educators and administrators working to increase numbers of medical students entering rural practice.

Aims:
This paper uses routinely collected administrative data to describe the backgrounds and map the high school locations of MUNMED students, graduating classes 2011-2016, who completed MedQuest.

Methods:
High school locations of medical students who completed MedQuest were described and mapped using ArcGIS. SPSS was used to describe the backgrounds of MedQuest alumni.

Results:
Of 375 students admitted from 2007 to 2011, 25% of rural background students had completed MedQuest while 15.3% of urban background students had completed MedQuest. Maps were produced to show high school locations of these students; 34.1% of MedQuest Alumni attended high school in locations of under 10,000 people and 46.3% attended high school in locations of under 25,000 people.

Conclusion:
MedQuest offers students exposure to health sciences during their formative years. An important aim of MedQuest is to increase health sciences exposure for rural students; this paper shows that MedQuest achieves a wide geographic reach that covers many rural communities throughout Newfoundland.
How is rural defined and used in Canada?

Author(s) and Affiliations: James Rourke, MD | Janelle Hippe, MA

Dr. James Rourke, (MD, CCFP(EM), M.Clin.Sci, FCFP, FRMRMS, FCAHS, LLD), has served as Dean of Medicine and Professor of Family Medicine at Memorial University of Newfoundland since his appointment April 5, 2004. He has been Chair of the Board for The Association of Faculties of Medicine of Canada and a Co-Leader with Future of Medical Education in Canada projects.

Dr. Rourke grew up on a farm and attended a one room rural public school. Dr. Rourke was an active rural family physician (including obstetrics and emergency work) in Goderich, Ontario, for 25 years with his wife and partner Dr. Leslie Rourke. Dr. Rourke has a long-standing interest in rural medicine and medical education and is a recognized leader at provincial, national and international levels and has 100 published medical journal articles and textbook chapters.

Dr. Rourke has received many honours and awards, including The Canadian Academy of Health Sciences, Fellowship; the University of Western Ontario, Honorary Degree Doctor of Laws, honoris causa (LLD), Society of Rural Physicians of Canada, Rural Leadership Award; the College of Family Physicians of Canada, W. Victor Johnston Award, the College of Physicians and Surgeons of Ontario Council Award, the D.I Rice Merit Award from the College of Family Physicians of Canada; the UWO Award of Excellence in Teaching by Part-time Faculty; the UWO Martin J. Bass Recognition Award for Exceptional Contribution to Family Medicine; and the Community Teacher of the Year from the Ontario College of Family Physicians.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. This study identifies currently used definitions of “rural” in Canadian medical education research literature.
2. This study describes the definition of rural developed at Memorial University of Newfoundland.
3. This study identifies percentages of rural background students and rural educational placements at Memorial University of Newfoundland.

Background:
One of the challenges to developing medical schools’ social accountability to the rural regions they serve is understanding and applying a practical definition of rural that can be used to measure success in rural recruitment, rural placements, and rural practice locations. Indeed, despite the preponderance of research linking rural background and rural placements to rural practice, there remains variation within the very same literature with regard to what constitutes “rural.” This paper proposes an operational definition of rural and will interest educators and administrators working to increase numbers of medical students entering rural practice.

Aims:
To develop an operational definition of “rural” as a useful tool for medical schools, governments, and other interested stakeholders as policies and programs to increase rural practice are created.

Methods:
PubMed was used to identify articles that utilized a definition of ‘rural’ to describe and measure relationships between medical student background, educational placements, and/or practice locations.

Results:
In total, 26 articles were included in the study. Definitions of rural included: population under 10,000; population under 25,000, population under 100,000, and provincially specific combinations of size and distance from larger centers.

Conclusion:
While residence in a community under 10,000 was the most common definition of rural used, variation among definitions was noted. We propose a definition that uses a continuum to define rural. Our proposed definition utilizes StatsCan Census and MIZ Data and categorizes rural on a continuum including: population <10,000, and population 10,000–24,999.
Progressive diabetic ketoacidosis simulation

Author(s) and Affiliations: John B. Watkins, Sarah A. Tieman, Douglas E. Carr, Indiana University School of Medicine - Bloomington, Bloomington, IN

John B. Watkins III, PhD has been teaching medical pharmacology for several decades, and has been responsible for implementation of the competency curriculum at IUSM - Bloomington since 1999. He has been involved in all stages of the current curricular reform effort for IUSM and has been encouraging use of simulation in undergraduate medical education.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To create a progressive simulation experience for third-year students.
2. To require self-directed learning of the management of a common disease.
3. To assist student-medical team interactions through an inter-professional educational paradigm.

Abstract:
The value of simulation experiences is becoming more obvious in undergraduate medical education. The objectives of the study were to create a progressive simulation experience for third-year students, to require self-directed learning of the management of a common disease; and to assist student-medical team interactions through an inter-professional educational paradigm. This simulation exercise for third year medical students allowed “real-time” experience of the clinical evolution of a patient with newly diagnosed type 1 diabetes mellitus (DM1). The third year students used critical thinking and communication skills to deliver appropriate treatment to the “patient” and “family.” The medical students were paired in teams for each of the four parts of the simulation: emergency room, critical care, ward care, and outpatient follow-up. Students not directly participating in the simulation observed each step so they could participate in the debriefing at the end of the simulation. Two senior nursing students were part of the care team to enhance reality and facilitate interdisciplinary communication techniques. The team applied multiple aspects of their knowledge base while moving through the different stages of the disease; debriefing with instructors and peers help fill in knowledge gaps. Rubrics to assess communication skills and team work skills are being developed for these types of simulations. The progressive simulation gave the students a better feel for the complexity of the clinical problem presented including awareness of care transitions and change over. We will present the developing rubrics for evaluation. Comments from both the medical students and the nursing students were quite positive. One student said, “Why don’t we do this type of simulation more often?” Student and preceptor evaluation highlight the value of progressive simulation encounters in undergraduate medical student education. This presentation will appeal to medical educators.
How do we compare? Longitudinal integrated clerkships: a Snapshot of an Australian rural clinical school curriculum for final year medical students

Author(s) and Affiliations: A/Prof Andrew Dean, Head of Ballarat Rural Clinical School, School of Medicine Sydney, University of Notre Dame Australia | Dr Zelda Doyle, Epidemiologist and Lecturer, Sydney Campus, School of Medicine Sydney, University of Notre Dame Australia

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Apply the Harvard Medical School-Cambridge Integrated Clerkship (HMS-CIC) evaluation tool to an Australian rural medical program.
2. Use this data for curriculum modification along Longitudinal Integrated Clerkship (LIC) principles.
3. Develop an inter-school benchmarking tool to enhance delivery of program consistency.

Background:
Qualitative and quantitative data has established the value of Longitudinal Integrated Clerkships in medical student education(1). LIC programs have been developed and introduced in Australia, focusing mainly on rural primary care (2). We wanted to benchmark our current rural clinical school program across our three geographically separate sites, against the verified study tools developed for the HMS-CIC model (3).

Method:
The HMS-CIC questionnaire tool (3) will be applied to final year medical student programs across our rural clinical schools to create a ‘snapshot’ of the current degree of implementation of LIC concepts. Our current rural school programme in our medical school overlaps with some aspects of the HMC-CIC pilot study, and we wanted to validate the student and teaching faculty perceptions of our current programme against the LIC structure.

Results:
Results will be compared to outcome data from LIC programmes elsewhere, and re-evaluated for our school after potential LIC implementation.

References:
Cultivating community engagement, expanding cultural competency and defining curriculum: The NOSM Aboriginal and Francophone experience

Author(s) and Affiliations: Lee Rysdale, Tina Armstrong, Danielle Barbeau-Rodrigue, Northern Ontario School of Medicine

Lee Rysdale is a Registered Dietitian with over 25 years of experience in clinical, community and public health settings as well as the Ontario provincial government. She is also a community based researcher with a focus on early years (birth to age 6) nutrition screening. As a regulated health professional, born and raised in Northern Ontario and a Northern Ontario School of Medicine (NOSM) faculty member, she is acutely aware of the issues and challenges in health service equity, access and delivery across the north. At NOSM, Lee is the Practice Learning and Research Coordinator with the Northern Ontario Dietetic Internship Program as well as provides curriculum development and delivery to undergraduate medical learners, and most recently has been articulating the best practices to advance and integrate Aboriginal, Francophone and Videoconference Telepractice competencies into the training and practices of allied health professionals and learners in Northern Ontario.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To discuss best practices needed to integrate cultural competency into health professional education and training.
2. To identify enablers and challenges in the implementation and evaluation of cultural competency in health education curriculum.
3. To discuss community engagement strategies that strengthen the social accountability preparation of cultural competent health professionals.

Background:
The Northern Ontario School of Medicine (NOSM) became the first medical school in Canada with a social accountability (SA) mandate. Community engagement is consistent with NOSM’s SA goal and includes a focus on Aboriginal and Francophone communities and organizations, rural and remote communities, as well as larger urban areas of Northern Ontario.

Aims:
With almost half (40%) of the province’s Aboriginal population and 25% of Franco-Ontarians living in Northern Ontario, all NOSM faculty and learners are encouraged to develop knowledge and understanding of the history, tradition, and culture as well as health concerns and needs of these two cultural groups. Best practices are needed to improve the processes and integration of Aboriginal and Francophone cultural competencies in fostering a community-engaged curriculum.

Methods:
Numerous knowledge development and exchange as well as evaluation activities have been conducted with key informants (NOSM staff, faculty and learners) as well as other stakeholders and community partners. The process was guided with an assessment framework of cultural competency indicators in health care related to education content and commitment and preceptor and learner performance.

Results:
Minimum and advanced competencies have been validated; learner and preceptor tools and resources have been developed, piloted and refined; and, preceptor training was assessed and implemented using distance education strategies.

Conclusions:
Plans include tracking and evaluating the success of these competency indicators at an organizational level and with individual preceptors and learners. This presentation will focus on the lessons learned in developing and implementing Aboriginal and Francophone cultural competencies at NOSM.


Developing and evaluating Aboriginal cultural self-efficacy in health professional learners

Author(s) and Affiliations: Lee Rysdale, Tina Armstrong, Denise Raftis, Northern Ontario School of Medicine

Lee Rysdale is a Registered Dietitian with over 25 years of experience in clinical, community and public health settings as well as the Ontario provincial government. She is also a community based researcher with a focus on early years (birth to age 6) nutrition screening. As a regulated health professional, born and raised in Northern Ontario and a Northern Ontario School of Medicine (NOSM) faculty member, she is acutely aware of the issues and challenges in health service equity, access and delivery across the north. At NOSM, Lee is the Practice Learning and Research Coordinator with the Northern Ontario Dietetic Internship Program as well as provides curriculum development and delivery to undergraduate medical learners, and most recently has been articulating the best practices to advance and integrate Aboriginal, Francophone and Videoconference Telepractice competencies into the training and practices of allied health professionals and learners in Northern Ontario.

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. To discuss cultural self-efficacy in health care and health professional education and training.
2. To identify effective learning experiences that can enhance cultural self-efficacy.
3. To discuss strategies to assess the impact of specific experiences on cultural self-efficacy.

Abstract:
The Northern Ontario School of Medicine (NOSM) model of distributed community-engaged learning involves communities actively involved in hosting students and significantly contributing to their learning. With almost half (40%) of the province’s Aboriginal population living in Northern Ontario, all NOSM faculty and learners are encouraged to develop knowledge and understanding of the history, tradition, and culture as well as health concerns and needs of this cultural group.

For NOSM allied health professional learners, minimum and advanced competencies have been validated along with training resources and Aboriginal focused placements. While there is some evidence that cultural competency training can increase awareness, knowledge and skills, cultural self-efficacy refers to how capable one feels functioning in culturally diverse situations. It has been suggested that those with more experience have higher cultural self-efficacy and are more likely to pursue opportunities to work with Aboriginal peoples. NOSM’s dietetic internship program has seen evidence that curriculum efforts may be supporting the recruitment of graduates to work in Aboriginal communities in Northern Ontario. But it is unknown if it is the individual and/or organizational factors that are shaping these learners’ cultural self-efficacy and their practice setting decisions.

This PeARL session will focus on:
1. How do we assess cultural self-efficacy?
2. What types of educational experiences increase cultural self-efficacy (e.g. workshops, placements)?
3. Are there specific aspects of the learning experience that are more effective?
4. How do we assess the impact of specific experiences on cultural self-efficacy?

Student satisfaction with community versus academic medical center clerkship experiences

Author(s) and Affiliations: Sarah Tieman, Indiana University School of Medicine

Sarah Tieman, MD is a lecturer at the Bloomington campus of Indiana University School of Medicine. She is the clinical coordinator for the 3rd year longitudinal integrated curriculum, now in its third year, as well as a course director for the Introduction to Medicine classes for 1st and 2nd year students. Additional areas of interest include communication in end of life care and longitudinal learning experiences for pre-clinical students.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Identify variations in student satisfaction with clerkship experiences based on community vs academic medical center.
2. Identify variations in student satisfaction with clerkship experiences based on block vs longitudinal scheduling.
3. Discuss variables that may affect satisfaction data.

Abstract:
Indiana University is a distributed medical school with seven campuses (six small community based sites and one large academic medical center). In the last several years the regional campuses have expanded from the pre-clinical years to include 3rd and 4th year. All sites but one are on a traditional block scheduling system for 3rd year. As part of routine program evaluation, medical students are surveyed by the Office of Undergraduate Medical Education at the end of each clerkship regarding their educational experiences in areas such as organization, feedback, teaching and learning environment. Overall, scores were equivalent across campuses and between scheduling approaches. In this limited analysis of clerkship program evaluation data, location and scheduling did not appear to have a statically significant effect on student satisfaction with clinical education.
Views from the field: Exploring the perceptions of students on the reality of interprofessional learning and practice in rural and urban settings

Author(s) and Affiliations: David Thompson - Lakehead University | Dr. Jacques Abourbih - Northern Ontario School of Medicine (NOSM) | Sue Berry - NOSM | Dr. Lorraine Carter - Laurentian University | Dr. Lisa Graves - University of Toronto and NOSM | Dr. Sarah Newbery - NOSM | Nicole Ranger - NOSM

David Thompson, a PhD candidate, is a Clinical Lecturer at Lakehead University in the School of Nursing and holds a joint appointment at the Northern Ontario School of Medicine as a Clinical Lecturer, Division of Clinical Sciences. David has authored and co-authored publications related to ways to increase the use of research in clinical practice across health professions. His PhD research is exploring how students engage in interprofessional learning from a complexity theory perspective.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To identify rural clinical education placement challenges in creating and fostering IP activities across the professions
2. To construct practical strategies for implementing authentic IP learning activities across the continuum of learning in rural communities
3. To generate future research questions and appropriate methodologies that may advance the impact measurement of health professional student and health care team IP interactions and learning in rural communities

Abstract:
Interprofessional education aims to improve interprofessional collaboration in health care. (CIHC, 2010) As a foundation for this workshop, the preliminary findings of the thematic analysis of a qualitative study will be shared to further the interpretation, perceptions, and reality of undergraduate medical students' reflections on and perceptions of IP learning and practice in Northern Ontario. Preliminary data suggests that as much as there is literature evidence to support the positive outcomes of IPC and IPE, there appears to be a disconnect between what is being taught about interprofessional practice and in reality what students are experiencing in rural and urban settings. This workshop will delve into the deeper issues of IP integration and immersion in academic and clinical curricula and urban and rural experiences.

How do graduates of longitudinal integrated clerkships fare on the Medical Council of Canada Qualifying Exam Part II?

Author(s) and Affiliations: Wayne Woloschuk, University of Calgary | Doug Myhre, University of Calgary | Wes Jackson, University of Calgary | Kevin McLaughlin, University of Calgary | Bruce Wright, University of Calgary | To be presented by Doug Myhre

Wayne Woloschuk, Ph.D. is a registered psychologist and the Director of Program Evaluation at the University of Calgary medical school.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Describe the main components of the LIC program at the University of Calgary.
2. Describe how to implement a matched control group.
3. Explain the evidence that supports equivalent performance of longitudinal integrated and rotation-based clerks at the postgraduate level.

Background:
The longitudinal integrated clerkship (LIC) has become a popular education model for training clinical clerks however, little is known about how LIC graduates perform in residency.

Aims:
We compared the clinical performance of residents who graduated from rural longitudinal integrated and rotation-based (RB) clerkships on the Medical Council of Canada Qualifying Exam Part II (MCCQE Part II).

Method:
Participants included medical school graduates (classes of 2009 – 2011) from the University of Calgary. We prospectively matched (first on Medical Skills II course, then GPA) each of the 34 LIC students with 4 students from the traditional (RB) stream to serve as controls (n=136). A dataset containing 170 graduates was forwarded to the Medical Council of Canada who subsequently supplied MCCQE Part II pass/fail status and total score for each graduate, and returned the dataset for our analysis. Data were analyzed using chi-square and Anova.

Results:
The final dataset consisted of 30 (88%) LIC graduates and 115 (85%) RB graduates. Analysis revealed a similar MCCQE Part II pass rate for LIC (28/30; 93.3%) and RB (107/115; 93.0%) graduates, p > .05. The MCCQE Part II mean total score for the LIC graduates (M= 527.4; SD=64.3) did not differ from the mean total score (M=529.9; SD=61.4) reported by the RB graduates, F=.04, p = .85.

Conclusions:
Completing the majority of clerkship in a rural community over an extended period allowed LIC graduates to perform as well as their peers on a measure of clinical skills taken 16 months into residency.
The power of PaNDA: NOSM student placement locale data provides accountability and quality improvement measures

Author(s) and Affiliations: Lee Rysdale, Rachel Schaaf, Sue Berry, Marion Briggs, David Marsh

Lee Rysdale is a Registered Dietitian with over 25 years of experience in clinical, community and public health settings as well as the Ontario provincial government. She is also a community based researcher with a focus on early years (birth to age 6) nutrition screening. As a regulated health professional, born and raised in Northern Ontario and a Northern Ontario School of Medicine (NOSM) faculty member, she is acutely aware of the issues and challenges in health service equity, access and delivery across the north. At NOSM, Lee is the Practice Learning and Research Coordinator with the Northern Ontario Dietetic Internship Program as well as provides curriculum development and delivery to undergraduate medical learners, and most recently has been articulating the best practices to advance and integrate Aboriginal, Francophone and Videoconference Telepractice competencies into the training and practices of allied health professionals and learners in Northern Ontario.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. To discuss a data strategy towards understanding learner placements and health human resource needs.
2. To identify the strengths and limitations of a learner placement database (PaNDA) as a quality improvement measure of social accountability indicators.
3. To discuss opportunities to strengthen the social accountability mandate of the Northern Ontario School of Medicine through student placement locale data.

Background:
The Northern Ontario School of Medicine (NOSM) distributed learning model involves communities actively hosting medical and allied health professional learners with a goal to expose, attract, and recruit learners to current and potential working environments of greatest need. A social accountability strategy to understand learner placement patterns plus responsive regular and ad hoc reporting is needed.

Methods:
Using the learner placement database (PaNDa), all 2012-13 learners (medical, non-medical and visiting) were inputted and collated using Excel© (2007) by program community, learner discipline and rotation period. Learners not captured (e.g. third year clerkship) were entered separately. All data was validated by respective programs for accuracy. Quantitative analysis using frequencies and pivot tables was conducted including percent learners and placements by LHIN (Local Integrated Health Network) and community size using Statistics Canada census (2011) for rural (˂ 4,999), small towns (5,000-9,9999), census agglomerations (CA) (10,000-24,999), regional centres (25,000 to 99,999), and census metropolitan areas (CMA) (≥ 100,000).

Results:
Results indicate 1364 unique learners, 3120 placements and 86553.5 Training Days. The majority (89%) of placements were in NOSM’s catchment areas (LHINs 12, 13 and 14). Of the 83 communities, 28 were rural, 13 small towns, 13 regional centres, 12 CA and 17 CMA contributing 4.7%, 10.8%, 16.2%, 10.2% and 57.6% Training Days respectively. Seven communities were out of province/international contributing less than 1% of overall Training Days.

Conclusions:
A PaNDA framework and process provides a benchmark and quality improvement measure of accountability indicators supporting recruitment in locales of health human resource need.

102 Teaching and learning the skills of telepractice/ telemedicine: Challenges and opportunities

Author(s) and Affiliations: Sue Berry, Marion Briggs, Lee Rysdale

Sue Berry, Executive Director of Integrated Clinical Learning at the Northern Ontario School of Medicine is an Associate Professor within the Division of Clinical Sciences and holds the rank of Assistant Professor within the School of Rehabilitation Science at McMaster University. For the past 25 years, her work in academic administration and expertise in developing innovative approaches has led to a number of innovative health professional and interprofessional education initiatives. Her scholarly work has included presentations and workshops nationally and internationally and has published on topics of interprofessional education and community engagement.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To discuss telepractice competency in health professional education, training and continuing professional development.
2. To identify barriers and facilitators in the implementation of telepractice curriculum in these various contexts.
3. To distinguish the similarities and differences between telepractice and telesupervision.

Abstract:
While most patients prefer face-to-face interactions with health professionals, the reality is that for many in northern and rural communities, this can be challenging due to travel, financial, and time constraints. Telepractice or telemedicine is the delivery of health care and exchange of health information over distances including diagnosis, treatment and prevention of disease, continuing education of health care providers and consumers, and research and evaluation.

As distance technologies and the demand for their use increases, the adoption of these technologies will require identifying the key knowledge, skills, and attitudes that learners and their preceptors need to be competent “tele-practitioners”. Defining these competencies will also support the development of effective curriculum and pedagogical approaches in undergraduate, graduate and continuing professional development contexts.

Practitioners may be prepared to learn to use new technology if they perceive the system is critical to their job performance or quality of service. Implementation success is also associated with the degree of need for the service and local health service structure as well as ‘people’ factors-acceptance by clients, families/caregivers, novice and experienced practitioners, and telepractice support staff.

This PeARL session will provide the context and focus on the following two questions:
1. Technology-mediated clinical practice - what competencies do learners need to conduct assessment and treatment from a distance - what are the barriers and facilitators of telepractice?
2. Technology-mediated preceptorship - what competencies would practitioners need to provide clinical supervision from a distance, supported by technology - what are the barriers and what supports telesupervision?

Investigating the impact of NOSM on the health of rural and Northern Ontario using health services data

Author(s) and Affiliations: John Dabous, Northern Ontario School of Medicine, David Marsh, Tim Dubé

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Identify methods for measuring social accountability by using health services data.
2. Identify measurable community health indicators that can be related back to social accountability.
3. Determine methods for linking the presence of new physicians to improved community health.

Abstract:
Researchers have shown the positive outcomes the Northern Ontario School of Medicine (NOSM) has had throughout Northern Ontario, highlighting the return of graduates to underserved areas, as well as the socioeconomic impact. However, further research is needed to specifically investigate the impact of NOSM on health care utilization and overall community health.

The purpose of this PeArl will be to discuss a proposed study which aims to investigate the impact of NOSM on community health status utilizing data from the Institute for Clinical Evaluative Sciences (ICES). ICES is a not-for-profit research institute encompassing a community of research, data and clinical experts, and a secure and accessible array of Ontario’s health-related data. The goal of the proposed study is to analyze the data in a way that could provide evidence on whether or not primary care has improved in Northern Ontario since NOSM graduates have begun practicing medicine.

The focus for this PeArl will be to identify ways to quantifiably measure the impact of NOSM graduates on the northern communities they are now practicing in. Some questions for consideration will be:
- What health services data can be used to measure social accountability?
- What are the most effective and reliable methods to quantify the impact of new physicians in communities using health services data?
- Considering the multiple variables involved, how can the presence of new practicing physicians (NOSM graduates) be linked to improved community health?

A Model for Rural Health Education for First Year Medical Students

Author(s) and Affiliations: Ruth L. Bush, MD, JD, MPH; Catherine McNeal, MD, PhD; Danielle M. Dickey

Dr. Ruth L. Bush received her MD from the University of North Carolina School of Medicine in 1992. She completed her residency in General Surgery at the University of California, Davis, Medical Center in 1999 and Vascular Surgery fellowship at Emory University Hospital in 2001. She completed a Juris Doctorate at Taft Law School and also a Master of Public Health from the University of North Carolina School of Public Health. Dr. Bush has held various appointments with the Texas A & M College of Medicine since 2007.

In July 2013, Dr. Bush was appointed Interim Vice Dean for the Bryan/College Station Campus. She chairs the College of Medicine’s curriculum committee. Also, she currently practices vascular surgery at the Olin E. Teague VA Medical Center in Temple, Texas and holds a faculty appointment at the Texas A & M School of Public Health.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To describe a novel medical education opportunity in rural community medicine.
2. To understand the broad primary care perspective needed to practice in a rural community.
3. To understand the importance of teaching not only biomedicine to students, but also the community perspective, psychosocial needs of patients, and the enhanced doctor-patient relationship necessary.

Background:
Innovative educational strategies which emphasize the barriers faced by rural residents living in medically under-served areas are necessary. Without adequate knowledge of the health care and health service needs, such communities will continue to be overlooked.

Aims:
The primary objective was to enhance students' knowledge of barriers to health care access and chronic healthcare needs in a rural population. A secondary objective was to provide educational experiences within an interprofessional environment.

Methods:
Multidisciplinary teams (physicians, hospital chaplains, social workers, nurse educators) including 1st and 2nd year medical students were paired with under-served families during the 2010-11 and 2011-12 academic years. Students created monthly interactive presentations and handouts for the families to facilitate conversation surrounding health views, needs, and concerns. Short term goals were set by the families and students were expected to find resources or ask questions pertinent to their specific families’ health concerns.

Results:
Twenty seven medical students participated over two years. Students (93%) learned about the difficulty of rural living and barriers to health care access. Other outcomes included knowledge of the health concerns/struggles prevalent in a rural community and the importance of the physician-patient relationship.

Conclusions:
Participants in this unique community-based rotation were able to understand healthcare disparities affecting rural families and to understand alternative medical resources necessary for optimized healthcare. By being immersed into a different culture and health care system, students’ awareness of social determinants of health and global health issues was increased.

Dentzer S. Reinventing primary care: a task that is far “too important to fail.” Health Aff 2010; 29:757
Rabinowitz HK, Diamond JJ, Markham FW, Wortman JR. Medical school programs to increase the rural physicians supply: a systematic review and projected impact of widespread replication. Acad Med 2008;83:235-43.
Example of an effective feedback loop in socially accountable medical education: NOSM’s engagement of Aboriginal communities

Author(s) and Affiliations: Kim Daynard, Director of Communications, NOSM | Tina Armstrong, Director of Aboriginal Affairs, NOSM

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. Describe key characteristics of an effective feedback loop in socially accountable medical education.
2. Understand the importance of effective feedback loops in the engagement of communities as quality improvement measures of socially accountable medical education.
3. Apply NOSM’s engagement of individuals delegated by Aboriginal communities at periodic workshop gatherings as an example of an effective feedback loop in socially accountable medical education.

Background:
From its inception, the Northern Ontario School of Medicine (NOSM) has hosted four formal workshop gatherings (in 2003, 2006, 2009, and 2011) to engage delegates from Aboriginal communities in discussions about the planning, processes, and activities of the School. At these gatherings, participants have been encouraged to offer input, make recommendations, and provide feedback on School developments as relevant to Aboriginal people and their communities.

Aims:
The goal of this research project is to determine if the routinely held NOSM-hosted workshop gatherings with delegates from Aboriginal communities have been effective as a feedback loop informing School decision-making processes. “Feedback loops” have been identified as critical to assessing the progress of medical schools in their efforts to address the needs of their communities (Woolard, 2006; Boelen & Woolard, 2009, 2011).

Methodology:
Aggregate data from input, recommendations, and feedback included in reports created after each workshop gathering were examined in terms of identifying how, and to what extent, the feedback loop has contributed to changes and improvements at NOSM that reflect the needs of Aboriginal communities in Northern Ontario.

Results:
NOSM’s engagement of delegates from Aboriginal communities at routinely held workshop gatherings has resulted in ongoing improvements that reflect the needs of those participating in the feedback loop. Specifically, qualitative data suggests that the areas of the School’s admissions and learner recruitment, communications, community engagement, curriculum, and research have been most impacted. Further quantitative data will be shared and discussed during the presentation. In addition, a new conceptual model of an effective feedback loop will be shared and discussed.

Conclusion:
Periodic NOSM-hosted workshop gatherings engaging delegates from Aboriginal communities have been effective as a feedback loop, resulting in positive changes to and developments in the School’s operations and programs.

“I followed him all the way” - the continuity-of-care experiences of longitudinal clerkship medical students

Author(s) and Affiliations: Kathryn M Weston, Graduate School of Medicine, University of Wollongong, Australia | David L Garne, Graduate School of Medicine, University of Wollongong, Australia | Judith (Nicky) Hudson, University of Newcastle Dept of Rural Health, Tamworth, Australia | John A Bushnell, Graduate School of Medicine, University of Wollongong, Australia | Sheree Lloyd, Graduate School of Medicine, University of Wollongong, Australia.

Dr Kath Weston is Senior Lecturer in Public Health in the Graduate School of Medicine, University of Wollongong, Australia. Since joining the GSM, Kath has published in the area of medical education and the longitudinal integrated clerkship model of medical education, and in developing authentic learning experiences in research. Kath also has a strong research interest in health literacy, and in public health impacts of infectious diseases and outbreaks.

Within the Graduate School of Medicine at UoW, Kath is a member of both the Research and Critical Analysis, and the Community, Primary, Remote and Rural teams. She lectures in various aspects of public health as well in research and critical analysis, immunology, vaccination and disease prevention. Kath is a member of the Public Health Association of Australia and the Australian and New Zealand Association for Health Professional Educators.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. A longitudinal integrated clerkship placement offers an opportunity for students to experience continuity of care and to develop relationships with patients.
2. An electronic clinical log of student-patient encounters provides useful data to determine the nature of individual student clinical experience.
3. Capturing information about repeat patient presentations allows analysis of student continuity of care experiences.

Background:
A graduate-entry medical school in New South Wales, Australia, with a mission to develop medical workforce for regional, remote and rural Australia, has incorporated a year-long community-based placement starting mid-way through year 3 of a 4-year course. All students are hosted by a general practice in a regional, remote or rural community, taking part in acute and chronic patient-care integrated across general practice, hospital and community settings. Students accrue a panel of patients who consult them throughout the year under preceptor supervision.

Aim:
To describe the characteristics of continuity-of-care experiences of a cohort of longitudinal integrated clerkship medical students placed in regional, remote or rural settings.

Methods:
The electronic clinical log entries for one cohort of longitudinal clerkship medical students (n=80) were analysed for narratives describing continuity-of-care experiences. The log entries of a subset of these students (n=20) were analysed to describe characteristics of the continuity-of-care experience, such as presenting health issues, frequency and characteristics of repeat presentations.

Results:
Electronic log narratives and entries revealed the development of patient-student relationships during the longitudinal placement, and provided insight into continuity-of-care as a learning experience. The students’ continuity-of-care experiences included patients with mental health issues, pregnancy, cancer and chronic disease, and those visiting the doctor for preventive health or screening.

Conclusions:
The longitudinal integrated community-based clerkship provides a powerful opportunity for learning through continuity-of-care experiences.
Use of context scoring in the medical school admission process as a tool in addressing the social accountability mandate of the Northern Ontario School of Medicine (NOSM)

Author(s) and Affiliations: Owen Prowse MD, MPH, FRCSC Asst. Prof. Surgery and Asst. Dean Admissions, Northern Ontario School of Medicine | Miriam Cain, Director of Admission and Learner Recruitment, Northern Ontario School of Medicine | Julie Pacifico, Admissions Officer, Northern Ontario School of Medicine | Robert Barnett, Director Strategic Planning and Integration, North East Community Care Access | Blair Schoales MD, FRCSC, Former Asst. Dean Admissions, Northern Ontario School of Medicine

Dr. Prowse is currently Assistant Professor of Surgery and Assistant Dean of Admissions at the Northern Ontario School of Medicine. He is graduate of the University of Toronto and a practicing surgeon with public health training from The Johns Hopkins University in Baltimore. He has a longstanding interest in both clinical and Aboriginal health education.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Defining rurality for use in context scoring.
2. Examining factors/verification processes in self-identified Aboriginal and Francophone applicants and their impact on context scoring.
3. Is context scoring an effective tool in the admissions process and does it help fulfill NOSM’s social accountability mandate.

Background:
Research has shown medical school graduates who have grown up in rural or remote areas are more likely to practice in a rural setting. To that end, the Northern Ontario School of Medicine was established in 2001 with a social accountability mandate to contribute to the health of the people and communities of Northern Ontario.

Aims:
To develop through the admissions process a mechanism to promote selection of a student body reflective of the needs, demographics and communities of Northern Ontario.

Methods:
We have developed a context scoring guideline to assess and rank applicants based on geographic, Aboriginal and Francophone backgrounds. This tool is used in conjunction with each applicant’s GPA and autobiographical sketch to facilitate ranking of applicants prior to interview selection.

Results:
From 2006 through 2013, 92% of students matriculating at NOSM were from Northern Ontario and 8% were from rural and remote areas from the rest of Canada. In addition, 7% of students were Aboriginal and 22% were Francophone. The average GPA score for students was 3.7 on a 4.0 scale consistent with medical schools across Canada.

Conclusions:
Use of context scoring incorporating length of time applicants have spent in rural and remote areas along with Aboriginal and Francophone backgrounds is an effective tool to address the social accountability mandate through the admissions process. This has helped guide selection of an academically strong medical school class that better reflects the population distribution of Northern Ontario.
What do medical students in an integrated longitudinal clinical placement actually see and do?

Author(s) and Affiliations: Kathryn M Weston, Graduate School of Medicine, University of Wollongong, Australia | Sheree Lloyd, Graduate School of Medicine, University of Wollongong, Australia | David L Garne, Graduate School of Medicine, University of Wollongong, Australia | Judith (Nicky) Hudson, University of Newcastle Dept of Rural Health, Tamworth, Australia | John A Bushnell, Graduate School of Medicine, University of Wollongong, Australia

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. A longitudinal medical student placement involving integrated primary, and secondary/tertiary care provides a rich and diverse clinical experience.
2. The longitudinal integrated clerkship provides increased opportunities for encountering complexity of care.
3. Students on long term placement spend a significant amount of time ‘doing’ rather than observing.

Background:
An Australian graduate-entry medical school, with a mission to address medical workforce shortage in regional, remote and rural Australia, has incorporated a year-long (38-week) placement mid-way through year 3 of a 4-year course. All students are hosted by a general practice in a regional, remote or rural community, participating in acute and chronic patient-care integrated across general practice, hospital and community settings. Students use an electronic clinical log to record details of the patients encountered in these clinical settings.

Aim:
To describe the nature of clinical experiences of a cohort of longitudinal clerkship medical students placed in regional, remote and rural settings.

Methods:
The electronic clinical log entries of one cohort of longitudinal clerkship medical students (n=80) were analysed to determine the types and complexity of presenting problems of patients encountered by medical students.

Results:
Over 20,000 log entries were made during the year-long placement. The integrated learning environment facilitated diverse experiences; two-thirds of the entries related to the general practice setting, and one-third to the hospital setting. Many patients had complex problems, with one-third of presentations involving at least 3 core problems. Most presentations (95%) involved the student ‘doing’ rather than observing; the most common procedures undertaken were vaccination and excision in the general practice; and cannulation and suturing in the hospital setting.

Conclusions:
The integrated learning environment in primary and secondary/tertiary care provides a rich and diverse clinical experience. A longitudinal integrated regional, remote or rural placement allows students to experience management of a wide range of clinical situations.
A medical workforce for regional, remote and rural Australia: are we on track to fulfil our mission?

Author(s) and Affiliations: David L Garne, Graduate School of Medicine, University of Wollongong, Australia | Kathryn M Weston, Graduate School of Medicine, University of Wollongong, Australia | John A Bushnell, Graduate School of Medicine, University of Wollongong, Australia | Judith (Nicky) Hudson, University of Newcastle Dept of Rural Health, Tamworth, Australia

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Most students who had undertaken a rural, regional or remote longitudinal clerkship felt they had the necessary skills to practice in a rural setting.
2. Sixty percent had a strong positive feeling about working in a rural setting.
3. Follow-up of these cohorts in the future will be important to see whether rural intention correlates with rural practice.

Aim:
To determine whether graduating medical students who have experienced a longitudinal-integrated-clerkship placement have the skills and desire to practice medicine in non-metropolitan settings.

Methods:
Data from a survey administered by the Federation of Rural Australian Medical Educators (FRAME) to the first four cohorts of UOW medical graduates were analysed. Future training and practice preferences, and readiness for rural medicine, were investigated.

Results:
Over 70% of the most recent cohort of graduating students (72%) felt they had the necessary skills to practice in a rural setting and 59% had a strong positive feeling about working in a rural setting. Within this cohort, 41% intended to apply for internship, and almost 50% intended to spend post-graduate training, in a non-metropolitan location. One-third of graduates indicated a career preference for General Practice, while 37% preferred Rural Medicine/Generalist Specialist. The trend to non-capital city preference for future practice amongst graduating cohorts was prominent in the two most recent cohorts (75%).

Conclusions:
Signs are positive that UOW medical graduates feel capable of and are interested in a career in rural practice.
From leadership to followership: supporting clinical academics to become culturally safe.

Author(s) and Affiliations: L Walters(1), C Reeves(2), K Glover(3), J Gladman(1), A Cawley(1), D Fearon(4), (1)Flinders University Rural Clinical School, (2) Centre for Remote Health, Alice Springs, (3) Pangula Mannamurna, Mount Gambier, (4) Northern Territory Clinical School, Flinders University

Presented by Carole Reeves

CURRENT POSITION: Associate Professor Rural Medical Education, Flinders University Rural Clinical School, Academic Coordinator PRCC (Parallel Rural Community Curriculum), GP Obstetrician at Mount Gambier Hospital, Vice President, ACRRM (Australian Council of Rural and Remote Medicine)

KEY EXPERTISE: Rural medical education development, curriculum design and assessment, course delivery in undergraduate and post graduate areas.

AREAS OF INTEREST: Community based medical education; Rural health; Aboriginal Health; Symbiosis in clinical education; and Rural medical workforce development.

PERSONAL: Lucie is married with 2 boys and lives and works in Mount Gambier. Her interests include exploring the South East coastline, waterskiing, watching her boys play sport. She is unashamedly parochial about the Limestone Coast, which she describes as her “piece of rural Australia”.

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. To explore the concept of followership and discuss its relevant to culturally competent clinical practice.
2. To examine how clinical academics can develop dual roles of leadership within the medical profession and followership within the Aboriginal communities with which they work.
3. To consider how to progress the learning journey of clinical academics.

Abstract:
Many medical schools have taken on a social accountability mandate to provide culturally safe contexts in order to encourage Aboriginal people to engage in medical education and to ensure that current and future clinicians provide health services which contribute to improving the health outcomes of Aboriginal and Torres Strait Islander peoples.

Recently one rural clinical school surveyed staff, and clinicians to understand the cultural climate of their organisation and to develop a strategic plan for Aboriginal health cultural training within the organisation. Using Mezirow’s Transformative learning theory as a conceptual framework, results from this study indicated that academic clinicians require good company to develop dual roles of leadership within the medical profession and followership within the Aboriginal communities with which they work.

Questions for discussion:
1. Is followership a key skill in the development of cultural competence in clinical settings?
2. Have you seen followership in action in the Aboriginal health context? How was it portrayed? How was it learnt?
3. Do you have experiences of good company contributing to learning followership? Do you have experiences of other ways of learning followership?

Who the presentation appeals to:
Aboriginal peoples, clinical academics, and program directors interested in Closing the Gap
Calling all comments: Using short phone calls as grading conferences in a LIC

Author(s) and Affiliations: Danielle Dickey, B.S. Ed.: Texas A&M Health Science Center College of Medicine, Director of Curriculum Support

After receiving her B.Sc. in Education from Baylor University, she taught junior high and high school for several years. Danielle started as a clerkship coordinator with Texas A&M Health Science Center College of Medicine then became the Campus Manager for the Bryan-College Station Clinical Campus where she is responsible for managing clinical campus affairs, including oversight of clinical education and physician and institution relationships with the local community and affiliates. Danielle's administrative duties expanded to include Director of Curriculum Support for Texas A&M Health Science Center College of Medicine where she and her team provide staff support for all COM courses. She is finishing her Master's degree in Higher Education Administration from Texas A&M University. She has a passion for education and development and believes that longitudinal, integrated teaching and learning is the best model for medical education!

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Develop an ongoing process for gathering feedback on medical student performance which allows for rich narrative description.
2. Provide a venue for longitudinal faculty preceptors to dialogue across disciplines about medical student performance.
3. Create a process for shared responsibility of student success by sharing information and creating individualized learning.

Background:
In traditional clerkships and in the pilot of the AIM longitudinal curriculum, COM has struggled to gather descriptive feedback from affiliate faculty. The clerkship directors need detailed comments for the MSPE. Also when students struggle in one clerkship, there is no mechanism for sharing information with the subsequent clerkship to address the gap.

Methods:
The directors have determined that quarterly evaluation forms will be completed by the preceptors. The clerkship coordinating staff will schedule 20 minute phone conferences with each team of clinical preceptors. During the phone conference, the coordinator will facilitate discussion on student performance using the clinical evaluation form as a guide. The faculty will be asked to determine specific methods to address student gaps or hone student skills, so that similar methods are being employed across disciplines by all preceptors as well as monitored across clerkships. Detailed notes will be taken of the discussion and populated into one overall narrative/commentary that will serve as both formative and summative feedback.

Results:
COM will begin this process in June with the new academic year. Effectiveness of the phone grading conferences will be measured by the amount usable narrative comments for student feedback and on the MSPE. We will survey preceptors, directors and students on the process and their satisfaction.

Conclusions:
Adjustments to the phone grading conference timing and structure will be made based on feedback.

Population target:
faculty, clerkship directors

Audience:
faculty, clerkship directors, students

McLaughlin K, et al. Clerkship evaluation-what are we measuring? Medical Teacher. 2009. 31(no. 2)

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NOSM postgraduate medical training: Creating sustainable funded programs for a community-engaged distributed education environment

Author(s) and Affiliations: Jennifer Fawcett, NOSM | Grace Vita, NOSM | Dr. Catherine Cervin, NOSM

Jennifer Fawcett is the Director of Postgraduate Education at the Northern Ontario School of Medicine. With close to ten years of experience at NOSM, Jennifer has witnessed the School’s growth from its inception culminating recently with the expansion of residency programs. Jennifer has a Masters degree in Public Health from Lakehead University in Thunder Bay, Ontario.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. A description of the postgraduate business case for distributed medical education.
2. Lessons learned in addressing the complexity of medical education funding.
3. A description of the methodology used to study the economic benefit of a new medical school.

Background & Purpose of Study:
Unique in Canada, Postgraduate Medical Education at the Northern Ontario School of Medicine (NOSM) is based on a community-engaged, distributed learning model across a vast number of community training sites. This innovative model comes with education, and administrative challenges and particular fiscal considerations. This oral presentation will provide a narrative description of a successful business model that outlines cost drivers for the required infrastructure to meet and exceed accreditation standards in geographically dispersed residency programs.

Methodology:
The presentation will include:
1. A description of the postgraduate business case for distributed medical education
2. Lessons learned in addressing the complexity of medical education funding
3. A description of the methodology used to study the economic benefit of a new medical school

Results:
This presentation will report on the results of the economic benefit study and the analysis of outcomes of the business case, focusing on the cost drivers in delivering distributed medical education.

Conclusions and Discussion:
Preliminary conclusions regarding cost drivers for distributed medical education will be shared and discussed. The importance of economic studies to monitor the impact of new economic activity and tracking studies to monitor the number of NOSM learners practicing in the Northern Ontario, are essential elements to provide evidence of the benefits of NOSM’s unique model.

https://www.afmc.ca/pdf/fmec/12_Bates_Distributed%20Education.pdf
Case-based learning: Participant opinions of its value in medical education

Author(s) and Affiliations: Timothy Billington, University of Wollongong | Ian Wilson, University of Wollongong

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Describe the heightened deeper learning abilities consequent upon CBL participation.
2. Demonstrate the value of basic sciences knowledge in understanding medical cases in CBL.
3. Describe the roles of the University, the Tutor/Facilitator and the CBL group members.

Abstract:
Case-Based Learning (CBL) forms an important part of the University of Wollongong graduate medical degree and has an established place in medical education at many Institutions, worldwide. This (pilot) study sought perceptions of 30 students regarding the value CBL. We used a paper-based, human ethics- approved, 21-question survey, calling for some Likert-scale responses and some textual responses.

Results:
Results indicate that the majority of students: were adequately prepared by the University for learning in a CBL environment, understood their and their tutor’s role in CBL, recognized the importance of CBL-derived bio-science knowledge underpinning clinical cases and recognized that the University had sufficiently outlined the educational benefits of CBL. A majority of respondents recognised CBL as an important learning tool and had become deeper learners, with abilities heightened by CBL participation.

Three themes emerged from textual responses: the roles of the University, of the CBL Tutor and of the CBL group members. We conclude that most of the students saw CBL was an important contributor to their case learning activities and appreciated the value of CBL. Results of a larger, (non-pilot) study cohort will (also) be presented.

This presentation consists of survey data, pertains to medical students’ perceptions will appeal to medical educators and/or medical students.
Go to the people: Reflecting on the long-term outcomes of 1990’s community-engaged teaching and learning in Indonesia

Author(s) and Affiliations: Dr Brahmaputra Marjadi, School of Medicine, the University of Western Sydney

Dr Brahmaputra (Brahm) Marjadi was trained as a general practitioner in Indonesia in the 1990s, at a medical school that was particularly strong on community medicine. He has been an academic since 1996, first in Indonesia and then Australia (UNSW and UWS), with a wide-ranging teaching portfolio from medical microbiology to epidemiology, research methods, evidence-based medicine and medical anthropology. He is currently the Senior Lecturer in Community Engaged Learning at the School of Medicine, the University of Western Sydney. His research interest is healthcare services in low-resource settings. Apart from teaching and research in Indonesia and Australia, Brahm has worked in charity clinics, health promoting schools and a faith-based national healthcare association in Indonesia.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Understand the presented model of community engagement at an Indonesian medical faculty in the 1990s.
2. Appreciate the long-term manifestation of the learning outcomes from the community engagement experiential learning.
3. Reflect on the challenges in aiming for similar learning outcomes at the present day.

Background:
Final outcomes of attitudinal and behavioural outcomes of community-engaged teaching and learning (CETL) may take years to manifest, making medical students impatient and lose sight of CETL’s value.

Aim:
This presentation aims to give a personal account of the CETL impact on an Indonesian medical doctor and academic who underwent the process in 1991-1995, and now coordinates CETL in an Australian university.

Method:
Reflections on personal experiences using the qualitative research approach of complete participant observation.

Results:
Lessons learned from CETL led to better connection with patients in clinical encounters; a grounded understanding of the principles of health promotion; awareness of medical anthropology; encouragement for advocacy; and firm appreciation of the wider context of medical practice. Challenges in engaging present-day Australian medical students with the community will be discussed.

Conclusion:
While CETL practices are highly contextual, its principles and value are universal across settings and time. A broader base of medicine may assist students in appreciating the CETL value which often takes painfully long time to manifest.

Target Audience:
Any academics, professional staff and students involved in CETL programs.

This presentation is a personal reflection and thus this Abstract does not use any references. References may be added once the full presentation is developed.
Progressive clinical skills - teaching clinical reasoning skills in the Northern Territory

Author(s) and Affiliations: Dr Emma Kennedy, Senior Lecturer NTMP Flinders University | Professor Sarah Strasser, previous Associate Dean Flinders NT | Dr Kishan Pandithage, General Practitioner and clinical teacher, Darwin | Dr Paul Rivalland, General Practitioner and clinical teacher, Jabiru and Darwin | Dr Sarah Chalmers, Senior Lecturer in Remote Medicine, Nhulunbuy Campus NTMP | Dr Anne Kleinitz, Lecturer NTMP, Darwin | Dr Lina Zbaidi, GP registrar NT General Practice Education, Darwin

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Develop understanding of the components of clinical reasoning skills.
2. Develop understanding of a process of facilitating medical students’ learning of clinical reasoning skills.
3. Understand the relevance of the learning context to teaching clinical reasoning.

Abstract:
Clinical reasoning skill development is a core component of the clinical learning in a medical degree. The medical students learn content and process of a consultation through their experience with patients. There is a recognition that they learn experientially and through observation of their clinical teachers in the clinical context. The third element of their learning is through perception. The academic staff and clinicians of the Northern Territory identified that there were gaps in the students’ learning created by ever expanding curriculum and often unpredictable variations in clinical rotations. Our curriculum learned is established by the unique circumstances of patients’ presentation, clinical supervisors engagement with the student and variable nature of complimentary placements.

We have designed a series of clinical reasoning skills teaching sessions based on a curriculum that complements the clinical learning environment of the hospital and community placements. Our hope is that the sessions will improve the essential learning in this area. Each session has specific learning goals that focus on the development of competence in a consultation – managing content, process and perception of the dynamics. The Progressive Clinical Skills curriculum will be presented with reference to the relevant literature and our experience and evaluation thus far, discussed.

Comparable learning experiences at NOSM’s Longitudinal Integrated Clerkship

Author(s) and Affiliations: Jeff Bachiu, Northern Ontario School of Medicine | John Friesen, Northern Ontario School of Medicine | John Dabous, Northern Ontario School of Medicine

Jeff Bachiu, MEd (Adult, Community and Higher Education). Jeff is currently the manager of curriculum and planning in the Undergraduate Medical Education program at Northern Ontario School of Medicine (NOSM) in Sudbury, Ontario, Canada. He works with faculty and staff to ensure that the curriculum across all four years is delivered to students smoothly. This includes students in the compulsory 8 month community placement in the Longitudinally Integrated Clerkship in the third year of the program. In addition to supervising the administration of the curriculum, Jeff also manages the Curriculum Instructional Design team which is instrumental to curriculum development across all educational programs at NOSM.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Gain insight into NOSM’s methods for maintaining comparable learning experiences in the 15 LIC sites separated by up to 1,700 km.
2. Understand how NOSM’s student assessment data compares for all sites in our LIC, and.
3. Gain knowledge about NOSM’s use of program evaluation data to ensure continual quality improvement.

Abstract:
Year 3 of our 4-year program provides students with a longitudinal clinical experience at NOSM. Students are assigned to primary care practice settings in one of 15 communities in Ontario. The experience is grounded in family medicine and strives to install a generalist approach early in the clerkship. Students are given the opportunity to follow patients throughout their diagnosis and treatment.

Aim:
This presentation will show how NOSM combines curriculum design, student assessment data, program evaluation data, and effective communication strategies to ensure the delivery of comparable learning experiences for its Year 3 students during their LIC.

Methods:
This study will use a mixed methods approach with descriptive statistics and content analysis to demonstrate the comparability of our LIC sites.

Results:
NOSM has several years of data, as well as, evidence used in accreditation visits that demonstrate the comparability of our Year 3 sites. We will add new quantitative and qualitative data from the 2013/14 academic year to provide the most current analysis of our LIC.
Moving from community involvement to active participation, engagement, and ownership: Developing influential local groups for transformative health professional education

Author(s) and Affiliations: Danielle Barbeau-Rodrigue, Director Francophone Affairs NOSM | Tina Armstrong, Director Aboriginal Affairs NOSM | Sue Berry, Executive Director, Integrated Clinical Learning NOSM | Marion Briggs, Director Health Sciences and Interprofessional Education NOSM | Miriam Cain, Director Admissions and Learner Recruitment NOSM | Dr. David Marsh, Associate Dean Community Engagement NOSM

Originally from Sudbury, Ontario, Canada, Danielle obtained a Bachelor in Science of Language Degree from Laurentian University (LU). She is currently a Sociology Masters student at LU, her particular interest is culturally competent health care and health professional education. An Ontario public servant for 18 years, she worked for most of this time at Ombudsman Ontario resolving complaints about unsatisfactory provincial government services; she was also the French Language Services Coordinator for this office. Since 2005, Danielle has been responsible for the Francophone Affairs Unit (FrAU) at Northern Ontario School of Medicine. The Unit was established pursuant to the School's social accountability mandate and the commitment to a culture of inclusiveness and responsiveness to the needs of the Francophone people and communities of Northern Ontario. The FrAU strives to establish, nurture and grow collaborative partnerships with the Francophone community in its many sectors particularly health and education.

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Design a unique community-engaged education model in the context of the participants’ world by building on existing literature of community engagement / participation health care models.
2. Describe one approach used at the Northern Ontario School of Medicine (Local NOSM Groups).
3. Examine benefits and challenges of models of community engagement in medical education.

Abstract:
Active participation by local communities enables pride and ownership by community members in the education of health professionals, and is a key strategy in distributed health professional education. Local groups, such as Local NOSM Groups, are an integral part of the communities in which students live and learn, whether in longitudinal or short-term clinical education placements.

In this workshop, participants will explore the elements that support community ownership of health professional education beyond the university campus setting. Discussions and exercises will examine widely recognized successful models of community engagement used in health care services (Taylor, 2008) as a way to transfer and apply those successes to the education sector. Influential factors such as: diversity of the group, leadership of the group, size of the community, quality of relationships amongst members, values, and group commitment will be explored. Through small group activities using cases and workbook exercises, this workshop will enable participants to create a solid plan and direction to use for increasing the wisdom and expertise of communities with whom they have a relationship or aspire to have a relationship.

Local groups provide a mechanism for a partner community and a health professional school to stay abreast of each other’s respective developments. In fact, these local groups should be viewed as key assets in their respective community, as they are often the eyes, ears and image of the school within a given community.

This workshop will be of interest to community leaders, health professional educators and students.


Aboriginal health and cultural safety training, how do we know if health professional students and staff have connected the dots? A research and tool validation process

Author(s) and Affiliations: Courtney Ryder1, Heather Burton2 and Tamara Mackean1 | 1 Poche Centre of Indigenous Health & Well-being, School of Medicine, Faculty of Medicine, Nursing and Health Sciences, Flinders University | 2 DrPH Candidate, Public Health, School of Health Sciences, Faculty of Medicine, Nursing and Health Sciences, Flinders University

Courtney Ryder is the lecturer for the Poche Centre of Indigenous Health and Well-Being at Flinders University. She is actively involved with innovative curricula development, coordinating and teaching into topics in a range of health courses and has played a key role in the development of the Indigenous Entry Stream for graduate entry medicine. Courtney plays an active member of many high level academic committees providing space for Indigenous voices within strategic planning, governance, curriculum and admissions.

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. Identify the importance of accessing cultural safety in Aboriginal health training.
2. Explain research methods utilised in constructing a survey for Aboriginal health and cultural safety evaluation.
3. Understand research protocols utilised for the validation of this evaluation tool.

Background:
Aboriginal health and cultural safety training requires participants to challenge long held beliefs and attitudes. A range of different training models have been utilised from semester long topics to one off workshops. However there is limited quantitative evidence to support which methodology is most appropriate. This research team developed a survey tool to enable comparison across different lengths and styles of education programs in Aboriginal health.

Aim:
The presenter will describe and discuss the research protocol for development and validation of a survey tool to measure attitude change through Aboriginal health and Cultural Safety education.

Design:
The tool incorporates modified questions from four surveys to measure student attitude to Aboriginal health in various contexts. Choice of questions was supported from the Cultural Safety literature to enhance content validity. The pilot study with undergraduate and postgraduate students and staff assesses the validity and reliability of the survey through test-retest methods using weighted kappa and Cronbach α coefficient statistical tests.

Results:
Test-retest reliability results indicated substantial agreement was reached for 6 of the 15 items, moderate agreement for 5 of 15 items with a sample size of 41.

Conclusion:
This project has introduced a new validated tool focusing on Cultural Safety and Aboriginal health which will amplify the evidence-base underpinning Cultural Safety preparation for the health workforce.
How can Aboriginal health models incorporate western medical and other worldviews for better health outcomes?

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Courtney Ryder is the lecturer for the Poche Centre of Indigenous Health and Well-Being at Flinders University. She is actively involved with innovative curricula development, coordinating and teaching into topics in a range of health courses and has played a key role in the development of the Indigenous Entry Stream for graduate entry medicine. Courtney plays an active member of many high level academic committees providing space for Indigenous voices within strategic planning, governance, curriculum and admissions.

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. Recognise that Aboriginal health knowledge and models are independent in their own right, and need to work in a complementary manner with other medical models.
2. Evaluate the importance for changing paradigms in this area to build capacity and knowledge.
3. Understand Aboriginal patient centred and culturally safe care.
4. Generate frameworks to facilitate models of care for better outcomes through case study review.

Topic Outline:
Pedagogical approaches and educational content relating to Aboriginal models of health and well-being are considered in a context where Aboriginal health knowledge it is required to ‘fit into’ a western biomedical framework. Such an approach is fraught with danger and undermines key principles of engagement in Aboriginal health spaces. Aboriginal models of health and well-being can work alongside other medical models in a complementary fashion to build capacity for better health outcomes.

About the Workshop (inform and encourage participation):
The workshop will focus on cultural safety, reflective practice, patient-centred care working at the interface. Participants should feel comfortable engaging in group discussions. Clinical case studies will be used as a key teaching methodology.

Target Audience:
Ideal for academics, health professionals and students wanting to understand Aboriginal models of health and well-being and how they work alongside western biomedical frameworks to facilitate culturally safe health professional training.

Questions for Discussion:
1. Aboriginal health models, western biomedical models, how do they differ?
2. How can these frameworks work alongside each other at the interface of medical care?
3. How cultural safety and patient centred care frameworks connect to these models?
Reflection on the value of longitudinal generalist experience for undergraduate medical education

Author(s) and Affiliations: Professor Nicky (Judith N) Hudson | Hudson JN, University of Newcastle | Weston KM, University of Wollongong Garne D, University of Wollongong | Bushnell JA, University of Wollongong Farmer EA, University of Wollongong

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Reflection on the value of teaching and learning in generalism rather than specialism confirmed confidence in this approach.
2. Longitudinal supervision by preceptors engaged in generalist practice exposes students to whole person-care.
3. Continuous, rather than fragmented, relationships between preceptors, students and patients are valued by all.

Background:
Generalism, expertise in whole person medicine, comprises consultation skills; continuity of care; doctor-patient relationships; principles of person-centred decision making; practice of interpretative medicine; and first contact care for undifferentiated, complex and a wide range of problems. While specialists, offering condition-focused care, may employ some of these enablers of generalist-care, it is the whole-person focus that defines generalist expertise1. Long-term teaching and learning in generalist practice should foster attainment of skills and attributes for personalised patient-care.

Aim:
To offer a perspective on the value of longitudinal generalist experience for undergraduate medical education.

Method:
Review of the literature and reflection on outcomes from the first seven years of a graduate-entry medical curriculum emphasizing teaching and learning in generalism rather than specialism.

Results:
Analysis of clinical logs revealed students experienced continuity of care and curriculum, with active involvement in the care of undifferentiated patients and complex conditions. Preceptors reported commitment to whole-patient care for their communities, and to supervising long-term students in an environment2, perceived by patients to be learner-and patient-centred3. Graduates have accessed a range of postgraduate pathways, indicating a preference for generalist practice4.

Conclusion:
Longitudinal immersion of senior medical students in community-based integrated clerkships fosters active student participation in the continuity and personalised patient-care of generalist practice.

4. Federation of Rural Australian Medical Educators (FRAME) survey, 2010-2013
Upstream student/patient dyads: Addressing social determinants of health

Author(s) and Affiliations: Nancy W Dickey, MD Professor, College of Medicine Texas A&M University, Health Science Center Bryan, Texas

Dr. Nancy W. Dickey, President Emeritus of the Texas A&M Health Science Center, currently serves as a professor, Department of Family and Community Medicine and Department of Medical Humanities, College of Medicine and Department of Health Policy and Management, School of Public Health. She is co-director of the Rural and Community Health Institute, a consultative group facilitating best practices in patient safety, enhanced quality of care, and physician excellence. Created during her time as president, RCHI exemplifies translating sound policy into practice in traditional academic health centers and across the spectrum of practice sites and care delivery.

Nancy Dickey served as president of TAMHSC from 2002 through 2012. Dr. Dickey is a past president of the American Medical Association, and the founding program director of the Family Medicine Residency of the Brazos Valley, and was elected to the prestigious Institute of Medicine in 2007.

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Develop understanding of the impact of social/economic environment on a patient’s well-being and capacity/motivation to be adherent to a treatment plan.
2. Demonstrate capacity to define an “upstream” issue within a particular patient’s environment.
3. Demonstrate ability to identify community resources, innovative solutions, or other mechanisms of creating and implementing a solution to an “upstream” issue.

Upstream:
Focus on the social and environmental conditions that drive health and illness.

Background:
As medical director of a free clinic, “upstream” issues are profoundly visible. This population provides a laboratory for students to learn about/become involved in social determinants of health.

Aims:
Using a longitudinal experience, students will be assigned a patient, asked to become knowledgeable regarding the patient’s environment and within that environment to select a socio-economic issue impacting the patient’s health. Through development of potential solutions, students will gain understanding of social/governmental institutions effecting these issues.

Methods:
1. Develop a pilot curriculum for a cohort of students, evaluate the syllabus, curricular expectations, and metrics. implement the curriculum in 2015.
2. Pilot curriculum: (a) make longitudinal patient assignment, (b) assign reading and group discussion, (c) facilitate home visits, & (d) have students develop a plan to address the “upstream” issue(s).
3. Evaluation of the pilot curriculum includes pretest/post-test, student experience survey, participating patients survey, community institution survey.
4. Appropriate curricular revision before roll out 2015.

Results:
A syllabus, lessons learned from pilot, types of metrics to determine course effectiveness

Conclusions:
Feasibility of this type of active learning, functionality of overseeing curriculum with a large cohort, impact upon long-term philosophies of students.

Type of data: Theory and literature review with early data from the pilot which will be underway but not complete.

Population target: Low income at risk adults within 7 county area of central Texas.

Presentation audience: Curriculum advocates, upstream doctors/providers, those responsible for the social accountability issues of our health professions schools, those who serve an at risk population.
The LIME network indigenous pathways into medicine online resource and videos

Author(s) and Affiliations: Ms Odette Mazel | Ms Caitlin Ryan The University of Melbourne

Odette Mazel is the Program Manager for the LIME Network Program. She works with the other members of the LIME Team to plan, implement and evaluate strategies to ensure the quality and effectiveness of teaching and learning of Indigenous health in medical education and curricula. Odette has a Bachelor of Law and Arts and is currently undertaking her Masters Degree.

Caitlin Ryan is the Project Coordinator for LIME Network Program. This position is responsible for working with other members of the LIME team to develop and consolidate the LIME Network, develop the project website, and coordinate the LIME Connection Conference. Caitlin has a Masters of International Development from RMIT University, and a Bachelor of Arts from the University of Melbourne.

Abstract Stream(s): Community Engagement, Social Accountability, Aboriginal Health

Learning Objectives:
1. Help future Indigenous students determine which university will be the best fit for them as they study medicine.
2. Provide a first point of contact for Indigenous school leavers, mature aged students and graduates who are looking to undertake medical studies.
3. Provide access to role models – Indigenous students and doctors who are undertaking or have completed their studies in medicine.

Background:
While the numbers of Indigenous medical students have risen in recent years, the numbers of Indigenous doctors remains well below population parity. In order to increase the numbers of Indigenous doctors, it is important that information is made readily available on the range of pathways into studying medicine and the support systems available as well as the stories of others who are currently studying or who are already in practice.

The Leaders in Indigenous Medical Education (LIME) Network Program has developed a comprehensive database of information on Indigenous Pathways into Medicine for all medical schools in Australia and Aotearoa/New Zealand and, in partnership with AIDA and Te ORA, has recently produced four Pathways into Medicine Videos to complement the resource.

Aims:
The Indigenous Pathways into Medicine Online Resource is designed to:
1. Help future Indigenous students determine which university will be the best fit for them as they study medicine
2. Provide a first point of contact for Indigenous school leavers, mature aged students and graduates who are looking to undertake medical studies
3. Provide access to role models – Indigenous students and doctors who are undertaking or have completed their studies in medicine

Methods:
The Pathways Resource provides information relevant to Indigenous people interested in studying medicine that has been previously difficult to access. The resource gathers in one place, information about alternate entry pathways, preparatory courses, scholarships, housing, finance and support services available to Indigenous students at each medical school in Australia and Aotearoa/New Zealand. Coupled with the new Pathways videos highlighting the personal stories of current Indigenous students and medical graduates, this resource aims to encourage and support indigenous people to pursue their dream of becoming a doctor.

Results:
Since launching in September 2012, the Pathways Resource search page has been accessed 2,625 times. Individual course pages have been viewed a total of 7,471 times (an average of 233 views for each course page). The Pathways Videos have been watched 216 times (an average of 54 views for each video) over a two-week period since launching in late March 2014.

Conclusions:
There are many paths to gain entry into a medical degree as an Indigenous person. The Pathways Resource provides easy to access information about the range of ways in which it is possible. The videos that accompany the resource provide an insight into the personal stories of current students and graduates that are both inspiring and encouraging.

The presentation will appeal to representatives from medical schools interested in increasing and retaining through to graduation their numbers of Indigenous students.

We are grateful to all our committee members and interviewees for participating in this exciting project. The videos are now available for viewing on the LIME Network website via W:<http://limenetwork.net.au/pathways>.
Meaningful patient cohorts in a LIC

Author(s) and Affiliations: William Pieratt, DO; Director, A&M Integrated Medicine | Debbie Lynn, M.Ed.; A&M Integrated Medicine Administrator | Danielle Dickey, B.S. Ed., Director of Curriculum Support, Texas A&M College of Medicine

William H. Pieratt, III, DO, FACP practices Internal Medicine in College Station, Texas with Baylor Scott and White Health. He graduated from Texas A&M University then attended Texas College of Osteopathic Medicine, graduating in 1992. He proceeded to Scott and White Memorial Hospital in Temple, TX for his Internal Medicine internship and residency. He is a Clinical Assistant Professor of Internal Medicine and has served as the Associate Clerkship Director for several years. He is the new Director of Texas A&M’s longitudinal curriculum, A&M Integrated Medicine (AIM).

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Discuss what would be the foundational components of a patient cohort in a LIC.
2. Discuss how to create and build the patient cohort.
3. Discuss how to balance student continuity of care of cohort patients with other clinical responsibilities.

Abstract:
Texas A&M implemented a pilot LIC in AY13-14. The LIC is located in a mid-size city with a population of approximately 200,000 with 3 community hospitals and numerous ambulatory clinics. The pilot LIC promoted continuity of care and patient cohorts as a central learning modality to faculty and students. The pilot students took the opportunity to create a patient pamphlet for recruitment of cohort patients, and the students spend the first part of the year amassing cohort patients. Students had competing priorities between attending bimonthly clinic or following up with a cohort patient. We need a better way to identify the types and number of cohort patients to complement the third year medical school curriculum. Additionally, COM had no mechanism for tracking cohort patients for education and reflection without compromising patient information. As we plan for full implementation of a longitudinal curriculum, we want to include continuity of care for a specific list of patient types that will reinforce learning.

Questions for Discussion:
1. How many and what patients types should be included in a cohort?
2. What is the role of the student and preceptor in patient cohort creation?
3. How does a LIC curriculum balance priorities of clinic with patient continuity care and efficient use of student time/learning?
4. How do we track patient cohorts across multiple clinics and community hospitals?
5. What is the role of the student to the patient during continuity of care?

Population target: all populations
Presentation audience: faculty, clerkship directors, students, community engagement

125 Strategies to manage over-users of medical services

Author(s) and Affiliations: Dr. Philip McGuire, Midland Canada Site Liaison Clinician, for NOSM
Comprehensive Community Clerkship

For most of my 27-year Family Medicine practice, I have been active in emergency medicine, prenatal care and obstetrical deliveries, and in-hospital care. Throughout my career I have taught medical students and graduates. For three years now, I have concentrated on emergency room work and in-hospital care, with increasing third world volunteering over time. I have now taken on an academic position with the Northern Ontario School of Medicine, Canada, and am helping to establish an 8 month Comprehensive Community Clerkship program for medical students in the third undergraduate year of a four year program. This is based in a town of 15,000 (Midland, Canada). A portion of this clerkship will be spent in exchange with Walter Sisulu University in Mthatha, South Africa. I plan on increasing my work in developing countries, in service, medical teaching and program development.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To develop an approach to the frequent user of medical services.
2. To be able to clearly differentiate overuse of medical services from unmet needs.
3. To be able to impart to the medical learner an empathy and inquisitiveness about there frequent user of medical services.

Abstract:
Whether in the emergency room, clinic, or private family practice, we often encounter what we term “over-utilizers” – patients who repeatedly access the health care system for what we as health care providers feel are often inappropriate reasons. Our negative or frustrated emotive response to these patients can be transmitted to clinical learners, perpetuating an ineffective way of serving these patients.

The structure of the Longitudinal Integrated Clerkship lends itself to effectively learning about and dealing with the frequent visitor to the medical office or emergency department. Learners will identify early in their clerkship appropriate patients, whom they can follow and employ a number of identified strategies to help these patients over the time of their clerkship: Eliciting an obscure or linked underlying reason for the visits; effectively dealing with the anxiety component that drives many of these visits; providing consequences or other forms of behaviour modification. Defined strategies will be implemented and demonstrated by the learner. The learner will record and compare strategies employed for their effectiveness over time, while maintaining a compassionate and patient-centered approach to a patient.

The presentation is case-based, with examples of successful interventions. Pitfalls, limitations and challenges will also be discussed. This presentation is of interest to all clinicians who teach medicine at the undergraduate and post-graduate level.
Malignant hyperthermia in a local community: How a rural clinical school creates links for research

Author(s) and Affiliations: Dr Zelda Doyle - Rural Epidemiologist, Rural Clinical School, School of Medicine, Sydney, The University of Notre Dame, Australia | Associate Professor Joe McGirr - Associate Dean, Rural, School of Medicine, Sydney, The University of Notre Dame, Australia | Associate Professor John Dearin - Head of Lithgow Rural Clinical School, School of Medicine, Sydney, The University of Notre Dame, Australia | Dr Margaret Perry - Malignant Hyperthermia Unit, The Children's Hospital at Westmead. | Dr Neil Street - Malignant Hyperthermia Unit, The Children's Hospital at Westmead | Professor Paul Allen - Professor of Anaesthesia, Harvard Medical School, Boston, Massachusetts | Dr Sue Morey - Morey Australia P/L

Zelda Doyle is an epidemiologist based in Lithgow, a regional town west of the Blue Mountains in NSW. Currently she is working for The University of Notre Dame, Australia in their Rural Clinical Schools assisting with research design, implementation and analysis. Zelda also helps supervise both honours and masters students. Prior to working at The University of Notre Dame, Zelda worked in the private sector as the field officer for the Tasmanian Iodine Monitoring Program. She has a PhD in ethics and epidemiology from the University of Tasmania, a Masters in Science majoring in epidemiology from the University of London and the London School of Hygiene and Tropical Medicine, and a Bachelor of Science with Honours from the University of Queensland.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Utilising the Rural Clinical School (RCS) as a liaison with the community to undertake relevant community based research.
2. Highlighting the role of RCS’s in linking the local community with specialised quaternary medical facilities.
3. Involving students in community research to strengthen the links with the community.

Background:
Malignant Hyperthermia (MH) is an Autosomal dominant inherited pharmacogenetic disorder. Lithgow, a regional town in western NSW, has a large cluster of MH susceptible individuals. In 2012 a lecture by a visiting professor from Harvard on MH aroused considerable interest in the local community. As a result of the University of Notre Dame Australia (UNDA) RCS is undertaking a research study to determine the genetic pedigree of MH in the Lithgow community.

Aim:
To assist potentially affected members of the community in determining their MH risk.

Methods:
A key aspect of the study is the recruitment of volunteers. As the RCS is based in the community we have been able to facilitate partnerships with the family as well as media and other organisations for recruitment and funding. In addition the RCS has developed partnerships with leading researchers for analysis for known genetic mutations and potential in-vitro contracture testing. Honours students based at the RCS are also involved.

Results:
Family members will know their risk of MH and this knowledge will assist both the local community and clinicians in taking appropriate precautions.

Conclusions:
The unique position of the RCS has enabled the development of research that links students and the community to quaternary level medical facilities. It is an illustration of how an RCS can broker the necessary partnerships to undertake needs based research in a rural community.

Audience: Researchers, clinicians

Type of data: Qualitative and quantitative data obtained from interviews/blood tests and muscle biopsies

You can’t have enough discussion: the value and impact of small group sessions in specialist continuing education seminars in Malawi, Rwanda and Zimbabwe

Author(s) and Affiliations: Donald Bramwell1, Paul Anderson2, Jegan Krishnan1 | 1. International Musculoskeletal Research Institute/Flinders University | 2. Specialists without Borders

I am currently employed as Head: Education and Research at the International Musculoskeletal Research Institute (IMRI). IMRI is an independent body associated with the Department of Orthopaedic Surgery: Flinders Medical Centre, Repatriation General Hospital and Flinders University.

Research interests: The role of assessment in facilitating effective learning, The development of discipline-specific and interprofessional competencies in practice, Educational initiatives in clinical and nonformal settings, Short and long term outcomes for patients undergoing surgical or non-surgical management, Organisational and educational innovation

Abstract Stream(s): Social accountability

Learning Objectives:
1. Small group learning provides opportunity for discussion and relevance.
2. Presenters and attendees both take time to adapt to small group learning.
3. An explicit focus on innovation ensures flexibility to adapt to learners’ needs.

Abstract:
Didactic continuing education sessions might lead to sustained changes in clinical practice (Erickson et al 1996). However, small group clinical education sessions are better suited to allowing attendees to develop, retain and apply knowledge and practical skills relevant to the context of their ongoing patient care. (Sloan et al 1997; Stevens et al 2009). By facilitating interactions between and among presenters and attendees, small group sessions ensure presenters learn about the knowledge and skill level of attendees, and to modify the content and focus of the session in response to questions, responses and discussion. Voluntary organisation, Specialists without Borders (SWB) has run short seminars in Rwanda, Malawi and Zimbabwe over the past 10 years. These seminars are attended by general and specialist practitioners and allied health professionals, specialist trainees and medical students. Presenters are experienced professionals, mostly physicians and surgeons. Seminars aim at improving local capacity through training and collaboration.

Over the course of the decade-long engagement with African health professionals, SWB has modified the format and content of the seminars, moving from long lectures only to a mix of short lectures and small group sessions. The continuing change in format has been undertaken despite all seminars receiving strong endorsement and high approval from attendees and local organisations.

UCLA SMDEP a student centered enrichment program designed by unique evaluation and assessment model

Author(s) and Affiliations: Lawrence ‘Hy’ Doyle, Associate Professor, Principal Investigator UCLA SMDEP

Lawrence ‘Hy’ Doyle is an Associate Professor at David Geffen School of Medicine at UCLA. He has developed one of the most innovative undergraduate pipeline programs for first and second year undergraduates which includes PBL cases, Khan Academy on-line materials, small-group projects focusing on health disparities, and skills development workshops. Hy has been involved in the education and development of health professionals to serve underserved and disadvantaged communities for more than thirty years.

He also is Executive Director of the UCLA PRIME program, a five-year dual-degree program designed to develop leaders in healthcare for disadvantaged and medically underserved communities.

Hy’s recent efforts have been with the Association of American Indian Physicians and the Native Hawaiian Center of Excellence at the John A. Burns School of Medicine in Honolulu, to develop more effective educational experiences for American Indian, Alaska Native and Native Hawaiian students interested in careers in healthcare to serve their home communities.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Will be able to describe the steps in the evaluation model.
2. Will exhibit understanding of components in Logic Model used in program development.
3. Will be able to discuss formative and summative elements of assessment in participants existent or planned program.

Abstract:
An educational assessment model will be presented in this workshop for program administrators, medical educators, faculty and students through the discussion of the development of the UCLA SMDEP, a six-week summer enrichment program for first and second year undergraduates, most from disadvantaged backgrounds.

The evaluation plan, included needs analysis, logic modeling, Delphi study, formative assessment, summative assessment and reflective practice in providing a program that is refined after each of its ten iterations.

Programming includes Problem Based learning cases to help the students develop a consistent analytic approach to gathering patient information, generating alternate hypotheses, and identifying additional tests or information necessary to make a clinical assessment.

For the 2014 iteration students were presented information in what is called a ‘flipped classroom’. This is an educational model in which the students review selected content material in on-line presentations before class, and then use class time with the instructor to answer test-questions and discuss reference materials, rather than sitting through lecture.

UCLA SMDEP Program also uses a small-group health disparity project in which the student-groups identify a community experiencing health disparities, design a health care intervention, and describe a manner in which they could evaluate a success.

All of the educational segments of the program were developed as part of the development and ongoing assessment generated by the Evaluation Model designed to suggest a framework for such program development

A model for enhancing community engagement of undergraduate health professional students on rural placement

Author(s) and Affiliations: Karin Fisher University of Newcastle, Department of Rural Health Tamworth | Luke Wakely University of Newcastle, Department of Rural Health Tamworth | Kelly Squires University of Newcastle, Department of Rural Health Tamworth | Lisa Shipley University of Newcastle, Department of Rural Health Tamworth | Katrina Wakely University of Newcastle, Department of Rural Health Tamworth | Leanne Brown University of Newcastle, Department of Rural Health Tamworth | Tony Smith University of Newcastle, Department of Rural Health Tamworth | Nicky Hudson University of Newcastle, Department of Rural Health Tamworth

Karin is a Tamworth-based Research Academic at the University Department of Rural Health, University of Newcastle and Adjunct Senior Lecturer at University of New England School of Health and Rural Medicine. Karin has been involved in a number of research projects that used both quantitative and qualitative research designs since receiving her doctorate in 2008. She has authored a number of peer reviewed journal articles as well as refereed and non-refereed research based national and international conference papers. Her current research interests include health workforce, community engagement, primary health care and public health issues.

Abstract Stream(s): Longitudinal Learning

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All of the educational segments of the program were developed as part of the development and ongoing assessment generated by the Evaluation Model designed to suggest a framework for such program development

Virtual Clinics and vertical medical education

Author(s) and Affiliations: Dr Patricia Knight-Billington, Prof Dimity Pond, University of Newcastle | Prof Gerard Gill, Deakin University | Professor Nicky (JN) Hudson, University of Newcastle Department of Rural Health | Dr Charlotte Hespe, University of Notre Dame | Dr Judy Mullan, University of Wollongong | Dr Kath Weston, University of Wollongong | Prof Ian Wilson, University of Wollongong

Dr Patricia Knight-Billington has a wide ranging experience in teaching, research and project management, and is the research fellow for the project. She has been working for the GSM for five years and has experience in and knowledge of the school's community engagement and research and critical analysis programmes.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Demonstrate the educational possibilities of presenting clinical reasoning in virtual clinical scenarios.
2. Recognise the potential for vertically integrated educational materials presented in virtual clinics.
3. Identify potential scenarios which can be used in a virtual clinic format.

Background:
A medical education trial, funded by the Department of Education’s Broadband Enabled Education Skills and Service program, incorporated 'virtual-clinic' sessions utilising internet-based, interactive teaching. The goal was to assist a dispersed rural healthcare workforce, including medical students and registrars, with the development of skills and knowledge regarding management of a range of scenarios.

Aims:
The aim was to enhance clinical reasoning skills through demonstration by skilled practitioners of the critical appraisal of differential diagnoses and management plans. This was then discussed by an expert panel with “Twitter” based interactions with the on-line audiences.

Methods:
We developed a simple, mobile format for recording clinical scenarios. The recorded sessions were then broadcast across multi-university sites, and were also available to practices with medical students or registrars involved with our partner training organisations. The final product was an interactive virtual clinic with pre-recorded clinical segments and an interactive panel discussion between each segment (facilitated using Twitter) of approximately an hour’s duration.

Results:
Web-usage and Twitter analytics demonstrated upwards trends in audience participation over the trial. Evaluation responses demonstrated positive responses to the technical and educational aspects of the program.

Conclusions:
An on-going and regular program of education delivered using internet-based video-streaming to promote real-time discussion between medical students, registrars and content experts appears effective in supporting those working in rural communities. The future potential, predicted by early results, is significant in terms of enhanced patient care and vertically integrated physician education in distant rural and remote areas.
131 Allocation of medical students to a 38 week longitudinal integrated community-based placement

Author(s) and Affiliations: Tracey Duguid, Acting Manager Community Primary Rural & Remote

Tracey Duguid is the current Acting Manager Community Primary Rural & Remote at the Graduate School of Medicine University of Wollongong. This role has broad responsibility for the operational requirements of the Rural Clinical School, Indigenous Health Unit, Community Engagement, Public Health and General Practice Academic Unit. Tracey's substantive position at the University of Wollongong is the Manager of the Rural Clinical School, a position which she established during 2012/2013.

Prior to joining the University, Tracey worked for NSW Health managing the Executive Unit for the South Eastern Sydney Illawarra Area Health Service. This provided the opportunity for Tracey to gain a significant understanding of the operational requirements to deliver public health care services across a wide range of areas and develop a commitment to the vision of the Graduate School of Medicine at the University of Wollongong.

Tracey lives in the coastal town of Shellharbour with her family.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. As students work closely with health providers for the year-long placement, it is important to get the matching process right.
2. The needs and requirements of both health providers and students are taken into account when allocating students to the longitudinal placement.
3. Both students and practices have the right to appeal allocation decisions made.

Abstract:
The University of Wollongong’s Graduate School of Medicine (GSM) is one of Australia’s newest medical schools with the first intake of students in 2007. The four year graduate entry Bachelor of Medicine Bachelor of Surgery (MBBS) degree provides a unique curriculum by being the only medical school in Australia where all students undertake a 38 week longitudinal integrated community-based placement in regional and rural Australia (Phase 3).

The GSM has a broad range of partners who assist in offering Phase 3 across New South Wales including privately owned General Practices, Hospitals and Aboriginal Medical Services. To ensure these partnerships are well supported and effective, the GSM has invested in resourcing each of the current 10 hubs with academic and professional staff, accommodation, IT infrastructure and clinical teaching facilities.

The aim of the poster is to describe the comprehensive process undertaken to allocate students to Phase 3. In this poster we will describe the process of obtaining key information from students and the management of confidential student information ensuring the integrity of the process.

We will explain how students are “matched” taking into account the community and the requirements of privately owned general practices, Aboriginal Medical Services and hospitals.

Finally we will describe the appeal process which aligns with the established University’s Student Academic Consideration process. This poster will provide valuable insights into the process of allocating students to longitudinal integrated community-based placements that may be used by other medical schools hoping to offer similar initiatives in their future programs.
Learning with community – students’ reflections on social accountability after community experiences

Author(s) and Affiliations: Lionel Green-Thompson, Centre for Health Science Education, University of the Witwatersrand, South Africa | Patricia McInerney, Centre for Health Science Education, University of the Witwatersrand, South Africa | Robert Woollard, Department of Family Medicine, University of British Columbia, Canada

Lionel Green-Thompson is an anaesthesiologist currently working as clinical coordinator in the Centre for Health Sciences Education at the University of the Witwatersrand in Johannesburg, South Africa. He is completing a doctorate in the social accountability of medical education. His interests include clinical competence, assessment and complexity thinking.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Understand the role of communities in the definition of social accountability for students.
2. Reflection is important to prevent desensitisation of students.
3. Rural and community placements have a positive effect on students.

Background:
Social accountability is an important goal for institutions which train health professionals. There is little data on the perceptions of students in this regard or the extent to which social accountability can be developed in the individual practitioner.

Aims:
The study set out to explore the perceptions of final year students in a South African medical degree program regarding social accountability and the areas of their learning which supported or detracted from its development. Much of the focus and reflection related to the experiences the students had in community placements, primarily rural.

Methods:
A qualitative study was conducted amongst the final year classes of 2012 and 2013. Four focus groups were conducted in 2012 with volunteers. Theoretical sampling was used to create seven focus group discussions with the final year class of 2013. The data were analysed using open coding with constant comparison.

Findings:
Five categories emerged from these focus group discussions. These categories are:
- “It’s poorly defined” – balancing expectation and obligation (related to their understanding of social accountability)
- “web of interconnected relationships” (defining community)
- “losing my heart and losing my compassion” (the hardening of their attitudes towards patients)
- “more wide angled view of things” (the role of the curriculum)
- “if I don’t go there, who will go” (intention to work in under resourced areas of country)

Conclusions:
Students express social accountability as a process of development with experiences which act as catalysts and others which detract from its development.

Assessing patient-centered care in an objective structured clinical examination

Author(s) and Affiliations: LuAnn Wilkerson, David Geffen School of Medicine at the University of California, Los Angeles

LuAnn Wilkerson, Ed.D., directs the Center for Educational Development and Research at the David Geffen School of Medicine at the University of California, Los Angeles. As Senior Associate Dean for Medical Education, she oversees curriculum development, faculty development, program evaluation, educational research, instructional technology, and simulation related to medical student education. She is a Professor in Medicine with active research projects in problem-based learning, clinical teaching, interprofessional education, and curriculum evaluation and serves as Program Director for the UCLA Faculty Fellowship in Medical Education.

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. Describe critical attitudes and skills essential to a patient-centered care (PCC) approach to cultural competency.
2. Consider ways to integrate the assessment of PCC into an Objective Structured Clinical Examination (Single case, Embedded items).
3. Consider how to provide feedback to students on the results of PCC assessments.

Objective:
To compare the reliability, validity, and feasibility of an embedded patient-centered care scale with the use of a single culturally challenging case in measuring students' use of PCC behaviors as part of a comprehensive OSCE.

Methods:
A total of 322 students from two California medical schools participated in the OSCE as beginning seniors. Cronbach's alpha was used to assess the internal consistency of each approach. Construct validity was addressed by establishing convergent and divergent validity using the cultural challenge case total score and OSCE component scores. Feasibility assessment considered cost and training needs for the standardized patients (SPs).

Results:
Medical students demonstrated a moderate level of patient-centered skill (mean = 63%, SD = 11%). The PCC Scale demonstrated an acceptable level of internal consistency (alpha = 0.68) over the single case scale (alpha = 0.60). Both convergent and divergent validities were established through low to moderate correlation coefficients.

Taking social accountability forward – a proposed framework

Author(s) and Affiliations: Lionel Green-Thompson, Centre for Health Science Education, Wits University, South Africa | Robert Woollard, Department of Family Medicine, University of British Columbia, Canada | Patricia McInerney, Centre for Health Science Education, Wits University, South Africa

Lionel Green-Thompson is an anaesthesiologist currently working as a clinical coordinator in the Centre for Health Sciences Education at the University of the Witwatersrand in Johannesburg, South Africa. He is currently pursuing doctoral studies in the social accountability of medical education and practice. His interests include clinical competence, assessment and complexity thinking.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. A systems approach is a central component of understanding social accountability.
2. Various relationship centred processes interact with each other continuously to achieve accountability.
3. Social determinants of health need to be aligned with curricula.

Background:
The concept and practices of social accountability may be the most effective vehicle for the transformation of health professionals into change agents. While the currently available evaluation frameworks highlight an institution's social accountability, there is little data on how this may be achieved in education programs and expressed in graduating students.

Aims:
To develop a framework for the discussion of social accountability with different stakeholders

Methods:
Qualitative studies were done amongst communities, students and partners in the education of medical students at Wits University. Three different “lenses” emerged from these data which express these stakeholders' perceptions of the needs and delivery of socially accountable health care. These three lenses were integrated into a single framework. The emergent framework was evaluated by a national panel of health science education experts. There was general validation of the model as a transformative lens for engaging and planning for practical learning and the expression of social accountability, institutionally and individually.

Findings:
The framework acknowledges that health and wellness can only be understood as a complex adaptive system in which the following components constantly interact: the social determinants of health, curricula alignment, empowered communities and community based relationship centered learning. Faculty development of role models is required in order that the faculty community becomes a change agent. The framework delineates capacity development of student's critical skills and curricular opportunities for students to reflect on both positive and negative role models as essential elements.

Conclusions:
Health for all is dependent on understanding relationships as a central cog which moves the many parts of the system.

Blueprinting a new medical school – the challenge offered by the Nelson Mandela Metropolitan University, South Africa

Author(s) and Affiliations: Ian Couper, Centre for Rural Health, University of the Witwatersrand | Steve Reid, Primary Health Care Directorate, University of Cape Town | Richard Cooke, Centre for Rural Health, University of the Witwatersrand | Julia Blitz, Division of Family Medicine and Primary Care, Stellenbosch University | Zuki Zingela, Department of Psychiatry, Dora Nginza Hospital, Port Elizabeth

Ian Couper, a family physician, is Professor of Rural Health at the University of the Witwatersrand (Wits), Johannesburg and Head: Clinical Unit (rural medicine) in the North West Provincial Department of Health. He is founding director of the Wits Centre for Rural Health, and is currently academic head of the Wits Department of Family Medicine.

He chaired the international Wonca Working Party on Rural Practice from 2007 to 2013. He serves as editor of the African section of the international journal Rural and Remote Health. He was a member of the expert panel that produced the WHO Global Policy recommendations "Increasing access to health workers in remote and rural areas through improved retention" and of the WHO Core Guidelines Group that developed the recommendations on "Transforming and Scaling up Health Professionals’ Education and Training". He is currently a member of the WHO Guidelines Review Committee.

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Discuss principles on which to base the blueprint for a new medical school.
2. Understand convergence (using established practices in health professional education) and divergence (using innovative, forward-thinking approaches) in medical education.
3. Describe lessons learned from developing a medical school program de novo.

Background:
The Nelson Mandela Metropolitan University (NMMU) has taken the strategic decision to start planning towards establishing a medical school based in Port Elizabeth (PE) in the Eastern Cape Province, South Africa. An external Expert Reference Group (ERG) was appointed to assist NMMU by developing a blueprint for a new medical school that should be socially accountable and innovative, using a model that is appropriate to the South African context in general and the Eastern Cape specifically.

Aim:
To develop a model for a new medical school in South Africa.

Methods:
The ERG conducted a number of site visits to facilities in and around PE, interviewing clinicians and managers; engaged with NMMU academics and support staff from a range of departments and seniority levels, including program leads and senior executives; consulted with local health professionals, unions and other stakeholders; reviewed local and international literature; and obtained input from key medical educators involved in socially accountable and innovative training globally.

Results:
A set of 14 principles were proposed as a basis for the blueprint. These are clustered around social accountability and community engagement; holistic, generalist clinical competence; innovative teaching practice and curricular approaches; and promotion of access and diversity. A curriculum framework and pathways, with multiple entry and exit points, was developed.

Conclusion:
The principles and their implications for the program will be presented, as a useful basis for thinking around the development of new programs in similar contexts.
Using multiple methods to measure outcomes of longitudinal integrated clerkships

Author(s) and Affiliations: Dr Deborah Fearon, Flinders University | Dr Carole Reeve, Flinders University | Dr Gayle Roberton, Flinders University

Dr Debbie Fearon is a graduate of the Auckland School of Medicine. She trained in Paediatrics in New Zealand and the United Kingdom. She has a special interest in Indigenous Child Health.

In 2007, Debbie started as a Paediatric Consultant at Alice Springs Hospital. She was appointed as a Lecturer for Flinders University soon after and promoted to Senior Lecturer in Rural and Remote Medicine in 2012. Debbie has recently been appointed as the first Clinical Dean for Alice Springs Hospital.

In 2013, Debbie led a team that implemented the first ever Longitudinal Integrated Clerkship in Alice Springs Hospital.

Abstract Stream(s): Longitudinal learning

Learning Objectives:
1. To identify multiple methods that can be used to evaluate the value of LIC’s for students, clinicians and patients.
2. To identify which methods would be acceptable where small numbers of students make statistical significance unlikely to be achievable.
3. To identify which methods would be more meaningful for clinicians and hospital managers without a background in education.

Abstract:
In a review article published in Medical Education in 2012, a group of academics from Flinders University called for further explanatory research to be done on LIC’s to develop a more complete understanding of the outcomes of this type of learning (2).

The outcomes discussed in this article were:
1. Academic results
2. Student clinical performance
3. Student values and ethics
4. Students’ learning experiences
5. Impact on clinical supervisors

An additional outcome that has been previously described in the literature is the experience of patients with longitudinal students (1).

How best should we measure each specific outcome?
There have been many different methods used in papers published in the literature to compare LIC to TBR students but they have mostly relied on formal examination results and/or student self-reported questionnaires. Additionally, the numbers of students in each individual LIC program are often small, which means that the results of measured outcomes are often not statistically valid.
Drawing on the advice and support of experts, we plan to use as many methods as possible to evaluate the LIC program that was started in Alice Springs in 2013, so we can provide our local management and clinicians with sufficient data to ensure they feel confident about making a decision on whether to continue LIFT past 2014.

Closing the gap – Are we teaching students enough about good clinical governance?

Author(s) and Affiliations: Dr Kathy Brotchie, Monash University, School of Rural Health Churchill

Dr Brotchie is a rural General Practitioner working part-time in an Aboriginal Health Service in Gippsland, 3 hours east of Melbourne Australia. She is also a Senior Lecturer for Monash University, where she coordinates the clinical skills program for the first year of the graduate entry MBBS program at the Gippsland Medical School in Churchill, Victoria. Her role includes both program development for the teaching of all systems as well as writing all the teaching and assessment materials. Dr Brotchie is also a Quality Assurance Examiner for the Royal Australian College of General Practitioners where she assists with both the written and Clinical examinations. Dr Brotchie previously lived in Thunder Bay from 2007-2009 where she worked for the Northern Ontario School of Medicine. Her husband was born in Port Arthur, Ontario and lived for the first four decades of his life in Murillo and Thunder Bay.

Abstract Stream(s): Longitudinal Learning, Aboriginal Health

Learning Objectives:
1. Explore the concept of clinical governance in comprehensive primary health care.
2. Consider the implications for the learner of longitudinal placement in a situation of poor clinical governance.
3. Discuss the opportunities for closing the gap through enhanced education in clinical governance for medical students undertaking longitudinal placements.

Abstract:
Clinical governance, the systems by which all individuals in a health organizations are responsible for safe quality patient care, is an essential element of all medical practices. Students in longitudinal placements are best placed to observe structures for creating effective teamwork, shared decision-making, accreditation and quality improvement processes and how the health bureaucracy interacts with patient care. Minimizing the risks for both patient and practitioner requires understanding of medico-legal processes and the application of sound systems for managing complex patient care.

Appreciation of good clinical governance is not universal to all health care organisations. This provides challenges to the suitability of longitudinal student placements in these clinical settings. Safety to both patient and student may be compromised in a practice where complex teamwork systems are absent or poorly understood. All the elements required to deliver safe defensible comprehensive primary health exist beyond competency in clinical skills and reasoning. AHPRA expects that practices will provide newly registered clinicians with support to learn all the aspects of clinical governance through a robust process of supervision. Whether this actually takes place is not audited currently. How do we determine that the practice has the expertise to ensure that our learners can observe the best practice in primary care systems? Is the practice with good systems a better learning opportunity than one without? Is the absence of good systems a contributor to the failure to close the gap in indigenous health? Will our students be able to propagate better systems where poor ones exist?

Victorian clinical governance policy framework A guidebook. Published by the Statewide Quality Branch, Rural and Regional Health and Aged Care Services, Victorian Government, Department of Human Services, Melbourne, Victoria 2009.
Exploring the link between the admission process and the social accountability mandate of the Northern Ontario School of Medicine

Author(s) and Affiliations: Dr. Owen Prowse, Northern Ontario School of Medicine (NOSM, Lakehead University) | John Hogenbirk (M.SC.), Centre for Rural and Northern Health Research (CraNHR), Laurentian University | Mary Hanna (M.A.), CraNHR, Laurentian University | Dr. David Marsh, NOSM, Laurentian University | Robert Barnett (M.A.), NOSM, Laurentian University | Dr. Blair Schoales, NOSM, Lakehead University | Julia Bickford (PhD), CraNHR, Laurentian University

Owen Prowse MD, MPH, FRCSC. Dr. Prowse is currently Assistant Professor of Surgery and Assistant Dean of Admissions at the Northern Ontario School of Medicine. He is a graduate of the University of Toronto and a practicing surgeon with public health training from The Johns Hopkins University in Baltimore. He has a longstanding interest in both clinical and Aboriginal health education.

Abstract Stream(s): Social Accountability, Aboriginal Health

Learning Objectives:
1. How do applicant rating systems influence class demographics?
2. How does changing the scoring and weighting systems effect class demographics?
3. What are the implications of a revised ranking system on cultural or linguistic minorities and other applicants?

Background:
There is evidence that Indigenous medical students and other minorities (Moreau et al., 2010), as well as those from rural areas are more likely than other students to return to their home communities or other underserviced areas upon graduation (Raghaven et al., 2013; Viscomi et al., 2013). Northern Ontario is a medically underserved area that is geographically vast and sparsely populated. There are sizable cultural and linguistic minority groups of Indigenous and Francophone peoples distributed throughout Northern Ontario. The Northern Ontario School of Medicine’s (NOSM) social accountability mandate aims to be responsive to Northern Ontario’s cultural and geographical diversity.

Aims:
Research will evaluate how NOSM’s current applicant rating system may be changed to obtain a student population that is more representative of Northern Ontario. Funding is provided by Ontario’s Ministry of Health and Long-Term Care.

Methods:
Data collected by NOSM and the Ontario Universities Application Centre as part of application and admissions processes will analyzed. Mathematical models will explore the effects of alternate scoring and weighting criteria on student rankings.

Results:
Findings will be available by early autumn. Results will inform if and how NOSM’s current ranking process can be modified to achieve a more representative student population while continuing to produce highly qualified physicians.

Conclusions:
Findings may contribute to improving outcomes of the admissions process for future applicants to NOSM and other medical schools: particularly cultural/linguistic minority applicants. Ultimately, healthcare delivery may be positively influenced through the enhancement of physician-patient and physician-community relations.

Northern Ontario School of Medicine undergraduate learners’ perspectives on rural practice and medical discipline

Author(s) and Affiliations: Margaret G. Delmege (1) | John C. Hogenbirk, (1) | Hoi Cheu, (1) | Roger Strasser (2)
To be presented by Owen Prowse

Margaret G. Delmege BA (Hons). Margaret is a Research Assistant with the Centre for Rural and Northern Health Research since January 2008. She holds a Bachelor of Arts (Hons), Combined Specialization in Sociology and Law & Justice from Laurentian University, Sudbury, Canada. She is currently wrapping up her Master of Public Health at Lakehead University, located in Thunder Bay, Canada. Her research interests include the career decision making processes of medical learners; and food equity for Northern Ontarians.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Identify some of the ways in which undergraduate medical learners think about the intersection of medical discipline and rural practice.
2. Determine some of the main reasons why medical learners wish to train & practice in Northern Ontario.
3. Assess the ways in which medical educators can address learners' concerns related to rural medical practice.

Background:
Medical learners are faced with several decisions throughout their career and one of the earliest is their choice of medical discipline. Medical learners recognize that choice of medical discipline intersects with preferred practice location as not every location can support all medical disciplines.

Aims:
To better understand early career decision-making by undergraduate medical learners at the Northern Ontario School of Medicine (NOSM) with respect to their choice of medical discipline and practice location.

Methods:
Qualitative analysis of interviews conducted at entry to and exit from NOSM’s 4-year undergraduate medical education program. We report on paired interviews conducted with 27 volunteers from the first 5 cohorts (2005-2009).

Results:
Findings from interviews with learners who were considering rural practice show that choice of medical discipline was intertwined with decisions about where they preferred to practice. For some interviewees, the knowledge required for rural family practice was a deterrent as it was considered too broad in scope. Other interviewees interested in rural family practice anticipated seeking additional training during their residency program in order to meet the anticipated needs of their patients and rural practice communities.

Conclusions:
Shorter length of postgraduate training concomitant with the presence of family obligations were important factors for those interviewees interested in Family Medicine, whereas compatibility with and key interactions with preceptors were influential in selecting any specialty. Most learners recognized that rural practice was intricately linked with only certain types of medical disciplines and planned accordingly.
Embedding community engaged learning within medical education: Levers, barriers and strategies for sustainability?

Author(s) and Affiliations: Dr. Josephine Boland, School of Medicine, National University of Ireland, Galway IRELAND | Dr. Maureen Kelly, Discipline of General Practice, School of Medicine, National University of Ireland Galway IRELAND | Dr. Margaret McGrath, Discipline of Occupational Therapy, College of Medicine, Nursing and Health Sciences, National University of Ireland Galway IRELAND | Lorraine McIlrath, Director of the Community Knowledge Initiative, National University of Ireland Galway IRELAND | Dr. Diarmuid O’Donovan, School of Medicine, National University of Ireland Galway IRELAND

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Differentiate between the purpose and practice of community based medical education (CBME), community engaged learning (CEL) and volunteering.
2. Share international experiences of embedding community engaged learning within the undergraduate medical curriculum, with attention to the significance of context and culture.
3. Critically explore strategies for embedding community engagement within a Medical School.

Abstract:
Community engagement involves building sustainable relationships to realise shared goals, based on values and principles such as partnership, reciprocity and capacity building, respect, social justice and equality. Community based medical education (CBME) is a well-established core element of the undergraduate curriculum. With community engaged learning (CEL) students have the opportunity to contribute to and learn from local and global communities and develop a sense of social accountability, while enhancing their professional and personal development. Meeting a community-identified need and reflective practice are distinguishing features of CEL, representing particular opportunities and challenges in the context of medical education. What conditions are necessary to ensure meaningful engagement with community as a core attribute of community engaged learning?

Special study modules and electives (local or international) have the potential to promote achievement of these goals, often as elective, or even peripheral, elements of the curriculum. Strategies for embedding CEL include mapping student outcomes explicitly with core professional competences while also highlighting the civic goals and outcomes which distinguish it from CBME. What are the benefits and risks associated with these complementary or even competing strategies?

We explore these challenges as we share our journey towards embedding engagement and we invite participants to share strategies they have adopted. The presentation will draw on our own research and scholarship on community engagement, emerging good practice and our collective professional experience. It will be of interest to medical educators interested in critical reflection on core values and in pragmatic strategies for sustainable community engagement.

**Communication for the patient’s needs... the key to competent healthcare**

**Author(s) and Affiliations:** Danielle Barbeau-Rodrigue Francophone Affairs, Northern Ontario School of Medicine | Lynn Cassimiro Academic Affairs, Hôpital Montfort Hospital | Jacinthe Savard School of Rehabilitation Studies, University of Ottawa | Josée Benoît Clinique universitaire interprofessionnelle en soins de santé primaire, University of Ottawa | Jacinthe Beauchamp Centre de formation médicale du Nouveau-Brunswick, Université de Moncton University | Dre Lyne Pitre Academic Affairs, Hôpital Montfort Hospital | Marie Drolet School of Social Work, University of Ottawa

Originally from Sudbury, Ontario, Canada, Danielle obtained a Bachelor in Science of Language Degree from Laurentian University (LU). She is currently a Sociology Masters student at LU, her particular interest is culturally competent health care and health professional education. An Ontario public servant for 18 years, she worked for most of this time at Ombudsman Ontario resolving complaints about unsatisfactory provincial government services; she was also the French Language Services Coordinator for this office. Since 2005, Danielle has been responsible for the Francophone Affairs Unit (FrAU) at Northern Ontario School of Medicine. The Unit was established pursuant to the School’s social accountability mandate and the commitment to a culture of inclusiveness and responsiveness to the needs of the Francophone people and communities of Northern Ontario. The FrAU strives to establish, nurture and grow collaborative partnerships with the Francophone community in its many sectors particularly health and education.

**Abstract Stream(s):** Community Engagement

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1. Differentiate between the purpose and practice of community based medical education (CBME), community engaged learning (CEL) and volunteering.
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Special study modules and electives (local or international) have the potential to promote achievement of these goals, often as elective, or even peripheral, elements of the curriculum. Strategies for embedding CEL include mapping student outcomes explicitly with core professional competences while also highlighting the civic goals and outcomes which distinguish it from CBME. What are the benefits and risks associated with these complementary or even competing strategies?

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144  Case based learning through peer review

Author(s) and Affiliations: Nancy W Dickey, MD | Kathy Mechler, MS, RN, CPHQ | Rural & Community Health Institute | Texas A&M University Health Science Center College of Medicine

Nancy W Dickey, MD and Kathy Mechler, RN, MS, CPHQ are co-directors of the Rural & Community Health Institute and are both faculty members at the College of Medicine, Texas A&M University Health Science Center College of Medicine. Ms. Mechler has years of experience as a hospital administrator and as a quality improvement specialist. For the last decade they have been central to systems improvement activities in rural Texas as well as identifying ways to use the tools of quality and safety in the medical school and other health professions training environments.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Demonstrate ability to review a chart to identify documentation, judgment, medical issues regarding quality & safety of care.
2. Demonstrate learning in a just culture through a systems review.
3. Ability to detect variances from the standard of care and discuss intervention points that might have led to different outcomes.

Abstract:
Peer review has traditionally been a means of overseeing physician performance and identifying problem providers, usually institutionally based. For a decade the Rural & Community Health Institute (RCHI) does virtual system oriented, inter-professional, performance improvement directed peer review.

Just as students are learning from banks of cases used in simulation labs and small group discussions, they can learn from real cases about issues that may seem esoteric in the early stages of medical education but which train them to be comfortable in reviewing work of peers, to identify systems issues impacting care, and to discuss potential variations in approach that may enhance patient outcome.

Records, fully redacted for anonymity, will be provided for students groups to review. Students will be encouraged to seek references for differential diagnosis, systems issues, pharmaceutical selection, etc. They will then participate in a discussion about the case in a moderated/facilitated group with experienced reviewers who will lead the students in processes oriented to quality & safety improvement rather than punitive “gotcha” processes. As the course is implemented, we are looking for outcomes that suggest students understand the value of the process and ultimately will not accept traditional judgmental processes.

As this is a course proposal, there are as yet no conclusions. Thus, the data will be from actual peer review impact on physicians and theory/literature supporting this type of education. The presentation should appeal to faculty interested in innovative curriculum, quality improvement, and inter-professional learning.

The population that the study pertains to any patient population.

Creating effective change agents: Leadership training for students within the context of community engagement

Author(s) and Affiliations: Susan Rogers, MDiv, Sr. Program Coordinator - Duke Primary Care Leadership Track | Barbara Sheline, MD, MPH, Director - Duke Primary Care Leadership Track (PCLT) | Joseph Jackson, MD, Assoc. Director - Duke Primary Care Leadership Track | Bruce Peyser, MD, Assoc, Director - Duke Primary Care Leadership Track

Susan Rogers has been the Coordinator of the Primary Care Leadership Track (PCLT) at the Duke School of Medicine since its launch in 2010. A native of and former social worker in Durham, North Carolina, which is home to Duke University and provides the context for the PCLT’s community engagement, Susan is passionate about the preparation of medical students to engage with communities in community-identified health initiatives. A graduate of the Duke University Divinity School, Susan is an ordained minister in the American Baptist Churches, USA and has pastored urban churches in the Metropolitan New York area. She is also the Course Coordinator for the Practice Course at the Duke School of Medicine, the school’s longitudinal dr.-patient relationship course. Susan is one of the authors of the article in press at Academic Medicine about the Primary Care Leadership Track.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Share the areas of focus in Leadership Training for community engaged students.
2. Understand the importance of following as well as leading in the context of community engagement.
3. Explore the training ground for leadership development that is the Primary Care Leadership Track curriculum.

Abstract:
Creating effective change agents to affect the health of the public requires leadership training. The Duke Primary Care Leadership Track (PCLT) prepares students to exercise leadership in service to society. The leadership curriculum focuses on self-awareness, communication skills, commitment to the growth of others and willingness to take risks. Students learn the importance of following as well as leading in the context of community-engaged work. Leadership training begins in Pre-orientation to the first year and continues through all four years.

During Pre-orientation, students have time to reflect on their leadership values, explore issues of trust, openness to feedback and the importance of taking risks. Later in the curriculum, students identify their leadership style in an afternoon workshop and practice communication given their styles. During Year 2, they gain practical experience working with community health teams. Because community-engaged research demands collaboration with community members, students receive professional leadership coaching throughout their research year (Year 3). In Year 4, senior students serve as mentors for other students in the PCLT.

The PCLT curriculum, especially the LIC, allows for customizing parts of the students’ clinical learning process and thus becomes a training ground for leadership development. Students learn to self-assess and advocate for their learning needs. Openings in their weekly schedule give students flexibility to seek opportunities such as observing a clinic for children with obesity or autism, adding extra time reading EKGs with a cardiologist, or following an acupuncturist. PCLT faculty act as mentors during this process through regular meetings with students.
Effect of interprofessional training at rural small hospital ~ rural community is suitable field for interprofessional education~

Author(s) and Affiliations: Ryota Nakaoke MD,PhD | Tohru Osibuchi MD | Susumu Shirabe MD,PhD,

Ryota Nakaoke MD, PhD, Associate professor; Nagasaki University Hospital Organization of Rural Medicine and Resident Education

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Interprofessional education.
2. Community engagement.
3. Program evaluation.

Abstract:
We started 4 weeks rural training program at small rural hospital in 2005. 114 residents had trained community medicine at the rural small hospital from 2005 to 2013. All the hospital staffs and community health workers support to resident training in rural community. They do Home visiting with nurse, and Health promotion and yearly resident medical checkup with public health nurse. Co-working with other health professionals is feature of our program. Almost 40% of program is supported by other health professionals. Evaluate effect of this program on residents with pre and post questionnaire. And using a Visual Analog Scale (VAS) to measure their attitude.

Yearly resident number is increase from 2 on 2005 to 35 on 2014. Score of knowledge of collaboration work is significantly increase and understanding details of other works are also significantly increase. Nurse Pre 52.1 Post 70.3 (p<0.001), PT,OT Pre 47.2 Post 64.3 (p<0.001), Care manager Pre 40.9 Post 60.6 (p<0.001). These result shows work with other professional had increase the understanding each other. On the other hand, residents do not have enough understanding of the other health profession and recognize on co-working field. Understanding score of Care work is lowest of these score and it would give a good feedback for them.

Training at rural small hospital is good for interprofessional education field.

We started rural training program at small rural hospital in 2005. 114 residents had trained community medicine at the hospital from 2005 to 2013. All hospital staffs and community health workers support to resident training. Co-working with other health professionals is feature of our program. Almost 40% of program is supported by other health professionals. Evaluate effect of this program on residents with pre and post questionnaire. Score of knowledge of collaboration work is significantly increase and understanding details of other works are also significantly increase. These score shows work with other professional had increase the understanding each other.
Remote clinical school - Where are they now?

Author(s) and Affiliations: Dr Sarah Chalmers, Mrs Michelle Hockings, Nhulunbuy campus NTMP

Dr Sarah Chalmers is the Senior Lecturer of the Nhulunbuy campus, part of Flinders NT Remote Clinical School. She works as a GP in town, and has previously worked as a DMO at Gove District Hospital and as a GP for a remote outreach AMS in Arnhem Land. She has been the Nhulunbuy Senior Lecturer since 2009.

Abstract Stream(s): Social Accountability, Aboriginal Health

Learning Objectives:
1. To showcase a remote health program for final year students.
2. To demonstrate the success of the program.

Abstract:
The Flinders NT Remote Clinical School offers a 24 week placement across Nhulunbuy and Alice Springs to Flinders final year students. In Nhulunbuy the 2 six week rotations aim to showcase the varied types of practice in a small remote town. Rotation supervisors are long term remote GP/DMOs who actively encourage students to consider a career in remote health.

The program has been running in Nhulunbuy since 2007. This is the first time we have presented the outcome of former students in terms of their current work locations and aspirations for the future.
Learner experiences of a hybrid distributed pediatrics residency program

Author(s) and Affiliations: Rachel Ellaway - NOSM | Maureen Topps - University of Calgary | Tara Baron - NOSM | Alison Peek - NOSM

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Describe the different dynamics of tertiary and community residency experiences.
2. Appraise the strengths and weaknesses of different learning contexts.
3. Apply the findings of this study to their own work.

Background:
The NOSM pediatrics residency program is run in collaboration with the University of Ottawa. Pediatrics residents spend 50% of their time at the large urban children's hospital in Ottawa and 50% of their time at Northern Ontario community sites.

Aims:
To explore whether this hybrid model provided learners with sufficient clinical experience at different locations, and to understand how residents' experiences changed depending on training location and context.

Methods:
A 2-year tracking study was conducted, tracking pediatric residents’ (n=10) clinical encounters and interviewing them to map how their experiences differed depending on their location. Descriptive statistics were generated on participants' clinical log data and a thematic line-by-line analysis was conducted on transcripts of participant interviews and focus groups.

Results:
Although residents saw a wide range of patients in urban and community settings, there were significant differences in the nature of these encounters. Ottawa-based experiences were more multiprofessional and academic but residents had a narrower scope of practice with little or no longitudinal patient contact. Northern Ontario experiences involved greater autonomy and scope of practice and much greater longitudinal of patient contact but less complexity as serious/complex cases were sent to Ottawa or Toronto.

Conclusions:
This hybrid residency model demonstrated that learners benefited from having both kinds of experiences. The implications are that community and tertiary training experiences should be combined to optimize student learning.

This presentation is of relevance to those with an interest in postgraduate medical education, longitudinal learning, and distributed medical education.
Teaching clinical urology to learners training as “Generalists” in a rural setting

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EMMANUEL O. ABARA MB. FRCSC. FACS. FICS. Director, Richmond Hill Urology Practice & Prostate Institute; Consultant Urologist: Kirkland Lake & District Hospital, MICS Group of Hospitals, Sensenbrenner Hospital, Kapuskasing. Graduated 1976 from University of Ibadan as a Gold medalist in Community Health.

General Surgery training in Universities of Benin and Port Harcourt. Urology Residency at the University of Toronto with fellowship in General Urology, Pediatric Urology and ESWL.

Current interest in Rural Health and enhancing urologic care through Telemedicine. Two-time recipient of the Canadian Urological Association “Community Urologist Award” 1995 & 2001. Has presented papers at local, national and international meetings. Guest Speaker and Faculty at institutions in Africa. Has published in peer reviewed journals and acted as review editor and adviser to journals and periodicals. Interested in Community Engagement in Education, Arts and Medicine.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. Distinguish opportunities and challenges of teaching specialty urology to Learners training as “Generalists” in a rural setting.
2. Discuss “core values” and “jewels” of rural practice that will result from such a program.
3. Learn about knowledge-based resources, value of collaboration, and community engagement in patient-centered care.

Background:
Northern Ontario School of Medicine (NOSM) is a 21st century Medical School with the whole of Northern Ontario as its campus of Distributed Learning Centres including rural and remote small community hospitals all technologically wired. Several learners (medical students, and residents) have over the years spent some time in rural hospitals either as electives or core rotations.

In this session, knowledge gained over the past 25 years will be shared and new perspectives discussed.

Learning Objectives:
1. Distinguish opportunities and challenges of teaching specialty urology to Learners training as “Generalists” in a rural setting
2. Discuss “core values” and “jewels” of rural practice that will result from such a program
3. Learn about knowledge-based resources, value of collaboration, and community engagement in patient-centered care

Method of Delivery:
Power point presentation, questions and answers. Small group break out sessions for discussion will be incorporated.
Hospital Policy, the Learner and Quality of Care: A student -Centered Learning Tool

Author(s) and Affiliations: Emmanuel O. Abara, MB, FRCSC FACS FICS, Assistant Professor Northern Ontario School of Medicine (NOSM), Danica E, Medical Student IV, NOSM, Julie Boucher, MD, Family Medicine, NOSM

EMMANUEL O.ABARA MB. FRCSC. FACS. FICS. Director, Richmond Hill Urology Practice & Prostate Institute; Consultant Urologist: Kirkland Lake & District Hospital, MICS Group of Hospitals, Sensenbrenner Hospital, Kapuskasing. Graduated 1976 from University of Ibadan as a Gold medalist in Community Health.

General Surgery training in Universities of Benin and Port Harcourt. Urology Residency at the University of Toronto with fellowship in General Urology, Pediatric Urology and ESWL.

Current interest in Rural Health and enhancing urologic care through Telemedicine. Two –time recipient of the Canadian Urological Association “Community Urologist Award” 1995 & 2001 Has presented papers at local, national and international meetings. Guest Speaker and Faculty at institutions in Africa. Has published in peer reviewed journals and acted as review editor and adviser to journals and periodicals. Interested in Community Engagement in Education, Arts and Medicine.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. Define Hospital policies and how they impact on the practicing physician.
2. Gain insight into learner perspectives on such an engagement and how they impact quality of patient care.
3. Share knowledge gained by engaging learners in policy reviews and initiations.

Background:
Policies in Organizations exist to assist in the smooth running of such organizations for successful achievement of their objectives and mandate. Hospitals, both small and big, rural and urban, university based or community based are rich with these policies. Most learners, may not be aware of various hospital policies that impact on clinical care of patients and the responsibilities practicing physicians and other health care workers. Engaging learners in dialogue and process of Policy reviews and initiation could be a useful aspect of Learner experience during their core rotation. Benefits- perceived and real, may emerge from such an exercise. In this session, we shall share knowledge gained from such exercise and propose further conversations.

Method of Delivery:
Power point presentation questions and answers. Small group break out sessions for discussion will be incorporated.
152 Specific challenges in starting Longitudinal Integrated Clerkship (LIC) in an Academic Medical Centre (AMC)

Author(s) and Affiliations: W Heddle | A Poncelet | G Roberton | P Worley | Flinders University | University of California, San Francisco

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. The challenges that are unique to establishing a LIC in an AMC.
2. How to overcome these challenges.
3. The network of centres using LIC in AMC.

Introduction:
LIC programmes started in Rural and Community Medicine as a means of both increasing clinical placement options and rural medical workforce. The benefits of such programmes, particularly in improved patient centredness and social awareness have resulted in such programmes being started in urban academic medical centers (AMCs). This workshop enables participants to explore unique challenges in an urban academic LIC, using the experiences at the Parnassus Integrated Clinical Student Experiences (PISCES) at the University of California, San Francisco (UCSF) and the Longitudinal Integrated Flinders Training (LIFT) program at Flinders Medical Centre/ Flinders University as a springboard.

Challenges:
1. Conversion from long established Traditional Block Rotation (TBR) to LIC (with teaching schedule matched to TBR)
2. Many subspecialists (majority of consultant staff are sub- or sub-sub-specialists) required to teach generic clinical skills with patients referred for specific subspecialist advice
3. Inflexibility in complex network of academic medical center
4. Lack of understanding by senior clinicians of what constitute good learning opportunities for medical students
5. Multiple levels of trainees:
   a. Year 3 students, year 4 students, elective students,
   b. Interns,
   c. Residents at multiple training levels,
   d. Fellows
6. Frequent changes of duty consultants on roster
7. Overwhelming emergency clinical workload
8. Lack of time opportunity to educate preceptors about LIC and benefits
9. Space limitations
10. Productivity pressures for faculty
11. Competition for resources with students on traditional rotations
12. Expanding program to all students
13. Integrated structure of program contrasts with departmental structure for faculty, resources
14. Limited teaching capacity in small specialist units

Associate Professor William Heddle is a Cardiac Electrophysiologist and has developed a strong interest in Medical Education since 2007; he has been Coordinator of the LIFT Pilot program (of Longitudinal Medical Education) in the School of Medicine, Flinders University, and is currently Associate Dean and Head, Flinders Southern Adelaide Clinical School, one of the major Academic Units within the School of Medicine, Flinders University. In development of the LIFT Pilot he has worked closely with Professor Ann Poncelet, University of California, San Francisco, and Dr David Hirsh, Harvard Medical School.
Student centred learning for quality teaching in anatomy

Author(s) and Affiliations: Dr. Buddhika Weerasundera, Senior Lecturer Knowledge Health and Illness, Northern Territory Medical Programme, Flinders University

Dr. Buddhika Weerasundera MBBS, DLM, MD, DMJ Path. (Lon) MFFLM (UK), CTHE (SEDA, UK). I joined the University of Flinders Northern Territory Medical program in March 2012 after being a Visiting Tutor for several months. In my present position as a Senior Lecturer in Knowledge, Health and Illness I teach Anatomy, Pathology and Medical Ethics to students in the pre-clinical years.

I had my higher education in Sri Lanka and qualified as a Forensic Pathologist. I had further training at the Victorian Institute of Forensic Medicine in Melbourne and at the University of Sheffield in Britain. I have always liked teaching and prior to joining the NT Medical Program, I was a Senior Lecturer in Forensic Medicine and Toxicology at the University of Colombo in Sri Lanka where I immensely enjoyed medico-legal work.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Identify the teaching methods that were designed for learning anatomy.
2. Compare the changes that were implemented for dissections over a period of 3 years.
3. Analyse the effectiveness of the changes that were adopted.

Background:
The delivery of the anatomy curriculum in the NT Medical School is by using innovative methods and latest technologies to ensure the quality of training. In the Knowledge of Health and Illness (KHI) component of Years 1 and 2 of the Medical programme, the students participate in learning anatomy. It is provided by lectures via video conferencing from Flinders University in Adelaide and Practicals, Dissections and other teaching sessions conducted in Darwin.

Aims:
Continuous monitoring of our teaching methods and changing such methods to suit student requirements is important to create an effective learning environment. In the dissection component, students are expected to dissect a cadaver during their first two years of learning. Over the last three years we have introduced changes to the teaching methods used in this process to enhance student learning.

Methods:
The changes that were effected are the incorporation of innovative methods for teaching and introducing changes to the timing of the dissection programme in the curriculum. These changes were made in association with the Body Donation Programme of University of Adelaide, Audio Visual Unit of the NTMP and the curriculum committee of the University of Flinders.

Results:
Student performances in anatomy of the three batches of students at the KHI exams and the feedback from the students of these batches are analysed to determine the effect of these changes.

Conclusions:
Feedback from students and their performance at examinations suggest that the changes have had an overall positive impact.

Implementing a successful reflective practice program at six different distributed ICC sites – an exercise in diversity and adaptation

Author(s) and Affiliations: Dr. Maggie Watt MD, CCFP, FCPC – Site Director – Cowichan Valley Integrated Clerkship Site, Island Medical Program, University of British Columbia Faculty of Medicine | Dr. Becky Temple MD, CCFP, CCPE – Site Director – Fort St. John Integrated Clerkship Site, Northern Medical Program, University of British Columbia Faculty of Medicine | Dr. Patricia Seymour, MD, CCFP – Clinical Instructor, Department of Family Practice, Island Medical Program, University of British Columbia Faculty of Medicine

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Present a novel approach to teaching reflective practice in an ICC / LIC.
2. Review the findings of the UBC Evaluation Studies Unit’s assessment of the Tool Kit Launch at the six distributed ICC sites at UBC.
3. Discuss how innovation at each site can have a positive impact on the entire program.

Abstract:
The Professional Competencies (PC) Tool Kit is an applied, skill-based approach to teaching reflective practise to medical students. The PC Tool Kit is a set of twenty-eight cards divided amongst six broad domains of professional competency. Each card is a tool for learning. Each card reduces broad, complex issues that define professionalism, into “bite-sized” essential elements, defining a topic in a catchy title and laying out a specific set of concrete skills to be acquired within the clinical setting. The purpose of the PC Tool Kit is to promote the development of reflective skills as an integral part of a student’s clinical skills and knowledge acquisition, and in a manageable ‘bite sized’ and habit based fashion.

The Tool Kit was piloted at a small ICC (LIC) site on Vancouver Island, Canada, with three students in the 2012/2013 academic year. Due to the success of this program, the Tool Kit was rolled out to the entire six University of British Columbia ICC sites in the 2013/2014 academic year.

The Evaluation Studies Unit of the University of British Columbia Faculty of Medicine examined the different ways in which this program was delivered in the contexts of the six different ICC sites. The study will be completed in July 2014 and the results presented at the Muster. Preliminary results highlight how each site has rolled out the Tool Kit slightly differently. In Fort St. John students photographed the cards but still found it difficult to “think” about them throughout the day and or week. The cards were then photocopied and placed in a visible location on all the patient wards, in the doctors’ lounge etc. This triggered conversations with nursing and other allied staff throughout the week that the card was in “play”, and led to a much richer student and interdisciplinary experience.

This presentation will appeal to students and faculty who are interested to learn about innovative methods to run reflective practice sessions.

Year 3 Integrated Community Clerkship (ICC)
Reflective Practice Module Evaluation Plan 2013-14, Evaluation Studies Unit, University of British Columbia, Faculty of Medicine.

Dr. Maggie Watt is a full service Family Physician who lives and practices in Duncan, B.C., on Vancouver Island, Canada. She is Site Director for the Cowichan Integrated Clerkship, one of the UBC Faculty of Medicine’s six ICC sites, which are distributed across BC.
155  Peer and student support group (PaSS): Supporting rural learners and teachers

Author(s) and Affiliations: Jill Konkin, MD, Division of Community Engagement, University of Alberta | Fred Janke, MD, Division of Community Engagement, University of Alberta | Darren Nicholes, MD, Division of Community Engagement, University of Alberta | Carol Suddards, MD, Division of Community Engagement, University of Alberta

Dr. Konkin has been the Associate Dean, Community Engagement, in the Faculty of Medicine & Dentistry (FoMD) since January 2011. She provides leadership in the areas of Indigenous, inner city, international, rural & regional health plus community engaged research. Responsibilities include meaningful engagement of communities, fostering social accountability in FoMD and advocacy for social justice and health equity issues at the intersection of health services delivery and medical education. She implemented a longitudinal integrated clerkship as well as a program that delivers a 2nd year undergraduate course in rural communities. A graduate of University of Calgary’s MD and Family Medicine Residency programs, Dr. Konkin has spent her clinical career as a rural generalist. She has had many leadership roles in medical and medical education organizations.

Current research interests include rural medical education, professional identity formation and longitudinal integrated clerkships.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Discuss models for support of students and learners in rural communities distant from urban campus.
2. Identify opportunities to engage full-time with community based clinical faculty.
3. Identify areas of support of interest and benefit to students in rural placements.

Background:
Supporting students and community faculty in rural longitudinal integrated clerkships can be challenging.

Intervention:
In the second year of the University of Alberta’s longitudinal integrated clerkship, the Integrated Community Clerkship (ICC), a group of senior faculty members was assembled as the Peer and Student Support (PaSS) Group. The objectives of PaSS include:
• Educational support and mentorship for students and preceptors
• Direct observation of students and preceptors with timely feedback
• Feedback to program director from students and community preceptors
• Involvement in other formal academic activities of ICC Program including Orientation

PaSS Group members are assigned to an ICC community and are expected to visit their community every 6 to 8 weeks in the 10 months of the program. They use the Mini-CEX as a tool for observation with the students and the Peer Observation of Peer Teaching Tool (POPTT) developed within the Faculty to guide observation and feedback to preceptors.

Results:
Program evaluation studies indicate that both students and preceptors find the visits of the PaSS group members valuable. Students identify that the PaSS Group member as someone who can give direct feedback on skills and knowledge (100%), to whom they can ask questions (89%) and with whom to relax and enjoy talking about their learning (78%). Community preceptors state that the visits help them feel more connected with the Faculty of Medicine & Dentistry and better supported in their teaching.

Conclusion:
Implementation of the PaSS Group has been a positive addition to the ICC, valued by students and preceptors.
Curriculum Development for Community Engagement

Author(s) and Affiliations: Dr. Josephine Boland, School of Medicine, National University of Ireland Galway, IRELAND | Dr. Margaret McGrath, School of Health Sciences, National University of Ireland Galway, IRELAND

Dr. Josephine Boland is Senior Lecturer in Education and director of the Masters in Clinical Education in the School of Medicine, National University of Ireland Galway (NUIG). She supports teaching, learning and assessment development in the School. She has experience supporting civic engagement within the curriculum, nationally and internationally and as a civic engagement mentor for Campus Engage. As a founding member of Community Engaged Research in Action (CORA) – a community of practitioners of community engaged research – she supports and undertakes collaborative research projects with local community partners, drawing on the principles of participatory research practice. Her research interests and publications centre on civic/community engagement, curriculum mapping and assessment in medical education. She has 30 years experience as an educator in post-secondary, higher, teacher and medical education.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Identify opportunities for embedding community engaged learning in medical education, drawing on relevant and feasible curriculum design models.
2. Draft some key elements of a community engaged curriculum (learning outcomes, the student engagement experience and strategies for assessment).
3. Explore opportunities, strengths and limitations associated with different models of community-university partnership in the particular context medical education.

Abstract:
This workshop provides an interactive experience in planning a curriculum for community engaged learning in medical and health sciences education. Key characteristics of community engaged learning will be explored e.g. meeting a community identified need, learning for academic credit, integration of discipline specific knowledge and skills with reflection as a key component. Alternative models will be presented, highlighting key decision to be made, using a deliberative model of curriculum development. Participants will work in groups to explore opportunities for a student engagement experience, drafting learning outcomes which combine the civic, academic, personal and professional domains. Alignment with core competencies in medical education will be considered. Strategies for the assessment of student outcomes – including capacity for reflection – will be considered. Models of university-community partnership and some attendant ethical issues will be critically explored.

Participants will work with others sharing an interest in community engagement, to identify opportunities for multi-disciplinary initiatives and avenues for collaboration. Issues of sustainability will be explored and some strategies for enhancing it will be discussed. The workshop aims to prompt participants to reflect critically upon their motivation for incorporating community engaged learning in medical/health science education and in community life and to clarify their expectations. The workshop draws on the facilitators’ experience designing and implementing community engaged learning, providing faculty development, nationally and internationally and their research and publications. It will be of interest to medical educators and community partners interested in designing community engaged learning deliberatively and collaboratively.

Experiences in the implementation of longitudinal medical student placements in urban general practice – lessons learned and recommendations

Author(s) and Affiliations: Marie-Louise Dick | Margaret Henderson | David King | Lis Miller | Jocelyn Selwood | Jill Thistlethwaite | Susan Upham | Mieke Van Driel | All authors are affiliated with The Discipline of General Practice, School of Medicine, The University of Queensland, Brisbane. Australia

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. To describe the implementation of a longitudinal integrated program in an urban setting.
2. To discuss issues encountered in implementing a longitudinal program as an adjunct to a rotation-based system.
3. To discuss the resultant changes and success of the program.

Background:
There is excellent research evidence demonstrating the success of innovative longitudinal integrated clinical curricula1, but most examples have been in rural locations.

Aims:
The University of Queensland, School of Medicine’s Urban Longitudinal Integrated Community Care (Urban LInCC) Project aimed to increase clinical training capacity and provide an urban longitudinal community placement for medical students. The focus was on developing clinical skills and gaining experience in continuity of patient care and the complexities of managing patients with multiple problems.

Methods:
In 2012, the program offered a longitudinal community placement for a small number of Year 3 medical students for 1 – 2 days/week for most of the year. This was modified in 2013 to offer half-day/week placements to Year 2 students, for 13 or 26 weeks. Curriculum documents were developed mapping course learning objectives with suggested learning activities for community placements. Survey evaluations from GP teachers and students were collected, and a semi-structured interview guide explored the experiences of a sample of participating GPs and students.

Results:
Integrated longitudinal learning was difficult to manage as an adjunct to the structured Year 3 rotation-based curriculum. A regular timetabled clinical placement session and lack of rotation-specific requirements facilitated the Year 2 implementation. A range of rich learning experiences was reported.

Conclusions:
The Urban LInCC project established new clinical placements and learning opportunities for medical students. Initial implementation difficulties guided successful modifications to the program. Recommendations to enhance longitudinal learning opportunities are provided for those interested in the development and/or delivery of similar programs.

The development and implementation of an international student and graduate outcome cohort with medical schools aspiring to social accountability

Author(s) and Affiliations: Larkins, Sarah. James Cook University, Australia | Michielsen, Kristien. Ghent University, Belgium | Iputo, Jehu. Walter Sisulu University, South Africa | Elsanousi, Salwa. Gezira University, Sudan | Mammen, Marykutty. Walter Sisulu University, South Africa | Graves, Lisa. Formerly Northern Ontario School of Medicine, Canada | Willems, Sara. Ghent University, Belgium | Cristobal, Fortunato. Ateneo de Zamboanga University, Philippines | Samson, Rex. Ateneo de Zamboanga University, Philippines | Ellaway, Rachel. Northern Ontario School of Medicine, Canada | Ross, Simone. The Training for Health Equity Network | Johnston, Karen. James Cook University, Australia | Derese, Anselm. Ghent University, Belgium | Neusy, Andre-Jacques. Training for Health Equity Network

Dr Sarah Larkins is an academic General Practitioner with research interests in strengthening health systems to meet the needs of rural, remote, Indigenous and tropical populations, and training a health workforce with knowledge, attitudes and skills to do this.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Explore the practice intentions at entry of 944 students from schools with a social accountability mandate.
2. Understand the link between selection strategies and student profile characteristics at five schools with a social accountability mandate.
3. Describe how selection criteria and medical school experiences can contribute to producing a workforce with the knowledge, attitudes and skills to respond to priority health needs of populations.

Background and aims:
The Training for Health Equity Network (THEnet) aims to reduce health inequalities by training a workforce that is responsive to the priority health needs of under-served communities. THEnet currently consists of 11 medical schools with a social accountability mandate. This study describes the impact of selection strategies employed by THEnet schools on student diversity, intention to practice with under-served populations and eventually on actual practice and the degree to which this corresponds with need.

Methods:
This prospective cohort study involves entering students from THEnet medical schools who completed a standardised questionnaire based on the Australian Medical Students' Outcomes Database tool with modifications for international contexts. The questionnaire assessed students' background, rurality of schooling and practice intentions. Results were compared with medical schools using standard selection procedures where possible.

Results:
Initial findings from the entry survey from 944 learners across five countries are presented, demonstrating a diverse student profile with higher proportions reporting intent to practice in under-served communities compared to other schools. These will be compared with selection strategies and curricular strategies encouraging a commitment to service. Methodological challenges will be discussed.

Conclusions:
Despite dramatically different contexts, THEnet schools demonstrate student profiles and intentions that differ from other medical schools. The students will be followed up longitudinally to assess the degree to which these intentions translate into practice. Strategies to increase social accountability in medical education play a pivotal role in addressing priority health needs and current workforce shortages in rural areas.
Do medical students maintain their empathy differently depending on the location of their study in year three?

Author(s) and Affiliations: Sarah Mahoney | Mark Slee | Tim Neild | Ruth Sladek | All Flinders University

Dr Sarah Mahoney is Academic Coordinator of the Onkaparinga Clinical Education Program and Head of Year 3 of the Flinders MD program. She is a general practitioner with over 30 years clinical experience in a variety of settings including rural and urban general practice, emergency medicine and population health.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Empathy in medical students at Flinders University.
2. Factors that may impact on empathy scores.

Background:
There is now a significant body of research showing that students often lose some of their empathy for patients during year three, their first full clinical immersion year.

Aims:
The study aimed to determine whether there is any loss of empathy occurring in the clinical year for medical students at Flinders University. Since Flinders students can undertake year 3 in a tertiary hospital, in rural and remote settings, or in hybrid programs, the study also aimed to determine whether there were any differences related to the site of year three.

Methods:
All Flinders students were surveyed using the Jefferson Scale of Empathy at the beginning and end of the academic year in 2013.

Results and Conclusions:
Preliminary results and conclusions will be presented at the conference.

Hojat et al 2009. The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School. Acad Med Vol 84 no 5
Social accountability and community engagement in the local urban context

Author(s) and Affiliations: Sarah Mahoney | Linnea Boileau, Flinders University

Dr Sarah Mahoney is Academic Coordinator of the Onkaparinga Clinical Education Program and Head of Year 3 of the Flinders MD program. She is a general practitioner with over 30 years clinical experience in a variety of settings including rural and urban general practice, emergency medicine and population health.

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Social accountability in the local setting in Australia.
2. Community engagement in urban settings.

Abstract:
This workshop will use the experiences of the Onkaparinga Clinical Education Program (OCEP), an urban community-based medical education program at Flinders University, as an illustrative example of some ways to address these three questions. (30 minutes)

The attendees will then break into three groups, each addressing one of the three questions. (30 minutes)

The groups will then reconvene to share the key points discussed by each group, and to provide opportunities for whole group discussion around each of the questions.

Mahoney et al 2012 The Cube: an approach to social accountability in an urban community-based medical education program with a reflection on the benefits, barriers and opportunities. The Australasian Journal of University-Community Engagement
Survival as a pathway in transformative learning: Experiences of medical students in a rural clinical school

Author(s) and Affiliations: Sarah Mahoney | Jennene Greenhill | Lucie Walters | Julie Ash | Narelle Campbell | Janet Richards, All Flinders University

Dr Sarah Mahoney is Academic Coordinator of the Onkaparinga Clinical Education Program and Head of Year 3 of the Flinders MD program. She is a general practitioner with over 30 years clinical experience in a variety of settings including rural and urban general practice, emergency medicine and population health.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Experiences of medical student in longitudinal rural settings.
2. Medical Student sense of survival of year 3.

Background:
Many medical schools now provide options for medical students to undertake longitudinal clinical placements in rural and remote settings. Students in these programs usually need to learn to live in an unfamiliar community in addition to their clinical learning. Mezirow’s transformative learning theory describes ten phases starting with a disorienting dilemma. This paper discusses one disorienting dilemma described by students in a longitudinal series of interviews.

Aims:
To understand better the learning journeys of medical students in the clinical years, particularly in longitudinal programs.

Methods:
Structured interviews have been conducted with students in year 2, at the beginning and end of year 3, during year 4 and during their intern year.

Results:
This paper focuses on just one aspect of the results of the study, the sense of ‘survival’ of a grueling time in year 3.

Conclusions:
Year 3, or the first clinical immersion year, is often seen as the most difficult year of a medical course. For it to be seen as something to be ‘survived’ suggests that students might need more support during this year of study. More research is required to determine whether this is a widespread phenomenon.

Student approaches to Learning: Comparison of longitudinal integrated and rotation based clerkships

Author(s) and Affiliations: Jill Konkin, MD, Division of Community Engagement, University of Alberta | Carol Suddards, PhD, Division of Community Engagement, University of Alberta

Dr. Konkin has been the Associate Dean, Community Engagement, in the Faculty of Medicine & Dentistry (FoMD) since January 2011. She provides leadership in the areas of Indigenous, inner city, international, rural & regional health plus community engaged research. Responsibilities include meaningful engagement of communities, fostering social accountability in FoMD and advocacy for social justice and health equity issues at the intersection of health services delivery and medical education. She implemented a longitudinal integrated clerkship as well as a program that delivers a 2nd year undergraduate course in rural communities. A graduate of University of Calgary’s MD and Family Medicine Residency programs, Dr. Konkin has spent her clinical career as a rural generalist. She has had many leadership roles in medical and medical education organizations.

Current research interests include rural medical education, professional identify formation and longitudinal integrated clerkships.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Discuss the learning environment in the Longitudinal Integrated Clerkship (LIC) and Rotation Based Clerkship (RBC) models and the impact on a medical student’s approach to learning.
2. Identify key elements in clerkship models that foster deep learning.
3. Discuss the motivators for learning in LICs and RBCs.

Background:
Learning environments significantly influence an individual’s approach to learning. A comparison of the influence of the rotation based clerkship (RBC) and the longitudinal integrated clerkship (LIC) on medical students contributes to a deeper understanding of the impact of these models. Students who experience both LIC and RBC are well placed to describe and compare the clerkships.

Method:
In this hermeneutic phenomenological study, reflective conversations were held with students at the end of 3rd year (LIC) and again at completion of the 4th and final year (RBC). It focuses on the approach to learning adopted in each environment.

Results:
In the LIC, students focus on the provision of safe, competent care to patients with whom they have ongoing therapeutic relationships. Students often measure their learning through patient outcomes. Their teachers are guides and mentors. In the RBC, patient care is more episodic and teachers more transitory with few opportunities for continuity. Patient care tasks are often isolated and disconnected. Students’ focus changes to the discreet, often disconnected, expectations of their many teachers. Students measure their success by comparison with each other and through the institution’s assessments.

Conclusion:
LIC students learn with, from and about patients and, importantly, they learn FOR patients, applying their learning in authentic circumstances. RBC students regularly rejig their learning focus to the expectations of each preceptor and each rotation with fewer opportunities to apply what they know to patient care. In the LIC, the opportunities for deeper, more self-directed learning are more abundant.
Transformational change in a big, old, traditional medical school: The “how” of becoming socially accountable

Author(s) and Affiliations: Jill Konkin, MD, Division of Community Engagement, University of Alberta

Dr. Konkin has been the Associate Dean, Community Engagement, in the Faculty of Medicine & Dentistry (FoMD) since January 2011. She provides leadership in the areas of Indigenous, inner city, international, rural & regional health plus community engaged research. Responsibilities include meaningful engagement of communities, fostering social accountability in FoMD and advocacy for social justice and health equity issues at the intersection of health services delivery and medical education. She implemented a longitudinal integrated clerkship as well as a program that delivers a 2nd year undergraduate course in rural communities.

A graduate of University of Calgary’s MD and Family Medicine Residency programs, Dr. Konkin has spent her clinical career as a rural generalist. She has had many leadership roles in medical and medical education organizations.

Current research interests include rural medical education, professional identify formation and longitudinal integrated clerkships.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Identify methods to facilitate transformational change within an existing medical school and apply them in a case study to enable the development of a socially accountable institution.
2. Compare and contrast key elements of leadership, goals/outcomes and relationships in institutions that begin with a social accountability mandate with those that were established prior to the social accountability imperative existed.
3. Develop a broad road map for change to social accountability in a well established medical school.
Community based research in practice: Shared reflections on process, outcomes and impact

Author(s) and Affiliations: Dr. Josephine Boland, School of Medicine, National University of Ireland Galway, IRELAND | Siobhan Kavanagh, Child and Family Research Institute, National University of Ireland Galway, IRELAND | Lisa Ann Kennedy, Centre for Effective Services, Dublin, IRELAND | Dr. Seamus Morrissey, Galway City Partnership, Galway IRELAND | Ena Norris, COPE Galway, Galway, IRELAND | Lisa Silke, COPE Galway, Galway IRELAND | Dr. Padraig MacNeela, School of Psychology, National University of Ireland Galway, IRELAND

Dr. Josephine Boland is Senior Lecturer in Education and Director of the Masters in Clinical Education in the School of Medicine, National University of Ireland Galway (NUIG). She supports teaching, learning and assessment development in the School. She has experience supporting civic engagement within the curriculum, nationally and internationally and as a civic engagement mentor for Campus Engage. As a founding member of Community Engaged Research in Action (CORA) – a community of practitioners of community engaged research – she supports and undertakes collaborative research projects with local community partners, drawing on the principles of participatory research practice. Her research interests and publications centre on civic/community engagement, curriculum mapping and assessment in medical education. She has 30 years experience as an educator in post-secondary, higher, teacher and medical education.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Consider the relevance and value of community-based research for a community engaged medical school
2. Distinguish between the principles and practice of community-based research (CBR) and community-based participatory research (CBPR)
3. Appreciate the importance of clarity of roles and expectations with mechanisms for re-negotiation in community-university partnerships.

Abstract:
Community-engaged research strategies offer health professionals, researchers, community leaders and policy-makers new methodologies to address complex health and social problems. This participatory research style is increasingly emerging as an alternative research paradigm with dialogue and critical reflection at its core.

The paper explores the opportunities and challenges associated with enacting the values and principles of collaborative participatory research practice. We critically examine the process, outcome, and impact of two community-based research projects. These were conducted by a university-based research team in collaboration with not-for-profit organisations tasked with responding to the needs of people who are homeless.

One project focused on staff capacity building in participatory strategies as a means to enhance client involvement. The other sought to include client voices in the planning of services. Both projects involved participatory research techniques such as flexible brainstorming and timelines, and each can be positioned on an engagement continuum comprising consultation, involvement, collaboration, and shared leadership.

We identify enabling conditions for effective community-based research. Particular attention is drawn to the implications of the style of university-community partner engagement for processes of data analysis and interpretation. We also report on follow-up work evaluating the experience of organisational partners and the later impact of research findings in the organisations, thus closing the cycle of critical reflection. We make the case that CBPR has value in university-community partnerships for health, while underlining the need for critical awareness among all partners and openness to an on-going negotiation of roles and expectations.

Boland, J., Kavanagh, S., Kennedy, L., and MacNeela (2013) ‘Perspectives on Structured Activity and Engagement Opportunities in Galway Simon Community’ A Participatory Study by CORA for Galway Simon Community
165 Medicine, Assessment and the Community: A Space for the Arts?

Author(s) and Affiliations: Dr Margaret Simmons, Monash University

Margaret works in the School of Rural Health, Monash University, Gippsland, Australia, teaching graduate medical students a social perspective on health. She also coordinates the Community Based Practice Program which aims to equip students with an interprofessional understanding of the social and community aspects of health through a community placement. Margaret's PhD used poetic representation to tell the stories of Gippsland women evacuated as children in WWII Britain who immigrated to Australia in the postwar period. Margaret’s research interests focus on narrative analysis, gender issues, aging and notions of home and migration and pedagogies of practice in medical education.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Understand more about rural community based placements.
2. Expand your knowledge of rural medical education.
3. Pique your interest in innovative assessment tools.

Abstract:
A rural cohort of first year graduate medical students have been offered the opportunity to submit a small part of their assessment as an original creative piece of work that might include poetry, sculpture, artwork, music, fabric work, photography or similar. This assessment forms part of their required tasks for the Community Based Practice Program, aimed to assist students to develop an interprofessional perspective on health while undertaking non-clinical placements in various rural community agencies. During their placement, students are encouraged to reflect on, and gain a greater appreciation for, rural health and social justice issues, advocacy for a 'whole-person' approach and an understanding of the social and economic contexts of health and illness, public policies and the welfare system. At the end of their 40 hour placement, students submit either a reflective journal or a creative project which are both expected to be thoughtful and considered accounts of their experiences, highlighting any changes in attitudes and values as a result. This presentation illustrates the potential for novel assessment tasks to assist students in reflecting on and learning from others in ways which can often be very meaningful and that provide alternative pathways for students to articulate their medical journeys.
“Wicked problems and exquisite dilemmas” for non-health professionals who teach health professional students

Author(s) and Affiliations: Ms Robyn Preston, General Practice and Rural Medicine, College of Medicine and Dentistry, James Cook University | Dr Kim Owens, Medical Education, School of Medicine and Dentistry, James Cook University | Ms Simone Ross, General Practice and Rural Medicine, College of Medicine and Dentistry, James Cook University

Robyn Preston studied anthropology and international development and has worked in local and global health NGOs. Despite 9 years experience teaching medical students, post-grad degrees in health and a PhD on socially accountable medical schools (which hopefully will be done and dusted by 27 October 2014), she sometimes still feels like a fake.

Dr Kim Owens has a PhD in archaeology and has worked in a variety of university curriculum management roles while ‘taking a break’ from ‘her real profession’ which has actually spent less time off the ground than her current work. After 7 years working in and around medical education in administrative and academic roles, she’s wondering what her ‘identity’ is and if it even actually matters as long as she does her work well and feels it’s worthwhile.

Abstract Stream(s): Community Engagement

Abstract:

Learning Objectives

• To share our experiences and dilemmas of being non-health professionals who teach health professional students
• To discuss any resolutions for our identified dilemmas
• To discuss the possibility of further research and developing a network
Evaluating the impact of a rural clinical school on rural communities

Author(s) and Affiliations: Sally Hall | Edward Reynolds | Miriam Glennie | Michelle Irving & Amanda Barnard, ANU Medical School.

Sally Hall is the research manager in the Rural Clinical School at the Australian National University. She is a nurse with experience in rural critical care, management, population health and primary care, and now works as a health services researcher with interests in safety and quality, interprofessional practice and professional culture.

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Describe a method for assessing the community level impact of rural medical teaching activities.
2. Identify impacts and influences operating at the community level in south eastern NSW.
3. Articulate a model of community impact of the ANU RCS.

Background:
To date limited research has been conducted on the impact of rural clinical schools upon the communities where they are located and engaged. This is an important, and increasingly topical, consideration in the context of service learning which enhances educational goals but also serves the public good.

Aim:
To describe the community-level impact of the ANU Rural Clinical School (RCS) on the host communities within its geographic footprint.

Method:
This qualitative project employed a two phase approach using focus groups, key-informant interviews, participant observation and documentary analysis. In Phase 1, staff and students were sampled to identify key themes and develop a working model of 'impacts' operating at the local level. Phase 2 drew on ethnomethodology and ethnographic rapid appraisal techniques, to gather data from community based individuals and groups, medical and allied health professionals, and local businesses to explore and refine these impacts and understand interactions and phenomena that explain the model. Data were analysed in NVivo using a grounded theory approach.

Results:
We present a preliminary model of multifaceted and interconnected effects which arise at a number of different levels in the community. In particular we explore the orientation, motivation and relationships of different actors in the local context.

Conclusion:
Our results illustrate the investment in social capital which has arisen as the product of ANU RCS activity in south eastern NSW, and the positive and negative elements of impact on the community. These results will be of interest to rural medical educators and administrators, and may inform the development of tools for measuring community-level impact.
“On your own at the sharp end”: A workshop to address the challenges of providing the institutional/educational leadership in an isolated/remote location

Author(s) and Affiliations: Prof Sarah Strasser, Flinders University, NOSM & Health Science North | Prof Hugh Grantham, Flinders University and International Guests

Professor Strasser has over thirty years in rural general practice and medical education with a particular interest in Aboriginal Health, Leadership and Innovation. She has been instrumental in establishing a number of new programs in both undergraduate and postgraduate medical education in Australia and Canada with a particular focus on community engagement and social accountability. She led faculty development at NOSM from 2002-2007 and then in 2009-10 was their Director of Phase 2 when the students live and work in small rural communities for a year. She returned to Australia as Director of Community Based Medical Education in the Northern Territory for Flinders University for 2007-9 when she secured the funding for the NT Medical Program; she became the inaugural Associate Dean from 2010 to 2013. In 2014 Professor Strasser returned to Canada as Associate Vice President, Academics and Inter-professional practice at Health Sciences North.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Specify issues that cause consternation for isolated/remote leaders.
2. Identify useful resources and practical next steps to take to help resolve these challenges more quickly.
3. Demonstrate their leadership skills.

Abstract:
This workshop will explore the challenges of providing the institutional/educational leadership in an isolated/remote location for those who have experienced or have fear of being “on your own at the sharp end”. These challenges may arise from being at a distance from the main campus; small campus and small numbers; and, those associated with unique cultural and logistical challenges. Issues of importance from the point of view of a leader will be presented as case scenarios and drawn from participants’ experience. These will be explored in the workshop to develop a conceptual framework with potential strategies.

A panel of global leaders in medical education known for their leadership skills will be available to discuss issues of relevance in particular jurisdictions or disciplines, to share their own most challenging moments and how they dealt with them.

As a result of this workshop the general principles on how to cope when you are “on your own at the sharp end” will be developed as a conceptual framework and practical guide for isolated/remote leaders to get to an optimal resolution in a timely manner. These will be presented back at a future conference for endorsement.

This workshop will be of interest to those who are either leaders or aspiring to be leaders in medical education and academic administration.
Slipping under the radar in a parallel universe - Social accountability and community engagement in a rural clinical school program

Author(s) and Affiliations: Dr David Campbell, Associate Professor Rural Medicine, School of Rural Health, Monash University

Dr David Campbell has worked as a rural doctor for the past 30 years. For the past 15 years he has been actively involved in rural medical education at many levels, including 10 years as Director of the East Gippsland Regional Clinical School for Monash University.

He is the current Censor in Chief for the Australian College of Rural And Remote Medicine, and is a past President of ACRRM.

Dr Campbell's interests include rural medical education at all levels, education for rural emergency medicine, use of simulation in clinical education, and academic and clinical leadership in rural medical education.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To discuss aspects of community engagement in a longitudinally integrated rural clinical program
2. To explore barriers to implementation of a 'centrally' developed curriculum in the rural community context
3. To present and discuss the opportunity for implementation of social accountability strategies as part of a rural clinical program

Abstract:
This workshop will involve an initial presentation of the longitudinal integrated clinical placement program delivered over the past 10 years by the Monash University East Gippsland Regional Clinical School based in Bairnsdale and Sale in Victoria. An outline of the community engagement activities, student recruitment activities, support for the local Aboriginal community, student community projects, interprofessional education program, and integration with other medical and health education programs, will be presented. This presentation will be based on evaluation research conducted by the East Gippsland Regional Clinical School over the past 10 years. Participants will then be invited to discuss the role of rural clinical schools in developing community engagement programs, their role in community development, and their role in being accountable to their community; participants will then discuss how to deal with perceptions and attitudes of "traditional" or mainstream medical education programs that may not share these values and vision of rural community programs.

Questions for discussion will relate directly to the learning objectives.

This workshop will appeal to rurally-oriented medical students and junior doctors; to existing rural practitioners; and in particular to rural clinical academics and academic leaders of rural community-based education programs. It should also be of interest to members of rural communities.
The Frozen North meets the Tropical North: six years down the track in the Centre of Australia

Author(s) and Affiliations: Dr Pascale Dettwiller, Director FNT Katherine site, Flinders University

Abstract Stream(s): Social Accountability

Learning Objectives:
1. To define Rural and Remote practice in context.
2. To understand the Australian context of rural medical education.
3. To explore rural programs that integrate communities and are designed to enhance medical education.

Abstract:
In July 2008, Professor Roger Strasser, founding Dean of the Northern Ontario School of Medicine, presented in Darwin to the Flinders Northern Territory faculty a talk entitled “The Frozen North meets the Tropical North”. This presentation explored the concept of rurality in the context of Northern Ontario and the underpinning principles for the creation of the Northern Ontario School of Medicine; the teaching tools implemented to address the distance education; the setting of the various remote learning centres embedded in the communities all across Northern Ontario and what rural education means in this context.

This presentation aims at introducing the Northern Territory Medical Program (NTMP) in Northern Territory (Australia), drawing a parallel with Professor Strasser’s 2008 presentation in highlighting difference, but more importantly the similarities between the two programs. In 2008 Flinders University launched the Rural Clinical Schools in NT and although the NTMP started only in 2011, Flinders has a long history of rural education in South Australia; in 2014 we will celebrate the inaugural cohort of NTMP graduates. This paper will expand on the achievements and challenges of/for NTMP to date.

Strasser R The Frozen North meets the Tropical North; 2008, presented at FNTRCS.
‘Be a change maker’: interagency collaboration between governmental department, university, training operator and community health services in the Katherine region

Author(s) and Affiliations: Judith McKay, Human Service Training Advisory Council | Pascale Dettwiller, Director FNT Katherine Site | Kailas Kerr, Director, Central Desert Training, Pty Ltd | Millwanga Sandy, FNT Katherine Site

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. Best Practice in collaborative workforce development approaches.
2. Language, Literacy and Numeracy (LLN) Skills – a key to improved workforce outcomes.
3. Success stories in Australian Aboriginal Health practitioners and workforce engagement in the community in a remote setting.

Abstract:
Solutions for today’s remote health workforce challenges are not easily defined or able to be achieved overnight. What we do know is that to bring about change we need to provide greater capacity for Aboriginal people to be a part of the solution.

At the outset of this project, employers identified that a language, literacy and numeracy (LLN) skill gap existed in the Aboriginal Health Workforce. This limited the capacity of Aboriginal Health Practitioners to operate independently and progress career pathways from entry-level positions to post-entry level positions. This is said to have contributed to the steady decline in the number of Registered Aboriginal Health Practitioners and required urgent attention. What we did not know was if a Workforce English Language and Literacy (WELL) program facilitated through a collaborative workforce development approach would improve staff wellbeing, performance and stop the churn that was said to be occurring in the Aboriginal Community Controlled Health Setting. A collaborative partnership was formed under the leadership of the Human Service Training Advisory Council through four Katherine health services, Central Desert training and Flinders Northern Territory – Katherine site.

This paper will present the findings from the evaluation undertaken by Flinders University in the community; barriers and enablers for the program; participants satisfaction; story of success in building capacity in Aboriginal health workforce. It will present the community engagement model adopted for the program and underpinning its success.

A greater focus on staff at the workplace takes time, costs a lot up front but worth every cent invested!
172 NOSM health sciences summer camps... a successful community-engaged collaborative model

Author(s) and Affiliations: Danielle Barbeau-Rodrigue, Northern Ontario School of Medicine | Tina Armstrong, Northern Ontario School of Medicine | Miriam Cain, Northern Ontario School of Medicine | Karl Rom, Northern Ontario School of Medicine | Maria Sokolova, Northern Ontario School of Medicine

Originally from Sudbury, Ontario, Canada, Danielle obtained a Bachelor in Science of Language Degree from Laurentian University (LU). She is currently a Sociology Masters student at LU, her particular interest is culturally competent health care and health professional education. An Ontario public servant for 18 years, she worked for most of this time at Ombudsman Ontario resolving complaints about unsatisfactory provincial government services; she was also the French Language Services Coordinator for this office. Since 2005, Danielle has been responsible for the Francophone Affairs Unit (FrAU) at Northern Ontario School of Medicine. The Unit was established pursuant to the School's social accountability mandate and the commitment to a culture of inclusiveness and responsiveness to the needs of the Francophone people and communities of Northern Ontario. The FrAU strives to establish, nurture and grow collaborative partnerships with the Francophone community in its many sectors particularly health and education.

Abstract Stream(s): Aboriginal Health

Learning Objectives:
1. Identify and discuss the impact and value of an early intervention initiative such as the week-long NOSM Health Sciences Summer Camps program.
2. Examine the elements and activities that make up the NOSM Health Sciences Summer Camps program.
3. Generate ideas which will lead to developing a similar early intervention program within their health professional faculty.

Background:
NOSM's Vision for a ‘Healthier North’ addresses its dedication to advancing the highest quality of socially accountable medical and health professional practice, learning, teaching, research and professionalism for the benefit of Northern Ontario populations. The reality is that Aboriginal, Francophone and rural youth in Northern Canada typically are at higher risk of not completing school, hence the need for a supportive early intervention program.

Aims:
These camps are offered to help and guide participants along their own path to choosing a meaningful health profession.

Methods: NOSM’s Health Sciences Summer Camps were developed to reflect elements of its programs. Since 2006, NOSM has provided northern high school students with a valuable opportunity to learn about health professional careers, obtain hands-on experiences such as casting and simulation, find a NOSM student mentor, and enhance their knowledge and awareness about aboriginal and francophone culture.

Results:
NOSM’s Admissions and Learner Recruitment, Aboriginal Affairs and Francophone Affairs Units, students and Faculty collaborate to provide socially accountable programming during the week-long camps which take place within the technologically advanced settings of the medical school campuses. The summer camp program has already produced tangible successful outcomes! Two of NOSM’s current 1st and 2nd year medical students were ‘summer campers’ in the inaugural 2006 and the 2007 camps respectively!

Conclusion:
The emphasis of the camps is to create a connection between meaningful health care interventions and the basic sciences all in a fun, safe yet educational environment. Participant eligibility is based on level of interest rather than grades or test scores.

2. Greenlaugh, T., et al, “We were treated like adults”-development of a pre-medicine summer school for 16 year olds from deprived socioeconomic backgrounds: action research study, BMJ 2006; 332:762.
Remote Health Experience (RHE): an innovative and unique education activity in remote Northern Territory, Australia.

Author(s) and Affiliations: Dr Pascale Dettwiller, Director Katherine Rural Clinical School, Flinders Northern Territory

Pascale Dettwiller is Associate Professor and Director at the Katherine Campus of the Rural Clinical School Campus of the Flinders University NT Medical Program, Katherine, Northern Territory.

She holds a Doctor of Pharmacy from the School of Pharmacy, Joseph Fourier University, Grenoble (France) and several Bachelor and Diploma awards in Teaching, Business, Nutrition and Herbal Medicine. She has held Senior Clinical Pharmacist positions in regional health centres in New Caledonia, Tasmania and Victoria. Pascale has vast experience in teaching and mentoring of pharmacy, medical and nursing students in Tasmania, Victoria and Northern Territory, especially in rural medical schools and health practices. She is a member of 12 professional societies and the Chair elect of Human Ethics at Menzies School of Health Research in Darwin. Her major area of research is in medication management and safety, drug usage evaluation and education around medication and adherence.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To explore simulated remote inter-professional training and education.
2. To understand the role of simulation in developing ability to work in collaboration to form partnerships with patients, carers, colleagues, and others interested in the health care of patients and/or communities.
3. To develop of lifelong learning skills necessary for professional development, adaptability to available resources and new technologies and the skills to teach others.

Abstract:
The Remote Health Experience (RHE) is innovative. In one period over three days RHE offers inter-professional interactions with other students, with other health professionals, and with the community; drawing in over 50 students from medicine, nursing, pharmacy and Aboriginal and Torres Strait Islander health practitioners, and almost 20 faculties from six different organisations.

The Remote Health Experience is unique. It is the only event of its kind offered to health professional students in Australia. It is set as a simulated rural/remote environment where students form health disciplines learn how to manage a critical situation, and how to work together and respect each other's discipline and point of view. The program has developed and expanded from a one day event, with feedback from students and input from faculty over the last few years, to now being a three day week-end activity, and attracting attendance and input from professionals far and wide!

This paper aims at presenting a summary of four years of progressive and adaptive design in providing a distinctive and unique program to help ensure graduates are ‘remote ready’. A qualitative and quantitative mix method was implemented to evaluate the activity. Student learning experiences can be enhanced through engagement and interaction in a rural/remote community context. Inter-professional learning in a rural/remote community placement can increase students' understanding of professionalism, teamwork and collegiality which are all important aspects of collaborative practice.
175 Case based learning through interprofessional peer review

Author(s) and Affiliations: Nancy W Dickey, MD | Kathy Mechler, RN, COO & Co-director, Rural & Community Health Institute | College of Medicine | Texas A&M Health Science Center | Texas A&M University

Dr. Nancy W. Dickey, President Emeritus of the Texas A&M Health Science Center, currently serves as a professor, Department of Family and Community Medicine and Department of Medical Humanities, College of Medicine and Department of Health Policy and Management, School of Public Health. She is co-director of the Rural and Community Health Institute, a consultative group facilitating best practices in patient safety, enhanced quality of care, and physician excellence. Created during her time as president, RCHI exemplifies translating sound policy into practice in traditional academic health centers and across the spectrum of practice sites and care delivery.

Nancy Dickey served as president of TAMHSC from 2002 through 2012. Dr. Dickey is a past president of the American Medical Association, and the founding program director of the Family Medicine Residency of the Brazos Valley, and was elected to the prestigious Institute of Medicine in 2007.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Identify appropriate cases for peer review learning.
2. Discuss the roles of various health professionals in peer review.
3. Identify the skills included in this form of learning including premature closure, appropriate documentation, differential diagnosis, etc.

Abstract:
Today students learn from cases in simulation labs/small group discussions; they can also learn from real cases chosen for systems issues, professionalism, & patient safety. Students develop skills in case analysis as well as training in reviewing and providing feedback to peers. Anonymous, redacted records are provided for student review. Pre-group work includes differential diagnosis, systems issues, pharmaceutical selection, etc. Students then participate in case-base facilitated discussion. Results include: demonstrated capacity to identify issues in documentation, systems failures, and hand-off communications. As a pending proposal, there are no conclusions. Presentation is based on existing physician peer review with student participation and theory/literature. Presentation should appeal to curriculum experts and quality improvement faculty.

Is community engagement fundraising/friendraising or is fundraising/friendraising community engagement?

Author(s) and Affiliations: Gail Brescia, Northern Ontario School of Medicine

Gail Brescia joined the Northern Ontario School of Medicine (NOSM) in 2007 and has held the position of Manager of Advancement since then. In 2013 Gail earned her Certified Fundraising Executive designation (CFRE), this is an international designation earned by fundraiser who have shown dedication, professional development and academic excellence in this field. The Advancement office is responsible all philanthropic donations and processing to NOSM, the Alumni Relations office and special events in support school initiatives. Gail currently serves as the President of the Thunder Bay (Lakehead) Rotary Club and is a Paul Harris Fellow.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Recognize what fundraising/friendraising is.
2. Identify who (individual, organizations, corporations)in a community has the ability and interest to support your institutions initiatives.
3. Understand how connections between individuals, organizations and groups can lead to friendraising and engagement in institutional initiatives.

Abstract:
Does financial support from a community guarantee a doctor? Return of Service? Is that really philanthropy? What is the return on my investment? If we give, they will come. Is the # of dollars coming in from a community an indication of how much they need a physician? How much financial support does a physician really need?

Fundraising is often referred to as FRIENDRAISING, the goal of having supporters to our institutions who are there to provide advice, assistance, and guidance; with the ultimate goal of financially supporting our initiatives. The pool of donors in rural areas is not the same as in large urban centers. Our economic challenges and business climates are different, the population is vastly different. The Northern Ontario School of Medicine is a new school and at this stage doesn't have the alumni base positioned to financially give back to their alma mater. Our Charter Class campaign was extremely successful raising $13million dollars for medical students. The majority of this support came from the citizens of Northern Ontario who were passionate and believed in having a medical school in northern Ontario. They wanted to see the physician shortage in our region become a thing of the past. How do we continue to engage our “friends” and encourage them to continue to support us.

Questions for discussion:
• Will community engagement ensure financial support for our institutions?
• Is the amount of dollars donated from a community, organization, or individual an indication of how much they believe in our cause?
• How true do you think the statement “If you ask for money you will get advice, if you ask for advice you will get money”?
• Does a Return of Service agreement guarantee a long term commitment? Is that really philanthropy?
Lessons learned in the development of self-directed online learning for community-engaged faculty development

Author(s) and Affiliations: Kim Falcigno, MEd, MBA, Director, Continuing Education and Professional Development, Northern Ontario School of Medicine

Kim Falcigno, MEd, MBA is the Director of Continuing Education and Professional Development in NOSM’s Faculty Affairs portfolio. At NOSM, the CEPD office is dedicated to helping provide Continuing Medical Education, Health Professional Development, Interprofessional Education and Faculty Development that meets the standards of the national accrediting bodies and of discerning health-care professionals in Northern Ontario.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. Describe the methodology/process used for the creation of this online learning project from initial concept through to implementation.
2. Have a deeper understanding of the impact of organizational structure (silos, collective agreements, etc.) on faculty development projects.
3. Appreciate the lessons learned from NOSM’s experience and apply this learning in your own future projects.

Abstract:
Northern Ontario School of Medicine (NOSM) opened in 2005 and offers an undergraduate MD program, numerous post-graduate Residency programs, the Northern Ontario Dietetic Internship program, Physician Assistant program and Continuing Education and Professional Development programming. The geography of NOSM separates people over great distances (over 800,000 km2), spans 2 time zones, and includes over 70 communities with a total population of approximately 800,000. Of these, over 1200 are NOSM Faculty/Preceptors and need to be supported in their faculty development needs, as mandated by accreditation standards for undergrad, post-grad and CEPD. This project sought to develop an innovative community-engaged model for preceptor development at NOSM by leveraging the online learning environment that has been up to this point used solely for student learning. The shift in the use of the online system to target faculty and preceptors revealed organizational constraints and limitations never before experienced. This project worked to successfully overcome the structural barriers to use and ultimately was able to produce a product that can now be accessed by the full range of NOSM preceptors, echoing the distributed community-engaged model of education NOSM is known for delivering to its learners—now the faculty can benefit from this tool.
178 John Flynn Placement Program – does community engagement shape rural careers?

Author(s) and Affiliations: Ms Lisa Godier(1) | A/Prof Lucie Walters(1&2) | Ms Kim Maddison (1) | A/Prof Louise Young (3) | Dr Lachlan McIver (1&2) | Dr Peter Stevens (1) | Affiliations: (1)Australian College of Rural and Remote Medicine | (2) Flinders University | (3) University of Queensland

Lisa is Prevocational training Manager at the Australian College of Rural and Remote Medicine. She was previously the Chief Executive Officer at Melanoma Patients Australia and prior to this a teacher at Southbank Institute of Technology.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. To understand how the John Flynn Placement Program provides students with meaningful community engagement.
2. To explore the impact of frequent short visits on students experience.
3. To measure the impact of the John Flynn Placement Program on career outcomes.

Background:
The John Flynn Placement Program (JFPP) was established in 1997. Funded by the Department of Health, is an important part of the Australian Government's strategy to attract more doctors to rural and remote areas to address areas of workforce shortage and improve the quality of healthcare for local communities. JFPP aims for medical students to experience both rural medicine and rural life as a way of increasing rural career intentions. Each year 300 students from Australian medical schools are placed with experienced general practitioners in rural and remote areas 4–7 locations across Australia. Medical students participate in rural practice placements with the same doctor in the same rural community for two weeks per year for three to four years.

Methods:
Students are followed up annually to explore their rural career intent. Recently a longitudinal tracking program has been commenced to follow medical graduates’ career progression.

Results:
Previous published data (2005 – 2009 placements) demonstrated that overall clinical and rural experiences were evaluated as extremely positive for both students and mentors. After four JFPP placements 65% of students intend to work in rural areas. This presentation will present graduate outcomes from the JFPP.

Conclusions:
Longitudinal experiences, such as the JFPP, can positively influence future career trajectories but the impact of urban centric vocational training might negate the full potential of this impact.

Improvisational scenarios to enhance communication and patient-centered education

Author(s) and Affiliations: Maurianne Reade, MD, CCFP (EM), FCFP, Assistant Professor, NOSM | Shelagh McRae MD, CCFP, FCFP, Assistant Professor, NOSM | Joahnna Berti B.A. (Hon), Director Outreach & Education - Debajehmujig Storytellers | Bruce Naokwegijig, Artistic Director (School) – Debajehmujig Storytellers

Maurianne Reade, M.D., C.C.F.P.(EM), F.C.F.P., Assistant Professor, NOSM; Co-Lead of Manitoulin Central Family Health Team. Rural family physician for 25 years; Program Director of the WildER Med conference.

Abstract Stream(s): Community Engagement

Learning Objectives:
1. Consider collaboration with artists and animators to enhance communication opportunities in undergraduate curriculum.
2. Discuss feedback provided by experienced animators as a means of contributing to true patient-centered education.
3. Compare standardized patient scenarios and those created by animators with improvisational components.

Abstract:
Second year students at the Northern Ontario School of Medicine participate in Integrated Community Experiences during their rural placements, typically with allied health providers.

The mandate of the Debajehmujig storytellers is to educate and share original creative expression with Native and Non-Native peoples, thereby vitalizing Anishnaabeg culture, language and heritage. The animators of Debajehmujig are experienced in improv techniques both in entertainment and educational settings.

We describe a pilot project where medical students from across Manitoulin Island joined animators to explore themes of mental illness and social disadvantage. The aims were to create opportunities for students to understand how arts organizations engage in the health of their communities, while enhancing communication skills.

Animators constructed complex characters and were asked to improvise within a set of parameters in simulated clinical encounters. The social context for each condition was constructed with special consideration given to cross cultural issues in Northern health care and regional economic realities. The experienced animators created realistic, fluid, and at times intensely emotional, encounters. Peer feedback was provided by the student partner, and person-centered feedback was provided by the animator.

Haidet(2007) proposed that “The essence of ensemble, whether in jazz or in medicine, lies in looking beyond one’s own perspective to see, understand, and respond to the perspectives of others”. Supplementing standardized patients with improvisational interactions may enhance cultural understanding and patient-centered communication by assisting students to approach “ensemble”.

This project should appeal to those interested in humanities in medicine, mental health education and patient-centered education.


A 360 view of simulated learning environments and interprofessional learning at a wilderness medicine event

Author(s) and Affiliations: Maurianne Reade, M.D., NOSM | Nicholas Jeeves, M.D., NOSM | Marion Maar Ph.D., NOSM | Joahna Berti B.A.Hon., Debajehmujig | Tara Rollins RNEC, NOSM | Heather Smith, BScN, NOSM | Nicole Cardinal B.A., B.Ed, M.A., NOSM | Lisa Boesch B.A., NOSM

Maurianne Reade is a rural physician, on Manitoulin Island. She is an Assistant Professor with NOSM, an occasional instructor for the Emergency Department Echo course and the Program Director of WildER Med. Her research interests are related to interprofessional education and communication. Her hobbies include making maple syrup, canoeing, hiking, skiing, snowshoeing and reading. Heather Smith is a second year medical student at the Northern Ontario School of Medicine (NOSM) with a strong interest in developing effective interprofessional education to improve patient care. She is currently researching the effects of a wilderness medicine conference on teaching collaboration. In 2013 she developed an interprofessional working group to bring a student perspective to the conversation of interprofessional curriculum and research development at NOSM and Laurentian University. She previously completed her Bachelor of Science in nursing at the University of Ottawa.

Abstract Stream(s): Longitudinal Learning, Community Engagement

Learning Objectives:
1. Consider Wilderness Medicine as a venue for the intersection of Simulated Learning Environments and Interprofessional Education.
2. Use the unique insight of facilitator and patient in evaluating interprofessional learning.
3. Discuss the merits of self-reflective and validated tools in evaluating interprofessional learning opportunities.

Abstract:
A 360 View of Simulated Learning Environments and Interprofessional Learning at a Wilderness Medicine Event

Educational innovators have been utilizing high and low fidelity simulations on an increasing basis in recent years. At the same time, there is a global enthusiasm for interprofessional education. Both are being valued for their contributions to patient safety. The combination of Simulated Learning Environments (SLE) and Interprofessional Education (IPE) is a newer concept but is considered authentic, effective, and a method of contributing to the sustainability of the workforce (Greenstock & Brooks 2011). Simulation learning may enhance the “Immersion” and “Mastery” levels of interprofessional competencies.

In this presentation we will discuss a wilderness medicine event where the interprofessional aspects have been integral and yet not addressed within the curriculum. Knowledge and skills acquired in didactic sessions and workshops are consolidated on a “race day” as participants must navigate to simulated learning environments in a maple bush. Patient-centered feedback regarding team functioning is provided. Our research has examined the perspectives of the learners, the facilitators and the simulated patients.

We have utilized a social constructivist approach and mixed methodology. The experience of participants was evaluated utilizing the Interprofessional Collaborative Competencies Attainment Survey and audio-diaries with subsequent thematic analysis. Semi-structured interviews of facilitators and simulated patients provide greater understanding of team functioning and the impact of factors such as settings and scenarios.

Clinical scenarios in a wilderness environment provide a safe yet challenging means of enhancing IPE competency acquisition. Our results argue for provision of tools for conflict resolution in short-lived teams.

Charles G, Bainbridge L, Gilbert J. The University of British Columbia (UBC) Model of Interprofessional Education. J Interprof Care 2010
ICCAS – Interprofessional Collaborative Competencies Attainment Survey (© MacDonald, Archibald, Trumpower, Jelley, Cragg, Casimiro, & Johnstone,
2009)
Developing a program logic for socially-accountable health initiatives

Author(s) and Affiliations: Simone Ross, James Cook University, Australia | Dr Torres Woolley, James Cook University, Australia | Dr Andre-Jacques Neusy, Training for Health Equity Network | Bjorg Palsdottir, Training for Health Equity Network | Kristien Michielsen, Ghent University, Belgium

Simone Ross, BPsych, MDR, is a Lecturer and the Home Group Program coordinator for the JCU School of Medicine & Dentistry.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Understand the need for building a theoretical and evidence base for SAHPE.
2. Understand how PLMs assist stakeholders plan and evaluate health initiatives.
3. Learn to apply a PLM approach to a health initiative.

Abstract:
Socially accountable health professional education (SAHPE) is gaining ground globally. However, it is a relatively new approach, and pending the development of a robust theoretical and evidence base, it is built on assumptions, interpretations and aspirations for social justice.

The Training for Health Equity Network (THEnet) is a growing global movement of health professional institutions committed to achieving health equity through community-responsive education, research and service. THEnet has recently developed its own program logic model (PLM) – a visual statement showing the link between its underlying SAHPE philosophy, appropriate education strategies, and Research and Evaluation framework.

By making explicit how THEnet considers SAHPE can ultimately achieve health equity – how key SAHPE conceptual and operational elements should transform graduates, local health services and communities – stakeholders are focused on achieving short- and medium-term graduate and community outcomes.

In the workshop, THEnet's PLM is presented as a 1-page diagram, developed using current logic theory and THEnet school experiences. The studies being undertaken by THEnet to fill existing evidence gaps are also briefly presented. The workshop will break down into smaller groups, wherein participants are assisted to apply a PLM to their own health initiative.

This workshop targets delegates wanting to:
• build evidence of SAHPE impacts
• develop a PLM for their own health initiative
Positive impacts on rural and regional workforce from the first seven cohorts of James Cook University medical graduates

Author(s) and Affiliations: Tarun Sen Gupta | Torres Woolley | Richard Murray | Richard Hays

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Describe the methodology used in tracking graduates from the JCU medical program.
2. Describe the career plans and practice locations of the first graduating 7 cohorts.
3. Identify important associations between hometown location / location of internship and subsequent postgraduate practice.

Background / Aims:
The regionally-based James Cook University (JCU) School of Medicine seeks to address the health needs of northern Australia by combining rurally-oriented selection and curriculum strategies. The School has graduated 536 students in its first seven cohorts from 2005 - 2011. This presentation describes the early career and practice locations of these cohorts (updated to include 2012-13 graduates), and the association between practice location and hometown at application and internship location.

Methods:
Hometown data for JCU graduates was retrieved from university databases, while postgraduate location data was obtained from personal contact (email, telephone, FacebookTM) or from the registration authority website.

Results:
Data is 99% complete for the practice location of 536 JCU graduates across postgraduate years 1 - 7. 60-65% of JCU graduates undertook internship and subsequent postgraduate practice in non-metropolitan locations, a significantly different pattern of practice to other Australian clinicians. Metropolitan-origin graduates who undertook metropolitan internships were significantly (p<0.001) less likely to practise in non-metropolitan locations than non-metropolitan students who undertook non-metropolitan internships (17% (23/134) of graduate-years versus 76% (597/789) of graduate-years). Of graduates who had commenced specialty training, 48% were in General Practice, including 13% (27/203) as Rural Generalists.

Conclusions:
This dataset provides the first real evidence from one of Australia's new medical schools on actual postgraduate practice location, as compared to 'intend to practise.' This early evidence supports the JCU model of distributed non-metropolitan medical education, and suggests more regionally-located internship and specialty training places would further increase rural and regional Australia's medical workforce.

Longitudinal tracking of graduates: ‘tips and tricks’ from the JCU School of Medicine and Dentistry

Author(s) and Affiliations: Dr Torres Woolley | Professor Tarun Sen Gupta | Sharon Barnwell

Torres Woolley, PhD, MPHTM, GradCertHlthInfCntrl, is a Lecturer and the Evaluation Coordinator for the School of Medicine & Dentistry, James Cook University, Townsville, Australia.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Formulate your own GT research questions, and discuss aspects of successful survey and database design.
2. Articulate what is the outcome of interest and what data should be collected.
3. Learn how GT data can be stored to ensure efficient manipulation.
4. Learn how GT data can be analysed and presented.

Abstract:
The JCU School of Medicine and Dentistry has collected graduate data since the first graduating cohort in 2005. Graduate tracking (GT) data is used for program improvement and confirming the School is achieving its mission of producing medical graduates to work in regional communities across northern Australia.

The School records each graduate’s hometown, their location of practice in each postgraduate year, and any postgraduate training undertaken. Close engagement with graduates and robust data collection strategies have ensured the School’s GT database is 99% complete. Analysis of GT data demonstrates the School’s emphasis on rural student selection, course content and rural clinical placements is working: rural-origin students are significantly more likely to practise in rural areas, and JCU graduates much more likely to do so than other Australian medical graduates (using the Medical Schools Outcomes Database as a comparator).

The workshop will be valuable for delegates new to surveying, current researchers interested in GT, and health faculty staff considering a similar project.

The session will be presented by the School’s evaluation coordinator and other staff involved in graduate outcomes.
Moving beyond the rural elective: Building and stabilizing the rural education team

Author(s) and Affiliations: Robert Miller, MD, CCFP, FCFP | William MacDonald, MD, CCFP | Cheri Bethune, MD, MCISc, CCFP, FCFP | Patricia McCarthy, MSc, PhD (c)

Cheri Bethune, MD, MCISc, CCFP, FCFP. Cheri Bethune is a professor of family medicine at Memorial University. She has practiced Family Medicine in Newfoundland for more than 30 years. She has been the Medical Director of the Shea Heights Community Health Centre since 1984 and has worked in many collaborative community projects.

Dr. Bethune is the Director of Faculty Development for the Discipline of Family Medicine. In this role she has worked to develop faculty development resources to enhance teaching and scholarship for both full- and part-time faculty in a highly distributed program of medical education. She is presently a member of two national committees with the College of Family Physicians of Canada which includes the Working Group on Faculty Development and the Working Group on the Certification Process. She is also a mother, a grandmother, and an avid athlete.

Abstract Stream(s): Longitudinal Learning, Community Engagement, Aboriginal Health

Learning Objectives:
1. Understand principles important in developing a rural education team for rural family medicine faculty and residents.
2. Explore opportunities for and challenges of building an educational framework for rural preceptors.
3. Identify key processes necessary for fostering community-based teaching and engagement.

Abstract:
This 90-minute workshop will entail a description of key principles, processes, and best-practice evidence related to rural education team development within a clinical context.

Using data obtained from literature reviews/theory and clinical experience, participants will develop understanding of integrative approaches to learning and strategies for fostering community engagement in rural settings. Principles of building a rural education framework including creating longitudinal experiences, building integrated teams, and respecting community contexts, and establishing interface between community needs and university resources will be explored.

Participants will also engage in small- and large-group activities involving the identification of barriers to and strategies for enhancing community engagement. Discussion topics include approaches to engaging local communities, regional healthcare authorities, and institutional bodies; capacity-building through faculty development in teamwork, leadership, and scholarship as it applies to Triple C principles; and establishing local autonomy and accountability.
Toward a Theory of Compassionate, Evidence-informed, Interprofessional, Person-centered Practice

Author(s) and Affiliations: Marion Briggs, BScPT, MA, DMan. Director, Health Sciences and Interprofessional Education, Northern Ontario School of Medicine

Marion Briggs holds a Bachelor of Science in Physical Therapy (University of Alberta, Canada), an MA in Leadership (Royal Roads University, British Columbia, Canada) and a Doctorate in Management (Complexity Research Institute, University of Hertfordshire, England). She is currently an Assistant Professor of Clinical Sciences and the Director, Health Sciences and Interprofessional Education at the Northern Ontario School of Medicine. Her Doctoral work and current research interests are in practice theory and interprofessionalism.

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Describe a three-dimensional, holistic theory of practice supportive to compassionate, interprofessional, person-centered care
2. Articulate how different intellectual traditions apply in the three dimensions of practice
3. Describe the elements and activities in each dimension of practice
4. Apply this theory of practice to undergraduate and graduate medical and health professional education in academic and clinical contexts

Abstract:
The use of “evidence-informed” practice has largely replaced the use of “evidence-based” practice as a corrective for the implication that ‘evidence-as-truth’ can be universally applied without consideration of the specific patient or context in which it was to be used. Similarly, the initial use of patient-centered care tended to imply that the expertise of healthcare providers was secondary to the wishes of the patient. This has been replaced by ‘person-centered’ care which leaves room to consider not only the expertise that patients and care providers bring to the healthcare relationship, but also includes the vital importance of respectful and collaborative relationships between care providers in the provision of effective, appropriate, and efficient patient care. Yet, these important concept modifiers (evidence-informed and person-centered) are often neglected. One reason they are neglected is that the theory of practice in medicine and other health professional education is narrow and tends to emphasize a single perspective of evidence-as-truth. Thus, the translation metaphor is still commonly evoked to describe the relationship between ‘evidence’ and ‘practice’ (the translation of evidence into practice). Medical and other learners are encouraged to be critical practitioners, yet are also taught the importance of being “right” and basing their practice on the “evidence”.

Using a combination of presentation as well as small and large group discussions, this workshop will examine a more robust, three-dimensional theory of practice that supports compassionate, evidence-informed, interprofessional, person-centered practice and explore how this theory of practice could be applied in undergraduate and post-graduate health professional curricula.

Conceptual design and evaluation of a new rural medical curriculum attracting and retaining health professionals in poor and rural areas in Germany

Author(s) and Affiliations: Markus L.H. Herrmann | Patricia Haenel | Eva Jansen

Markus L.H. Herrmann, PhD, MPH, M.A.; Head of Inst. of Family Medicine, Univ. Magdeburg

Abstract Stream(s): Community Engagement, Social Accountability

Learning Objectives:
1. Strategies to motivate students and young physicians to live and work in the countryside.
2. Concept and evaluation of a 2-weekend-program in rural health.
3. Participation process of students in development and evaluation of this program.

Background:
Medical education in Germany is primarily based in urban universities and tertiary care hospitals. This might contribute to a shortage in physicians in rural regions as the learning environment influences career decisions. Possible strategies to increase student's interest in rural medicine are necessary.

Aims:
A new clinical elective was offered to 14 fourth and fifth year medical students. The goals are to a) illustrate the attractiveness of rural general medicine, b) train crucial skills of general medicine, c) reflect on personal and professional goals, d) discover unknown ways of rural living.

Methods:
By participating of the students a new "two-weekend-program" of rural health had been developed, implemented and evaluated. The process of development and evaluation was accompanied by participation of the students. Different qualitative instruments and didactic elements were used. The seminar was audio- and videotaped and protocolled by students. The material was analyzed, using qualitative content and hermeneutic analysis. The elective took place in an ecovillage in the North of Saxony Anhalt.

Results:
The development of this new elective format and the results of the focus groups will be described. The most important topics include whether the elective influenced student's motivation to engage in rural medicine and which key elements of the elective had the strongest impact on student's career considerations.

Conclusions:
We present an innovative training format that supports student's interest in rural medicine and rural living. An integration of the students into the development of the course and positive real-life experiences during the elective can positively influence student's perception of rural medicine.
A model of oral health services in remote Aboriginal communities

Author(s) and Affiliations: Gwynne K, Poche Centre for Indigenous Health | Irving M, Poche Centre for Indigenous Health | McCowen D, Armajun Aboriginal Medical Service; Rambaldini B, NSW Centre for Oral Health Strategy | Skinner J, NSW Centre for Oral Health Strategy | Naoum S, Poche Centre for Indigenous Health | Blinkhorn A, University of Sydney Faculty of Dentistry
To be presented by Graham White

Kylie Gwynne is Director of the Poche Centre for Indigenous Health at the University of Sydney. She has twenty-five years' practice and policy experience in health and human services and a deep interest in innovative approaches to improving outcomes for individuals, families and communities. She specialises in translating policy and research into practice.

Established and funded by philanthropist Greg Poche AO, The Poche Centre for Indigenous Health seeks to leverage the best of the best in Universities with communities and governments to seek collaborative solutions that address complex health problems faced by Aboriginal people.

Abstract Stream(s): Community Engagement, Social Accountability, Aboriginal Health

Learning Objectives:
1. Describe collaborative impact model as applied in oral health care for Aboriginal people in rural/remote NSW.
2. Understand the process, partners and early outcomes.
3. Discuss the next steps.

Objectives:
The Poche Centre for Indigenous Health in conjunction with local Aboriginal Community Controlled Health Services, Local Health Districts and Centre for Oral Health Strategy aimed to develop a new sustainable model of oral health care for remote indigenous communities in the Northern Tablelands of NSW.

Methods:
Using the components of a collective impact methodology including: common agenda, shared measurement, mutually reinforcing activities, continuous communication and backbone support, a formal partnership between the parties was developed to undertake a new approach to deliver oral health services to rural and regional indigenous communities. A full process, impact and outcome evaluation of this dental service is being undertaken to measure the impact of both the partnerships model and the oral care in the community.

Results:
A common agenda of, improving the oral health of the communities, united all parties through the backbone support of the Poche Centre, using continuous communication loops, through a fully representative steering committee and individual meetings between Poche and all parties. A memorandum of understanding was signed between the parties regarding service delivery, professional development, supervision, roles and responsibility, data collection, patient management, equipment, policies and procedures, billing and patient records. Local capacity building and reciprocal relationships, based on existing and new infrastructure, are utilised between parties and all opportunities for further capacity development were identified and built on, with the intended planned redundancy of the Poche Centre. Early economic evaluation shows reduced costs with greater service delivery. Program evaluation will seek to refine and improve the service delivery.

Conclusion:
A collective impact model between two Aboriginal Community Controlled Health Services, State and Commonwealth Governments, and the University of Sydney has been effective in delivering a new model of oral health services to Aboriginal people in remote NSW.
Scaling up: from social accountability in medical schools to addressing health inequity and universal health coverage at a national or international level – what will it take?

Author(s) and Affiliations: Sarah Strasser, Flinders University, NOSM & Health Sciences North

Professor Strasser comes from a background of over thirty years in rural general practice and medical education. She has been instrumental in establishing a number of new programs in both undergraduate and postgraduate medical education in Australia and Canada with a particular focus on community engagement and social accountability. She led faculty development at the Northern Ontario School of Medicine from 2002-2007 and then in 2009-10 as the Director of 3rd year in the MD program when the students live and work in small rural communities for a year. In Australia as director of Community Based Medical Education in the Northern Territory for Flinders University in 2007-9 she secured the funding for the NT Medical Program and was the inaugural Associate Dean from 2010 to 2013. In 2014 Professor Strasser returned to Canada and currently is the Associate Vice President, Academics and Inter-professional practice at Health Sciences North.

Abstract Stream(s): Social Accountability

Learning Objectives:
1. Describe the social accountability statements for NOSM & Flinders.
2. Understand the processes and access to research available.
3. Knowledge translation/social spread issues are more widely understood & discussed.

Abstract:
Can the lessons learned at the local level of implementing a social accountability mandate in a medical school be applied on a grander scale to address health inequities in health care systems to achieve universal health coverage nationally and/or internationally?

Medical education informing clinical practice is often referred to as the key to making change for the better in clinical practice. Can we expand this notion further, as in up-scale to a health care system at a national or international level? At a local level it seems to be an overwhelming task to really influence the major change required at a systems and national/international level to establish & implement universal health coverage and thereby address health inequalities. What are the key success factors for social accountability in a medical school and how do they compare with those for universal health coverage in a national health system? What as medical educators can we do to influence this change? What skills training might be required? It seems an overwhelming task to do what it might take!

In this PeArL or Muster Unplugged session I am seeking your thoughts as to how medical educators and students might lead this change and how we can best assist them?

Audience: Anyone and everyone who is excited by this challenges

Building the Aboriginal health workforce in East Gippsland

Author(s) and Affiliations: Dr Jane Greacen (Centre of Excellence for Aboriginal Health in East Gippsland & Monash University) | Dr Doris Paton (Centre of Excellence for Aboriginal Health in East Gippsland (CEAHEG) & Monash University)

Abstract Stream(s): Community Engagement, Aboriginal Health

Learning Objectives:
1. Understand the support requirements of Aboriginal students in East Gippsland to enter health professional training.
2. Understand some of the barriers to this.
3. To discuss the strategies for improving access to tertiary health professional training.

Abstract:
In East Gippsland there is a group of Aboriginal people who want a local and practical program to help their children to complete their schooling and do well enough to enter medicine, nursing and other health professional training.

They developed a partnership with the EGRCS Monash University to support them. They then undertook research into identification of barriers to East Gippsland Aboriginal high school students becoming health professionals.

The research study considered these students in relation to:
   a) their current experience at school;
   b) their interest in becoming a health professional;
   c) the interest of their families in supporting them to undertake studies and pursuing a career in health;
   d) the capacity of their families to support them and the kind and extent of assistance they require.

Ethics approval was obtained from the Monash University Human Research Ethics Committee (MUHREC) to undertake this study.

A literature review of Australian and international reports and research was undertaken. Surveys and interviews (both qualitative and quantitative) of students and their parents/carers living in the East Gippsland region were undertaken.

In summary, the barriers to health careers facing Aboriginal students in East Gippsland reflect those found in research to date. These include negative school experiences including culturally insensitive curricula and teaching styles and low expectations of teachers, lack of information and exposure to professionals/role models in the early years of secondary school, inappropriate subject choice, lack of self-belief and confidence, and others.

They are now working to establish strategies to address these findings.


Australian Bureau of Statistics; Catalogue 4704.0

How well can a rural longitudinal integrated clerkship prepare a medical student for internship?

Author(s) and Affiliations: Jane Barker | Hudson Birden

Jane Barker has been a rural General Practitioner for over 25 years and a medical educator for the past 5 years, involved in the Wollongong LIC program as coordinator of the Lismore hub.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Residents' perceptions of the value of longitudinal placements in preparing them for internship.
2. Aspects of the Longitudinal placement that in residents perception prepared them for internship.
3. Suggestions for program changes that interns perceive would better assist them in developing intern preparedness.

Background:
Longitudinal Integrated Clerkships (LICs) have proven to provide effective learning environments for late-stage medical students (1) particularly in rural settings (2). LICs extend the apprenticeship model of medical education to its logical next step. Through the extended association between clinician educator and student, medical students become trusted to take on more of the role of a practitioner, to 'act up' (3) more into the role of practitioner, in a carefully supervised structure. (4). Clinicians serve as role models as role modeling is seen as the optimal method of developing professionalism (5).

Aims:
This study focuses on finding what aspects of participants' rural LIC training they found valuable to their internship experience, whether they thought that skills gained differed from those gained in an entirely hospital based program, whether spending their LIC term in a rural setting influenced them to seek a rural internship setting, and whether there were any deficiencies they have encountered in their training which might be used as a basis for improvement of the LIC program.

Methods:
In-depth, semi-structured interviews

Results:
Aspects of the LIC that were useful included practice in documentation gained in GP, autonomy that was allowed while practicing in rural emergency departments and general practice, and the ability to experience different modes of care provision that would be specialties in a metropolitan setting. Close relationship with preceptors, consultants, and registrars built confidence and enabled easier integration in teams during internship.

Participants who graduated early in the program thought that the GP/hospital rotation mix should have included more time in hospital, less in GP. Later graduates, after the mix was changed, were more satisfied with the preparation they gained though their LIC experience.

Participants felt more confident as an intern as a result of their rural LIC.

Conclusions:
A rural LIC in Australia has prepared students well for the challenges they are currently facing as interns.

2. Walters L. Demonstrating the value of longitudinal integrated placements to general practice preceptors. Medical Education. 2011;45(5):455-63.
The University of Toronto, Longitudinal Integrated Clerkship Students’ Perspectives

Author(s) and Affiliations: Stacey Bernstein | Mark Hanson | Lisa Graves | Raed Hawa, University of Toronto | To be presented by Lisa Graves

Dr. Bernstein received her Bachelor of Science degree in physiology from McGill University and is a graduate of the University of Toronto Faculty of Medicine class of 9T2. After completing her residency in Pediatrics at The Hospital for Sick Children in 1996 she began working at SickKids as a hospitalist on the general pediatric inpatient wards. She has been on staff in the Division of Pediatric Medicine at The Hospital for Sick Children for the past 12 years. She works on the inpatient wards as a clinician educator with a significant focus on teaching bedside medicine to medical students, residents and fellows. She is also an assistant professor at the University of Toronto. Dr. Bernstein is the Clerkship Director at the University of Toronto. She teaches in a variety of contexts in the Faculty of Medicine and she has an interest in faculty development and medical student education.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Understand students’ rationale for choosing to participate in the longitudinal integrated clerkship in Toronto, Canada.
2. Describe how the longitudinal integrated clerkship aligns with the students’ medical education experiences and current career plans.
3. Describe how the longitudinal integrated clerkship aligns with the students’ approach to learning.

Background:
The University of Toronto is one of the largest urban medical school in Canada with over 250 students in each medical year. The University of Toronto will be launching a pilot of a Longitudinal Integrated Clerkship (LIC) for eight third year medical students in September 2014.

Aims:
To showcase what is unique about the eight students in terms why they chose to participate in this inaugural program and how they see their learning aligning with the principles of (LIC).

Results/Conclusions:
We will review the major themes that emerge from reviewing the students’ letter of intent to join (LIC) as well from the face to face meetings that were arranged to welcome the eight students to the program. These themes centre on the belief that LIC provides “superior learning”, “better way of approaching clerkship”, “better communication and advocacy for patients”. Many of the students are interested in primary care. The major hesitation stems from being involved in a new program that will have “its pumps and kinks”.

2. Walters L, Demonstrating the value of longitudinal integrated placements to general practice preceptors. Medical Education. 2011;45(5):455-63.
The University of Toronto, Longitudinal integrated clerkship The patient panel: A unique challenge

Author(s) and Affiliations: Kymm Feldman | Stacey Bernstein | Raed Hawa | Karen Weyman | Al Chiodo | Danny Panisko | To be presented by Lisa Graves

Dr. Feldman is the Undergraduate Education Program Director in the Department of Family and Community Medicine, and the Director of the Women's Health Scholar Program, University of Toronto. She is an Assistant Professor and a recipient of the 2014 W.T. Aikins Award for Excellence in Undergraduate Teaching, Course/Program Development and Coordination.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Describe the context of creating the longitudinal integrated clerkship in Toronto, Canada.
2. Communicate potential strategies for administering a patient panel under our unique context.
3. Discuss the pros and cons of including a patient panel in a longitudinal integrated clerkship.

Background:
The University of Toronto is the largest urban medical school in Canada. With 250 plus students in each medical year, classes are separated into 4 Academies. Clinical programs take place in 29 full and community affiliated hospitals.

The University of Toronto will be launching a pilot of a Longitudinal Integrated Clerkship (LIC) in downtown Toronto for eight students in 2014. Due to the complexity of the patient panel, only 26.6% of LIC's report that they have this component to their LIC as reported by the Missile data. A patient panel will be included at the University of Toronto for each student. This poses distinct challenges for an urban setting that is not part of a 'closed hospital system'.

Aims:
To showcase a unique approach to the development, tracking and logging of a patient panel in an 'open' urban setting in a Canadian LIC.

Results/Conclusions:
The decision to pursue a patient panel, rationale for inclusion of mandatory core diagnoses, the patient panel list, challenges and solutions for development, patient tracking and logging will be discussed.
The University of Toronto, Longitudinal integrated clerkship A process map: Avenues and roadblocks

Author(s) and Affiliations: Stacey Bernstein | Raed Hawa | Karen Weyman | Molly Zirkle | Lisa Graves | Selena Lee | Samantha Fortunato | Jasmine Paloheimo | To be presented by Lisa Graves

Dr. Bernstein is an assistant professor at the University of Toronto and has been on staff in the Division of Paediatric Medicine at The Hospital for Sick Children for the past 12 years. Dr. Bernstein is also the Clerkship Director at the University of Toronto and has spearheaded the LIC program at University of Toronto to be launched in 2014.

Abstract Stream(s): Longitudinal Learning

Learning Objectives:
1. Describe the 18-month process and strategic plan used in the development of an urban LIC at a large medical school.
2. Identify barriers to implementation and strategize collaboratively around solutions.
3. Apply key resources necessary to implement an LIC.

Background:
The University of Toronto is the largest urban medical school in Canada with over 250 students in each medical year separated into 4 Academies over 29 full and community affiliated sites. The University of Toronto will be launching a pilot Longitudinal Integrated Clerkship (LIC) at one academy for eight students in August 2014 in a large downtown setting. 46 students at the same site are experiencing a block clerkship simultaneously. The LIC will extend over 51 weeks and include courses in Surgery, Medicine, Emergency Medicine, Ophthalmology, OTOHNS, Anaesthesia, Dermatology, Paediatrics, Psychiatry, Family Medicine, Obstetrics and Gynaecology. It will also include a patient panel.

Aims:
To showcase the development of a unique LIC in a multi-site urban setting that simultaneously offers a block clerkship.

Results/Conclusions:
Eight subcommittees were created (research, evaluation, curriculum, admissions, faculty development, gap analysis, technology and patient panel) to ensure a unique implementation model for LIC. Challenges facing implementation including satisfaction with the status quo, complex scheduling, lack of ambulatory experiences and space, recruitment of faculty and financial costs will be discussed with emphasis on solutions that were utilized.
We need to have a chat about that! Bringing social equity to the student conversation

Author(s) and Affiliations: Michael Douglas, University Centre for Rural Health, Lismore, NSW

Associate Professor Michael Douglas is a public health physician and clinician, whose primary interest has been in global health and the health of the Indigenous peoples of Australia. For more than 15 years he supported and led the development of health programs through a number of countries of the Pacific and Asia region, with a focus on infectious diseases, maternal and child health programs, and evaluating the effectiveness of health systems in meeting population needs. Michael has worked with Aboriginal communities in both clinical capacity, and at organisational level, with a number of years working in remote communities.

The pursuit of development of services for rural populations, particularly for isolated communities has been enabled through past appointments in leading Population Health Services in Western NSW, and Medical Services in Northern NSW. Currently, Michael is head of the education program of the University Centre for Rural Health, Lismore, NSW.

Learning Objectives:
1. Communicate an approach to bringing dialogue around community and social disadvantage and equity for students of multiple disciplines in a rural health campus.
2. Seek ideas in strengthening the approach.
3. Identify ways to evaluate the program.

Abstract:
We need to have a chat about that! Bringing social equity to the student conversation. Students of the health sector come from diverse experience, and bring a varying level of passion around the subject of social equity. The University Centre for Rural Health has established a program that provides a forum of dialogue and debate around the responsibilities of the health professional in the community. Themes explored include Indigenous health and disadvantage, refugee journeys, living with addiction, mental health, homelessness.

This session provides an overview of the program:
What has worked and not worked, and a subjective perspective of its modest success.
We are in this together: Evaluating the experience of a collaboration of medical schools in rural NSW

Author(s) and Affiliations: Michael Douglas Associate Professor, University Centre for Rural Health, Associate Professor, University of Sydney, School of Public Health, Senior Lecturer, University of Western Sydney, Clinical Senior Lecturer, Graduate School of Medicine, University of Wollongong

Learning Objectives:
1. Overview of a medical education collaboration between 3 medical schools.
2. Identify potential outcome measures.
3. Develop the scope of an evaluation framework.

The issue:
In 2008, a collaboration of 3 medical schools (University of Sydney, University of Western Sydney and University of Wollongong) was established to facilitate year-long placement of students in their final phases of study in and around a regional centre of northern NSW. The University Centre for Rural Health (UCRH) currently hosts around 55 students for a year of their medical degree.

The aims of the collaboration include the piloting of a joint medical school program and improvement of recruitment to the rural medical workforce.

The collaboration has been successful. In spite of differences in the philosophical and pedagogical approaches of the different courses, there remains a strong commitment to the collaboration by the respective medical schools, student academic and social experience has been positive, and local clinician and community participation in the learning programs enthusiastic.

The challenge:
- The process in making a successful collaboration work is easily documented. However, the longer term, less tangible aspects are elusive to identify. While the experience of students from each university is captured during and at completion of their placement, the long term benefits of a collaborative approach to medical training are more difficult to evaluate
- There are at least two dimensions of the Collaboration outcomes that need analysis: (a) that of rural training and (b) that of a common school with different curricula

This session seeks assistance in:
- Defining the short and long term measures of a collaborative approach to medical education in a rural environment
- Establishing an evaluation framework for regionally based medical education collaboration
Faculty Development Planning: A Key Strategy for Success in the Implementation of a Longitudinal Integrated Clerkship Pilot Program at the University of Toronto, Faculty of Medicine

Author(s) and Affiliations: Filomena Meffe | Jana Bajcar | Karen Leslie | Karen Weyman | Jasmine Paloheimo | Lisa Graves | Stacey Bernstein | All University of Toronto, Faculty of Medicine, Affiliates, Toronto, Canada | To be presented by Lisa Graves

Dr. Meffe is an associate professor in the Faculty of Medicine, University of Toronto (U of T) and clinician teacher, department of Obstetrics and Gynecology, St. Michael's Hospital, Toronto, Canada. She completed a Masters Degree in Clinical Epidemiology (1996) and Education Scholar's Program, Centre for Faculty Development, U of T (2004-06). She was the Director of Undergraduate Medical Education (2001-2013) and now Director of Faculty Development, Department of Obstetrics and Gynecology, U of T. She is the recipient of numerous awards for sustained excellence in teaching at both the local and national levels. From 2006, she has focused her research on interprofessional education and collaboration in maternity care with funding support from: the Dean's Excellence Fund, U of T (2005); Department of Obstetrics and Gynecology, U of T (2005); HealthForceOntario (2007-08, 2009-10); Ryerson University (2011); and the Canadian Medical Protective Association (2011).

Learning Objectives:
1. Learn about a collaborative model for faculty development planning for a new curriculum implementation.
2. Identify key strategies for success.
3. List challenges encountered by faculty development planners when a new curriculum is being implemented.

Background:
In September 2014 the Faculty of Medicine at the University of Toronto is launching a longitudinal integrated clerkship (LIC) pilot program in parallel with the current block clerkship. A locally designed faculty development (FD) plan was identified as a key strategy for implementation success1.

Aims:
This abstract describes an approach to LIC FD planning that informs, engages, and supports educational leaders, faculty teachers, and other health professionals.

Methods:
A FD subcommittee was established early on in the program development process. This subcommittee reports to the full LIC working committee and works in parallel to and in collaboration with other LIC subcommittees. We used a holistic and collaborative FD model2 to guide program design which integrates curricular needs, faculty learning needs, health care environment context and student needs with the goal of creating a “learning-centered” environment3.

Results:
The FD subcommittee identified these key areas when designing a learning-centered FD strategy for a LIC pilot program implementation: (1) sharing information about the program at multiple levels (educational leaders, front-line teachers), (2) engaging faculty members in the program development process early on, (3) supporting faculty members by providing learning about new content areas, required skill sets, potential challenges and rewards, and (4) identifying the relevant target audiences. Challenges faced by the FD subcommittee in designing this FD plan simultaneously with curriculum development will be shared.

Conclusion:
When incorporating a new curricular initiative such as the LIC, a comprehensive FD plan is a key strategy for success that needs to be considered early on in the design process.

References:
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3. Bajcar J, Boyd C. Creating a new pedagogy for Faculty Development in Medical Education. E-poster at Association for Medical Education in Europe, Milan, Italy (August 2014)
Evolution of the Indigenous Entry Stream in the NTMP

Author(s) and Affiliations: A/Prof Greg Raymond (Director of Preclinical Education - NTMP) | Cheryl Davis (Acting Director - Indigenous Transition Pathway, NTMP) | Dr Ruth Sladek (Chair of Admissions, Flinders University MD program, Bedford Park, SA) | Courtney Ryder (Poche Centre, Bedford Park, SA)

Learning Objectives:
1. To demonstrate the importance of recognising, acknowledging and articulating key issues and difficulties involved in recruiting suitable Indigenous students and to develop strategies to support them.
2. Recognise the need to develop evolving strategies developed by an interprofessional team of internal and external stakeholders.
3. Ensure best practice recruitment and retention strategies are upheld based on national Indigenous frameworks (eg AIDA, LIME, CDAMS).

Background:
The Flinders Northern Territory Medical Program (NTMP) began in 2011 as a joint initiative with Flinders University, Charles Darwin University and the NT and Federal Governments with a mandate to produce Indigenous and locally grown territorians doctors capable of serving in rural and remote communities. In 2010 to prepare for the inaugural cohort, the NTMP established an Indigenous Unit called “The Indigenous Transition Pathway (ITP Program)” to develop recruitment strategies in collaboration with the Flinders Medical Course Admission Committee targeted at potential candidates for entry into the new NT “Indigenous Entry Stream (IES)” pathway. There was a consistent view from ITP and Admission staff as well as NTMP academics that Indigenous students would benefit from a pre-admissions education program (Pre-Medicine Program or PMP) that could be completed during the year before enrollment. Out of 24 scholarship places allocated in any one year to NTMP students, the 2011 cohort saw 10 indigenous students enrolled however, recruitment of suitable candidates into the program in subsequent years has proved problematic and challenging.

There has been considerable discussion over the years on the ideal composition of the PMP, assessment strategies, length and location. Many changes have been implemented to the program over time including iterative changes that have been made to selection processes. It is important also to recognise and adopt key National Indigenous frameworks relating to recruitment & retention strategies such as AIDA and LIME to ensure alignment to these frameworks.

Methods:
This paper will document and compare recruitment & retention strategies from 2010 – present day (2014) used in the IES pathway for NTMP Indigenous students.

Results/Discussion:
Through analysis and evaluation of the data, by acknowledgment of challenges faced over the years, lessons learned and improvements implemented over the years in the IES NTMP pathway future directions will also be discussed.

Interprofessional education in the NTMP

Author(s) and Affiliations: Greg Raymond, Flinder’s Northern Territory Medical Program

Learning Objectives:
1. To create a discussion with like-minded colleagues about the use of IPE in medical curriculum. Examples of successes and where it hasn’t worked would be ideal.
2. Create discussion around the question “Should the NTMP incorporate IPE into Years 2-4?”
3. Identify if there are IPE models in place in other medical programs that would suit the NTMP?

Abstract:
Interprofessional Education hit the scene as an industry buzz phrase around 10 years ago as more and more papers began to appear at medical education conferences such as ANZHAPE. In recent years, entire themes at this conference have been dedicated to IPE. What is clear is that IPE uptake into medical school curriculum’s has occurred at different rates with some medical schools choosing to adopt very little IPE activities while other schools choosing a highly integrated IPE program across all years.

In 2011, the NTMP chose to embrace IPE curriculum by establishing a unique remote experience in Katherine originally launched as “Rural Health Day” held in Batchelor over a single day and in 2012 evolving into a 3 day event encompassing rural and remote health topics attended by 1st year medical students (NTMP), nursing students (CDU), pharmacy students (CDU) and Aboriginal health Workers (Batchelor Institute). Students were evenly distributed across different teams and asked to progress through a series of stations each focused on a different learning objectives. NTMP does not currently have any other IPE curriculum activities in years 1 & 2. At Flinders in the Riverland rural clinical sites, a well-established South Australian IPE program delivers integrated learning sessions for nursing and 3rd year medical students. An example of this is the “Deteriorating Patient” simulation sessions.

Health professionals working in rural and remote settings often do not have access to hospitals and large health teams placing a larger importance on the development of interprofessional communication skills within small teams. The NTMP will be graduating doctors soon that will be practicing in these environments.

What, if any, scope is there in developing IPE sessions for the NTMP program using existing models (such as the Riverland) that would extend the model across all 4 years?
Community engagement: Integration through the Memorial University Medical School Curriculum

Author(s) and Affiliations: Katherine Stringer, Discipline of Family Medicine, Memorial University | Scott Moffat, Discipline of Family Medicine, Memorial University | Catherine Donnovan, Discipline of Community Health, Memorial University | Janet Barlett, Discipline of Community Health, Memorial University | Patricia Penton, Discipline of Community Health, Memorial University | Sarah Eustace, Discipline of Community Health, Memorial University

Katherine Stringer is the Clerkship Coordinator at the Faculty of Medicine, Memorial University, Newfoundland, Canada and a family physician and assistant professor with the discipline of family medicine at the same university.

Her educational areas of interest include inter professional education as well as community based longitudinal learning. Her clinical areas of interest include care of the elderly and those with developmental disabilities.

Learning Objectives:
1. To describe the community based education aspect of the new integrated spiral curriculum of the Faculty of Medicine at Memorial University.
2. To highlight the positive outcomes of community based education in such a curriculum.
3. To consider difficulties of implementation of the community based aspects of such a curriculum

Background:
The Faculty of Medicine at Memorial University began to role out a new Spiral Integrated Undergraduate Medical Curriculum in September 2013. This form of longitudinal learning uses iterative revisiting of topics, subjects or themes throughout the curriculum.

Aim:
To create a new Community Engagement course using blended teaching methods in keeping with the Spiral curriculum, to promote community based generalist practice.

Methods:
This community engagement course uses both medical school and community based teaching to meet its objectives. The three 2 week community based teaching experiences are spread throughout the 2 preclinical years of the curriculum. Exposure in the first experience, known as “The Community Visit” is focused primarily on the community health aspects of the specific community with increasing focus on all aspects of a local family physicians practice during the second experience (The Housecall) and the third experience (The Black Bag).

Results:
Memorial University has successfully implemented the first 2 community visits and is about to implement the 3rd. Initial student and preceptor feedback has been very positive in improving motivation for community based practice and confidence in clinical skills. Areas requiring improvement include scheduling and linkage to the curriculum.

Conclusions:
A community based educational experience fulfills an important part of the new spiral integrated medical curriculum at Memorial University Medical School. Medical Students experience these communities from both a community health and a family medicine perspective. Further program evaluation and outcomes based research will be performed on completion of all 3 courses to shape future student learning experiences.

Memorial University Faculty of medicine Curriculum renewal. http://www.med.mun.ca/UGradME/MD-Program-Renewal.aspx
How to transform a specialized clinical palliative care unit into a teaching platform?

Author(s) and Affiliations: Peter Pype, Ghent University, Belgium

Learing Objectives:
1. How many students can be handled by 1 patient during bedside teaching?
2. How many educational strategies can be combined during bedside teaching?
3. How to prioritize educational time toward students, graduates or professionals?

Abstract:
We are planning to build a ‘comprehensive center of expertise’ in palliative care in Flanders, Belgium. The center will house a specialized palliative care unit (9 beds), the palliative home care team (7 nurses – 350 patients a year) and a palliative daycare center.

Additionally we will use this center as a teaching platform for both undergraduate students, graduates (family physician and specialist trainees) and for practicing professionals.

Finally we want to do research (clinical and educational) in this center.

Our region has 300 000 inhabitants, three hospitals (1300 beds), 300 family physicians.

Two universities are interested in collaborating and sending students.

Questions for discussion:
1. How much students / graduates / professionals can be trained in this center in one year without endangering the patients’ care quality?
2. Which teaching/educational techniques and architectural/structural requirements are best suited for this ‘mixed’ educational target?
Interprofessional workplace learning in primary palliative care

Author(s) and Affiliations: Peter Pype, Ghent University, Belgium

Learning Objectives:
1. Workplace learning is a reciprocal activity.
2. Workplace learning can be enhanced.
3. Workplace learning is context-dependent.

Background:
Most palliative patients prefer to be cared for at home by their family physician (FP) and the primary health care team. FPs collaborate with palliative home care teams (PHCT) for expert advice in the care for their patients. Undergraduate education and continuing medical education is often insufficient to prepare FPs for this task.

Aims:
To explore complementary ways of acquiring and maintaining palliative care expertise for FPs.

Methods:
Qualitative (focus groups), quantitative (cross-sectional survey) and mixed-method (designing and evaluation of a training program for PHCT nurses)

Results:
FPs acknowledge the learning effect of interprofessional collaboration with PHCT nurses (workplace learning). The cross-sectional survey shows that workplace learning is a reciprocal learning method were all professionals (both the FP as a ‘learner’ and the PHCT nurse as an ‘expert’) learn about all aspects of palliative care (physical, psychosocial and spiritual aspects) from different team members. The evaluation of the training program reveals that expert clinical nurses can be trained as facilitators for FPs’ workplace learning. PHCT nurses require a careful and individual mentoring during this role transition. The implementation of the new role depends on personal, relational and contextual factors.

Conclusions:
Workplace learning is a suitable complement to classroom-based learning for FPs to acquire palliative care competences. Workplace learning can be enhanced by training professionals to act as facilitators for other professionals’ workplace learning.

Discussion:
• Can undergraduate students be prepared for WPL?
• Is WPL a feature of this specific palliative care context?
Public Health – an essential part of rural practice?

Author(s) and Affiliations: Greville Wood MBChB(UCT), FRNZCGP, DOM(Stell), MFGP(SA), DipPEC(SA), DCH(SA) Clinical Director Rural Academic General Practice Grey Base Hospital High Street Greymouth, New Zealand.

Learning Objectives:
1. Is public health important in the rural health curriculum?
2. What skills are needed to manage the public health issues in general practice?
3. How do you measure success?

Background:
Over a decade of working with an isolated community, public health becomes an important part of community care. Case discussion of 3 examples that highlight the need of public health being part of the rural GPs repertoire of skills.

Aims:
To present 3 case discussions/scenarios that highlight the need for public health skills in rural general practice.

• Giardia, endemic in the community, the story of its control
• Strep. Erysipelas and its control in a closed community.
• A community's response to a Pertussis outbreak

To present a student’s reflection on his experience
To present a tutor’s experience
To encourage discussion on the need for public health in the curriculum

Methods:
Case discussion/scenario presentation, presentation of the student and tutor’s perspective
Handout of PowerPoint slides to aid discussion

Results:
Present what happened clinically in each of the 3 case discussions/scenarios
To present a student’s reflection on his experience
To present a tutor’s experience
To present a suggested Public Health curriculum

Conclusions:
These will be determined by the nature of the discussion that follows the presentation.

• Identify the population that the study pertains to – a small community living in isolation with a third world type population pyramid.
• Identify who you think your presentation will appeal to - those interested in public health, curriculum designers interested in ensuring what is included is of practical value in the life of the future doctor, community leaders interested in educating their communities to tackle community health issues.
205 Indigenous Health in Scandinavia - Pitfalls and Summits

Author(s) and Affiliations: Dr. Oleg V. Kravtchenko, Norway

Dr. Oleg V. Kravtchenko had graduated the Moscow Medical Academy in 1986 with postgraduate training at the Central Postgraduate University in Moscow and Eppendorf University in Hamburg with primary specialty in ENT-surgery. He was working in Russia and in Norway (after moving there in 1998 and getting another specialty as GP in 2002). He is currently co-owner of the Fredensborgklinikken, Bodoe, Norway, full-time GP and mentor for the postgraduate program in cooperation with Bodoe Community and University of Tromsoe. He lives in Bodoe, Nordland County, Norway.

Abstract:
The author will speak of the current situation with indigenous health in Norway and Scandinavia, focusing on historical and geographical background. He will also speak of the demographic trends in the area and the prospects of cooperation between native/traditional/alternative and western/modern/school medicine, including its impact on medical education and training. The presentation is based on theory/literature and partly on author's own experience.

Materials and methods:
Literature review and comparative analysis.

Conclusions:
There used to be many pitfalls on the way of cooperation between native and modern medicine and there's still certain level of misunderstanding and unhealthy competition between these two. However, there's a huge potential for cooperation if these two approaches overcome their differences for mutual holistic approach to healthcare. There are several good examples of this process already.
206 From scratch – a new medical school in Portugal

Author(s) and Affiliations: Pedro Marvao

Pedro Marvão is an Assistant Professor and vice-director of the medical course at University of Algarve. He has a degree in Biochemistry and a PhD in Physiology and is responsible for the coordination of the curriculum at the school. He is also a PBL tutor and lecturer in Physiology. His main interests are assessment, selection and small-group tutoring.

Learning Objectives:
1. Understand the reality of Medical Education in Portugal.
2. Understand the strengths and weaknesses of the medical school in Algarve.
3. Discuss solutions that were implemented and their applicability to other settings.

Background:
The year is 2008 and
1. Portugal has 7 medical schools all located north of the river Tagus.
2. All medical schools run 6-year traditional hospital-centric curricula
3. The southernmost province of Portugal, Algarve, is an area facing serious difficulties in health care due mostly to lack of qualified professionals.

Aim:
From the outset the project was devised to be a departure from previous Portuguese models of Medical Education and, as such, to serve as a test-bed and vehicle for innovations in curriculum, selection, assessment, etc.

Three cornerstones of our project:
1. Graduate-entry course with a 4-year curriculum.
2. Fully integrated PBL curriculum.
3. Main emphasis on primary care.

Methods:
- Being a graduate entry course allowed us to develop our own selection process, a two-step procedure:
  a. Cognitive aptitudes and English Language tests
  b. Multiple Mini-Interviews
- Translated and adapted a package of PBL cases from St. George's Medical School to serve as the core of our curriculum
- In the first two years students are placed in GP practices

Results:
In July 2013 the first cohort finished the course. The 29 students that finished the course are now doing their first foundation year and some conclusions are already possible.
1. Their preparation is generally considered to be very good.
2. 30% of the students from outside Algarve opted to stay in the region.
3. The course has attracted young, highly qualified, specialists to the region.
207 The impact of a distributed education model on specialty practice location intent

Author(s) and Affiliations: Douglas L. Myhre, MD, CCFP, FCFP, FRRMS | Paul J. Adamiak, MSc. | Jeanette S. Pedersen BA (Hons) | Cumming School of Medicine | University of Calgary, Calgary Alberta, Canada

Learning Objectives/Practice Points:
1. Medical education institutions can employ postgraduate distributed learning to address their social mission of ensuring equitable access to health care services.
2. Medical specialty residents report an increased interest in practicing at smaller centres following distributed education experiences.
3. Residents in medical specialties value distributed experiences due to collegiality of teaching staff, autonomy and presentation mix.
4. Training residents from different specialties and year of training in rural/regional communities is equally effective in increasing interest in practice in smaller communities.
5. Programs can be implemented while still in development stages as learners differentiate between the clinical and logistic experiences.

Background:
Objectives: There is an increased focus internationally on the social mandate of post-graduate training programs. This study explores specialty residents’ perceptions of the impact of the University of Calgary’s (UC) distributed education rotations on their self-perceived likelihood of practice location, and if this effect is influenced by resident specialty or stage of program.

Methods:
Residents participating in the UC Distributed Royal College Initiative (DistRCI) between July 2010 and June 2013 completed an online survey following their rotation. Descriptive statistics and student’s T test were employed to analyze quantitative survey data, and a constant comparative approach was used to analyze free text qualitative responses.

Results:
Residents indicated they were satisfied with the program (92%), and that the distributed rotations significantly increased their self-reported likelihood of practicing in smaller centers (p < 0.05). The findings suggest that the shift in attitude is independent of discipline, program year, and logistical experiences of living at the distributed sites, and is consistent across multiple cohorts over several academic years.

Conclusion:
The findings highlight the value of a distributed education program in contributing to future practice and career development, and its relevance in the social accountability of postgraduate programs.
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