

Paper ID: 1

Mental Healthcare Capacity Building Initiatives for Primary Care Providers in Outreach Communities

Supuneet Bismil^{1,2}

¹ St Joseph's Care Group, Thunder Bay (Canada)

² Northern Ontario School of Medicine (Canada)

Northwestern Ontario (NWO) has a large geographical spread, low density of population and high mental health care needs leading to significant challenges to provision of timely and adequate mental health care in the region. Over the past few years, we have engaged with various community organizations across the region to get a better understanding of felt learning needs of primary care providers to improve their capacity in providing adequate mental health care to their communities. In this interactive workshop, we will examine various factors affecting mental health care delivery in NWO, compare and contrast these factors in NWO to those in other communities in various parts of Canada and the rest of the world. We will present some capacity building initiatives that we have been offering to primary care providers in the region and discuss the applicability and implementation of similar initiatives in communities which workshop participants work in.

Paper ID: 2

Interprofessional School-Based Mental Health Services for Rural Adolescents in South Australia

Garreth Kestell¹, Lukah Dykes¹, Danielle Zerk², Kyla Trewartha², Rhianon Marshall² and Elena Rudnik³

¹ Flinders University (Australia)

² Clinical Psychologist (Australia)

³ Flinders University Rural Health South Australia (Australia)

Introduction: Adolescent mental health is an international priority and the impact of innovative service models must be evaluated. Secondary school-based mental health services (SBMHS) involving private general practitioners and psychologists are a model of care being trialed in South Australia. This research set out to quantify the impact of psychotherapy for rural adolescents in a school setting and explore the importance of session frequency.

Methods: Depression, anxiety and stress scores (DASS) were obtained and de-identified from students (n=65) by psychologists working at the SBMHS. A mixed model analysis was used with age, sex, treating psychologist, months from first session, and session number as fixed effects, with response variables of DASS.

Results: Students were aged 13-18 years (M=15.43, SD= 1.24), mostly female (F=51, M=14), attended a median of 6 sessions (range: 1-23 sessions) in one-year. 71.5% were classified as having extreme or severe anxiety and half had extreme or severe depression and/or stress scores. On average males had a greater increase in DASS over time but males attending more sessions benefited most from therapy.

Discussion: Psychologists are treating rural adolescents in schools for severe anxiety, depression, and stress. This pilot study indicates that a predictive model combining demographics, session frequency, and DASS may help identify who is most likely to benefit from individual psychotherapy. Variations in DASS of individuals over time indicate the need for a larger sample size and the collection of more information such as living situation and other stressors.

Paper ID: 3

"The experience guides my work now": Short-term rural and remote placements in a WA medical school

Donna Mak¹, Daniel Vujcich¹ and Sandy Toussaint^{1,2}

¹ Notre Dame University Fremantle (Australia)

² University of Western Australia (Australia)

Introduction: In 2005, the University of Notre Dame School of Medicine (Fremantle, Western Australia) established a mandatory rural/remote health placement program. The Program is delivered in two weeks over two years, and is largely resourced by voluntary human and social capital. Students live and undertake non-clinical work with rural/remote families and organisations in return for experiential learning. This study investigated whether the Program: (1) encouraged graduates to seek rural/remote employment; (2) improved graduates' ability to meet the needs of rural/remote patients in urban settings; and (3) could be sustained over time.

Methods: Qualitative data, collected from semi-structured, in-depth, ethnographic interviews with University graduates and community hosts who had participated in the Program, were transcribed, coded and analysed.

Results: Twenty-eight graduates and 15 hosts contributed data. The Program positively influenced graduates' desire to practice rural/remote medicine or helped to galvanise pre-existing interest. The majority of participants considered that the Program made them more responsive to the needs of rural/remote patients accessing urban health services. Hosts were unanimously supportive of the Program and its continuation.

Discussion: Short-term rural/remote placements can influence graduates to pursue a career in rural/remote medicine, and improve the ability of doctors to address rural/remote patients' needs in urban contexts. There is sufficient goodwill to sustain the Program, which depends on in-kind support from hosts.

Conclusions: Compared to other interventions that have been studied, this mandatory short-term placement required less financial investment and curricular time to encourage graduates to consider rural/remote practice and improve medical care for rural/remote people.

Paper ID: 4

Longer duration and varied settings of rural immersion related to rural work outcomes by doctors

Belinda O'Sullivan¹, Matthew McGrail², Deborah Russell³, Judi Walker⁴, Helen Chambers⁴, Laura Major⁴ and Robyn Langham⁴

¹ School of Rural Health, Monash University (Australia)

² University of Queensland (Australia)

³ Flinders University (Australia)

⁴ Monash University (Australia)

Aim: Optimal design of rural immersion programs is poorly established in evidence. This paper studied the associations between various durations and settings of rural immersion and rural work outcomes.

Methods: Eligible participants were medical graduates of Monash University between 2008 and 2016, in postgraduate years 1-9, whose characteristics, rural immersion information and work location had been prospectively collected. Separate multiple logistic regression and multinomial logit regression models tested associations between the duration and setting of any rural immersion during the medical degree and a) working in a rural area and b) working in large or smaller rural towns, in 2017.

Results: The adjusted odds of rural work were significantly increased if students were immersed for one full year (OR 1.79, 95% CI 1.15-2.79), for between one to two years (OR 2.26, 95% CI 1.54-3.32) and for two to three years (OR 4.43, 95% CI 3.03-6.47) relative to no rural immersion.

The strongest association was for immersion in a mix of both regional hospitals and rural general practice (OR 3.26, 95% CI 2.31-4.61), followed by immersion in regional hospitals only (OR 1.94, 95% CI 1.39-2.70) and rural general practice only (OR 1.91, 95% CI 1.06-3.45). More than one years' immersion in a mix of regional hospitals and rural general practices was associated with working in smaller regions/towns (<50,000 population) (RRR 2.97, 95% CI 1.82-4.83).

Conclusion: Longer rural immersion and immersion in both regional hospitals and rural general practices are likely to increase rural work and rural distribution of early career doctors.

Paper ID: 5

Satisfaction of Junior Medical Officers in Rural Australia

Matthew Lennon¹, Belinda O'Sullivan², Deborah Russell³, Matthew McGrail⁴, Joseph Suttie⁵ and John Preddy⁵

¹ University of New South Wales (Australia)

² School of Rural Health, Monash University (Australia)

³ Monash University (Australia)

⁴ University of Queensland (Australia)

⁵ UNSW (Australia)

Objectives: Junior medical officers (JMOs), graduates in their first three years of work, are an important part of the health care team. Attracting and retaining these doctors to rural areas underpins the development of the future rural workforce. This is the first national-scale study quantifying the satisfaction of JMOs located rurally compared with metropolitan areas to inform recruitment and retention.

Design: Cross-sectional multivariate logistic regression analysis.

Setting and participants: 442 JMOs participating in the 2015 Medicine in Australia: Balancing Employment and Life (MABEL) survey of doctors.

Main outcome measure: Professional and non-professional satisfaction items by work location.

Result: Overall work satisfaction was around 90 per cent amongst JMOs, with small significantly lower overall satisfaction for rural JMOs in multivariate analysis (odds ratio 0.62, 95% CI 0.42 – 0.93). Rural JMOs were significantly more satisfied with their work-life balance, ability to obtain desired leave and leave at short notice, personal study time and access to leisure interests compared with metropolitan JMOs. Metropolitan JMOs were more satisfied with the supervision from specialists, the network of doctors supporting them and the opportunities for their partners and children.

Conclusion: While both metropolitan and rural JMOs are generally satisfied, many professional and personal aspects differ considerably. To attract candidates to rural areas the benefits of rural JMO work, such as leisure and leave opportunities, should be emphasized and any perceived weaknesses mitigated, by strengthening of specialist mentorship and peer networks, providing social, employment and educational opportunities for families.

Paper ID: 7

HeartSAFE KI - a ground-up program of clinician-lead community education in rural Australia

Tim Leeuwenburg¹

¹ Kangaroo Island Medical Clinic (Australia)

Sudden cardiac death affects over 35,000 Australians annually. Despite massive advances in resuscitation science and novel technology such as mechanical CPR and ECMO, survival rates for out-of-hospital cardiac arrest remain low.

Kangaroo Island is Australia's third largest Island, with an engaged community. Like many rural communities, health outcomes are worse than metro counterparts. For every minute that passes in a sudden cardiac arrest, survival drops by 10%. Ambulance response times in rural South Australia are typically well over ten minutes (considerably longer) and many responders are unpaid volunteer staff, trained as Ambulance Officers (can defibrillate, place a laryngeal mask airway and administer adrenaline).

In 2016 three local clinicians (rural doctor, intensive care paramedic and volunteer ambulance officer) commenced a program of community CPR and Defibrillator training. Within 18 months we have trained over 15% of the Kangaroo Island population to commence CPR and use a Defibrillator in the event of suspected cardiac arrest.

Moreover, community groups have banded together to raise funds and install over 20 Public Access Defibrillators across Kangaroo Island - this, and the fact over 15% of locals are trained in resuscitation, means that Kangaroo Island was declared Australia's first 'HeartSAFE' community, joining an international brand.

This short talk explains the engagement by local clinicians to raise awareness, train lay community responders and advocate for funding. We also describe use of the GoodSAMapp smartphone technology to mobilise lay & emergency responders in a crisis, enhancing rural community resilience.

Paper ID: 8

CPR for Death by Powerpoint

Tim Leeuwenburg¹

¹ Kangaroo Island Medical Clinic (Australia)

Effective education should function not at a pedagogical level, but be more directed through the principles of andragogy (adult learning) towards heutagogy (learning about how we learn).

Sadly the 'powerpoint' presentation has been a mainstay of many conferences and medical education events. And yet evidence suggests that a simple presentation of words is an incredibly ineffective method of imparting information.

In this workshop we will encourage you to breathe new life into your 'powerpoints' - learn how to deliver short, effective presentations with powerful messages.

We will explore three main principles

- use of an effective story arc to engage audience and encourage learning
- the use of effective supportive media (slide deck, audio, video etc) to enhance and not distract from your message
- tips on delivery of your talk, to ensure your message is seen, heard and remembered

This will be an interactive workshop - bring your laptop or tablet, be prepared to tear down and rebound the way you impart medical education to maximise effectiveness using the techniques from world class conferences capturing the mind of forward-thinking educators such as smacc, dontforgethebbles and BADEMfest

Paper ID: 9

Building distributed primary care research capacity by leveraging a health systems research platform across Northern Ontario

Joel Andersen¹ and Tim Dube²

¹ Northern Ontario School of Medicine (Canada)

² McGill University (Canada)

Abstract:

Research is an integral component of medical training at the undergraduate and postgraduate level. Historically, research training has been the domain of university campuses and teaching hospitals. However, as a greater number of training programs shift towards a distributed model of medical education, new strategies for engaging medical students and residents have started to evolve from traditional models. Northern Ontario School of Medicine (NOSM), distributed resident training occurs across the entire geography of Northern Ontario. Postgraduate learners from family medicine and speciality training programs are spread across dozens of clinical learning sites. These learners are serviced by sister campuses which are over 1000 km apart in Sudbury and Thunder Bay. Moreover, these learners are trained by clinical faculty of 1800 practising physicians. With such vast geographic distribution, alternative models of research training have become a necessity. Here we describe a model for interdisciplinary research training based on a health systems research platform. The advantages of building a flexible research platform that can be levered by a faculty whose interest cover a wide breadth of scope and foster impactful research will be highlighted.

Learning Objectives:

- 1) Understanding how a health systems research platform can be leveraged to facilitate impactful research among distributed faculty and learners
- 2) Understanding the administrative capacity required to facilitate a distributed health system research platform

Paper ID: 10

Facilitation of Martial Arts as Leisure: Empowering First Nations Youth as form of Community Process

Carol Cameletti¹

¹ Northern Ontario School of Medicine (Canada)

This study investigates the nature of martial arts facilitation towards empowering First Nations youth who have faced adversity. Current research suggests that leisure participation in martial arts may promote health status, a greater awareness of community and a commitment to shared interests. An inquiry, however, is how the process of martial arts facilitation as leisure may most positively affect First Nations youth who have faced adversity. Ungar et al. (2008) suggest that having a sense of identity and empowerment in connection and responsibility to community may enhance resiliency in First Nations youth. A contextual framework that has emerged in the literature is the need to view resiliency as an artefact of both an individual's capacity to navigate their way to health resources and their community capacity to provide access to resources in culturally meaningful ways. By exploring the process of facilitating martial arts as leisure, this study examines assumptions and perspectives of martial arts facilitators in considering issues of resiliency to adversity. As martial arts facilitation is often intended to give direction and focus to the student mentee through self-discovery as a form of individual and community responsibility, the purpose of this study is to discern the nature, effect and process of such mentorship. By examining beliefs and observations of participant facilitators over a range of community programs in Ontario, this analysis is made to gain insight into the process of facilitation that may positively empower or affect the lived experiences of First Nations youth.

Paper ID: 11

Educating for collaborative practice, training the future rural workforce through IPE

Vanessa Ryan¹, Stef Lozbin¹, Sandra Crockett¹, Peter Burns¹ and Sarah Boyd¹

¹ Flinders University Rural Health South Australia (Australia)

Training the future health workforce in Australia needs to meet the complex and changing needs of an aging society. Aging populations, growing patient expectations, the increasing number of patients with chronic disease and health workforce shortages all contribute to this complexity.

Evidenced in the growing body of literature, collaborative interprofessional practice optimises health outcomes for people with complex problems. Similarly, Research has shown that where collaboration exists patient outcomes, quality of care and cost of care delivery are all optimised.

Graduates readiness for collaborative practice depends on how the educational environment meets the needs and complexity of the health service environment. Longitudinal rural immersion programs like the PRCC enables students to live and breathe the complexities of rural communities and rural practice. With the view to develop rural practice ready graduates, the clinical education team at Flinders University Rural Health SA (FURHSA) have been assisting health professions' students to develop their Interprofessional practice competencies.

This presentation will describe how FURHSA is addressing the complex health needs of rural Australia through the development and delivery of Interprofessional curricula aimed at building the collaborative skill set of health professions' students.

Paper ID: 12

Use of personalised music on the wellbeing of residents with Dementia

Grace Tiri¹, Jennene Greenhill¹, Elsa Barton¹ and Vivian Isaac¹

¹ Flinders University Rural Health South Australia (Australia)

Introduction:

Dementia is reported to be the second leading cause of death in Australia for which there is currently no cure. The use of music therapy is reported to have a positive effect on behavior, agitation, mood, emotion and cognition in people with dementia.

Aims:

This study examined the effect on resident wellbeing, clinical care and workplace culture when music was integrated into daily care plans of residents with dementia at a rural aged care facility.

Methods:

Personalised music was utilised over an eight week trial. Focus groups were conducted with nursing home staff and semi-structured interviews were undertaken with family members of participating residents. How music influenced resident's behaviour and wellbeing, social interaction between staff, residents and their families as well as the impact on the workplace environment and culture was explored.

Results:

15 staff, 10 residents and 5 family members participated. Using thematic analysis three themes emerged: quality of care, personalised care and better environment for staff and residents. Music was beneficial for residents who were reported to be happier and less agitated after listening to their own music. Staff found music a useful tool to promote positive behaviour that encouraged a less stressful environment and greater interaction among staff, residents and families.

Discussion:

This research highlights the positive effects on the wellbeing of residents, staff and families when personalised music is integrated into daily care plans.

Conclusion:

Further research is needed to expand this research to nursing homes in other rural locations to confirm this pilot data.

Paper ID: 13

The Northern Territory Medical Program: Locally, Regionally & Nationally Important

Sneha Kirubakaran¹, Koshila Kumar¹, Paul Worley², Joanne Pimlott³, Narelle Campbell⁴ and Jennene Greenhill⁵

¹ Prideaux Centre for Research in Health Professions Education, Flinders University (Australia)

² Australian Government Department of Health (Australia)

³ School of Management, University of South Australia (Australia)

⁴ Flinders Northern Territory (Australia)

⁵ Flinders University Rural Health South Australia (Australia)

In 2011, the Northern Territory Medical Program (NTMP) launched as a full medical school in Darwin as a distributed site of Flinders University School of Medicine and in collaboration with Charles Darwin University (CDU). It's establishment is socially and politically significant, driven by burgeoning community and workforce needs at the local, state and national levels.

This paper will overview the establishment of the NTMP, highlighting the social and political drivers, the challenges faced and the unique combination of factors that contributed to its story.

The establishment of the NTMP was researched as a Case Study. Key locations in Darwin and Palmerston were visited. Semi-structured interviews with key staff leaders were conducted. Documents, reports and audio-visual material were collected and analysed.

Crucial events, people, organisations and partnerships in the NTMP's establishment story were identified. Key themes emerged around social and political imperatives, 'serendipitous' circumstances and unique challenges.

Establishing a new medical school requires the skillful alignment of a complex array of inter-related factors by an enterprising team. It necessitates an intricate, non-linear, iterative transformation of the involved organisations. Concepts from the business, organisational and entrepreneurship literature may be helpful for founding teams to consider.

Paper ID: 14

The Northern Ontario School of Medicine: Blazing a Social Accountability Trail

Sneha Kirubakaran¹, Koshila Kumar¹, Paul Worley², Joanne Pimlott³, Roger Strasser⁴ and Jennene Greenhill⁵

¹ Prideaux Centre for Research in Health Professions Education, Flinders University (Australia)

² Australian Government Department of Health (Australia)

³ School of Management, University of South Australia (Australia)

⁴ Northern Ontario School of Medicine (Canada)

⁵ Flinders University Rural Health South Australia (Australia)

The Northern Ontario School of Medicine (NOSM) opened its doors in 2005 as the first new medical school in Canada after a 30-year hiatus. It was established with a strong social accountability mandate and it blazed a trail with its innovative structure, governance and community-engaged curriculum.

Establishing a new medical school requires the skilful alignment of a complex array of inter-related factors by an enterprising team. A comprehensive review of the medical education literature on new medical school establishment reveals a wealth of knowledge based on expert opinion and experience but without clear application of research methodologies nor theoretical frameworks.

Establishing a new medical school could be viewed as an entrepreneurial activity similar to establishing a new start-up company. Business, organisational and entrepreneurship theories could be applied to extend our understanding beyond the domain of medical education.

This paper will examine the establishment of NOSM using theoretical constructs from the business, organisational and entrepreneurship domains. NOSM will be identified as an example of Social Entrepreneurship – an entrepreneurial endeavour driven by social imperatives.

Can this reframing of a medical education activity as an entrepreneurial activity inform and assist future founding teams of new socially accountable medical schools?

Paper ID: 15

The Patient Perspective: Impact of Longitudinal Integrated Clerkship Students on Patient Experience

Jennifer Adams¹, Robert Flick², Caitlin Felder-Heim², Jennifer Gong², Alejandro Marin² and Kathryn Kalata²

¹ Denver Health and Hospital Authority (United States)

² University of Colorado (United States)

Background

Longitudinal integrated clerkships (LICs) offer numerous benefits to students and faculty, however, little is known about their effect on patients. Because LIC students take ownership in the care of complex patients, it is plausible that patient experience may be significantly impacted. Through qualitative analysis of patient interviews, this study aims to explore how medical students in LICs affect health outcomes and patient experience.

Methods

Semi-structured interviews were conducted to understand patient experiences working with an LIC student. Researchers independently analyzed interview transcripts and reached consensus on emergent categories and themes.

Results

Fourteen patients with three or more encounters were interviewed before saturation was reached. Patients grew to trust their student over time through students playing a variety of roles in patient care, demonstrating mastery of clinical skills, and mitigating health systems failures. Students demonstrated caring by their presence in multiple care settings, providing an extra level of service to patients, and considering social determinants influencing health. Patients described reaching a therapeutic alliance with students that led to an improvement in their health. When students completed the LIC, patients described a sense of loss ranging from sadness to abandonment.

Conclusions

Patients developed trusting alliances with LIC students and described improved health due to students' multifaceted involvement in their care. At the end of the program, patients described confusion and feelings of loss and abandonment. This study will inform curriculum development and has implications for hospital systems as they consider the impact of LICs and medical student involvement on patient experience.

Paper ID: 16

Standing Up to Block: Validating a Novel Ob/Gyn LIC Curriculum at the University of Toronto

Rajiv Shah¹, Alexandra Davidson¹, Anita Shah², Lindsay Shirreff¹ and Eliane Shore¹

¹ University of Toronto (Canada)

² McMaster University (Canada)

Introduction: Longitudinal Integrated Clerkship (LIC) was introduced at the University of Toronto (UofT) in 2014. A novel Ob/Gyn curriculum was designed incorporating both ambulatory and in-patient experiences with a new formal teaching program. LIC students are assessed midway through the academic year, as opposed to Block students who are assessed at the end of their six-week rotation. Both streams of students take equivalent examinations.

Aim/Objectives: The purpose of our study is to validate our Ob/Gyn LIC compared to the existing Block clerkship.

Methods: Written, oral, and clinical examination scores from September 2014 to March 2018 were compared between LIC and Block students based on year of LIC, hospital sites (n=4), and averages within years. Statistical analysis was performed with independent sample t-tests and one-way ANOVAs.

Results: Eighty-nine LIC students and 797 Block students were compared. There were no statistical differences between LIC and Block clinical and oral examination scores (Clinical: 81.0% vs 81.2%, Oral: 83.9% vs 84.4%, $p>0.05$). However, Block students did perform significantly better on written exams (83.0% vs 79.5%, $p<0.01$). LIC students at one hospital site showed significantly higher oral examination scores compared to all other sites (89.0% vs 82.0% vs 83.0% vs 81.6%, $p<0.05$).

Discussion: Our LIC curriculum prepares students as well as their Block peers for their assessments, but students in the LIC program have the added advantage of longitudinal relations with faculty and patients.

Conclusion: We have validated our Ob/Gyn LIC program and our curriculum can be appropriately modelled at other teaching institutions.

Proposal for a New Zealand Graduate Entry, Community Engaged Medical Program

Ross Lawrenson¹

¹ The University of Waikato (New Zealand)

New Zealand has a maldistributed workforce that is heavily dependent on recruiting international medical graduates (IMGs). Currently 43% of the medical workforce are IMGs, and in the Midland Region served by Waikato University 65% of newly qualified GPs and 71% of recently qualified specialists are IMGs. Shortages are particularly apparent in high needs communities and in general scope specialties in provincial regions. The University of Waikato in partnership with the Waikato District Health Board has proposed a third medical school for New Zealand which will concentrate on addressing the workforce needs of disadvantaged rural and provincial communities. The proposed program is a community engaged, graduate entry medical course. With the ageing population and the increase in long term conditions it has been recognised that the focus of health care needs to change. There is a greater emphasis on improving health through health promotion and preventive health services as well as in reducing health inequalities. In 2001, New Zealand adopted a Primary Health Care Strategy with the aim of improving health and reducing inequalities. It noted “the ratio of practitioners to patients is not closely matched to population need (some of the lowest number of doctors are in places of highest need)”. In 2007, the ‘Better Sooner More Convenient’ discussion document was released, seeking to shift health care provision to “a high-quality patient-centred health system that cares about the wellbeing of New Zealanders”. It noted that the numbers of general practitioners had been falling since 1999 and the importance of reversing that trend. In 2016, the New Zealand Health Strategy; Future Direction was launched. In its foreword the Minister noted “The health sector will need to be adaptable in coming years as developing technology changes how services can be delivered in ways we do not yet understand. The support of being one team with a common purpose provides the base for adaptation and innovation needed for value and high performance that will in turn lead to a sustainable and enduring public health service”.. The strategy recognises “the need to continually invest in training so that our health workforce has the skills needed to meet the health needs and expectations of caring for New Zealanders. The Waikato proposal addresses the challenges facing the New Zealand health system by focussing on the health needs of our provincial communities and trying through community engagement in partnership with our local health board to address the immediate and future workforce needs. The presentation will firstly focus on health needs in New Zealand and in particular the needs of communities in the Waikato region. We will then outline the proposed governance of a community engaged program that includes Māori, local health services as well as academics in the over view of the program. It will also outline the proposed entry requirements, the curriculum including aspects unique to New Zealand and intended outcomes of the program. Discussion will be invited on addressing the challenges of marketing a new program in an environment with two well established traditional medical schools who are strongly opposing a third player.

Paper ID: 19

Continuity with patients - the roles and functions of LIC students

Yaw-Wen Chang^{1,2}, Wen-Chii Tzeng² and Pauling Chu^{1,2}

¹ Tri-Service General Hospital, National Defence Medical Centre, Taipei, (Taiwan)

² National Defence Medical Centre, Taiwan (Taiwan)

Introduction

One of the principles of longitudinal integrated clerkship (LIC) is continuity of care. Medical students have longitudinal relationships with patients. This study explored the patients' perspectives of the roles and functions of LIC students.

Methods

It was a qualitative study. The data was collected by a trained research assistant with a semi-structured interview in person or over the telephone. The researchers thematically analyzed the transcribed verbatim using a general inductive approach to identify themes in patient's descriptions of their experiences interacting with LIC students.

Results

Patients felt supported because the students accompanied them like friends. Patients recognized the student's assistive roles in health care which was supervised by attendings. Through communication apps of handheld devices, patients could easily to access health advises from students. Patients and students learned simultaneously during the processes of consultation: the patient got health information and the students learned knowledge and communication skills. Interviewed patients had high satisfaction with this program.

Conclusions

The relationship between LIC students with patients differed from that between attendings and patients. From the patient's perspective, the roles of medical students were more like a learner and a friend. Therefore, what the patients expected the students learned from this relationship were empathy and doctor-patient communication, not only medical knowledge and skills.

Paper ID: 21

Aboriginal and Torres Strait Islander entry into medicine: the pathway from engagement, participation and attainment

Elsa Barton¹, Doug Turner¹, Donna Quinn¹, Darryl Cameron¹ and David Lim¹

¹ Flinders University Rural Health South Australia, (Australia)

Australian universities have set ambitious goals to increase the enrolment and completion rates of Aboriginal and/or Torres Strait Islander students with an aim of achieving health equity and a culturally diverse workforce. Flinders University Rural Health SA aim to increase opportunities for Aboriginal and/or Torres Strait Islander students to enter medicine and have focused efforts on community engagement, recruiting students into medicine through sub-quota and Indigenous Entry schemes and supporting students during their degree to graduate.

This session aims to explore and discuss:

1. The different approaches to community engagement from traditional to more creative forms of engagement.
2. Successful ways of recruiting Indigenous students into medicine and how to overcome the challenges of reaching those who may be the first in their family to go to university.
3. How to best support Indigenous students to succeed during their studies to completion and to ensure there is a consistent approach toward student support strategies across the University.

This presentation will appeal to clinical educators, academics and administrators interested in Indigenous health. The session will offer insights and shared learning from attendees on different approaches to Indigenous student engagement, participation and attainment undertaken and their success at other organisations.

Paper ID: 23

Vertical Integrated Learning in a Rural Longitudinal Integrated Clerkship

Jessica Beattie¹, Lara Fuller¹, Vivienne Ramsbottom² and Marley Binder²

¹ Deakin University, Geelong Australia, School of Medicine, Rural Community Clinical School (Australia)

² Deakin University (Australia)

Background: Vertical Integrated (VI) Learning recognises the potential for learners at different levels to benefit from learning together. In rural Longitudinal Integrated Clerkship (LIC) programs, students are frequently co-located with General Practice trainees, yet there has been limited exploration of the role VI learning plays in this context. VI is simply defined as multiple levels of learners learning together within a shared session.

Aim: To establish the ways that VI learning is experienced and perceived by practices and learners associated with Deakin's Rural Community Clinical School, a comprehensive LIC program.

Methods: Semi-structured, in-depth, qualitative interviews were undertaken, with 15 participants located in RCCS General Practices. Emergent themes were identified by thematic analysis.

Results: Five main interconnected themes were identified; (i) benefits, (ii) facilitators, (iii) barriers, (iv) understanding and structure, and (v) planning and evaluation.

Discussion: Understanding of VI learning, its structure and activities varied significantly between GP participants. Facilitators identified by learners included a collegial and supportive learning environment, with efficiency and satisfaction highlighted as positive benefits by practices. Barriers included financial and time limitations, the impact of group dynamics and meeting the needs of different levels of learners.

Conclusion/recommendations: VI learning involving LIC students and GP trainees can play a valuable role in a rural training environment. Stakeholders are encouraged to work together to create resources for General Practices that enhance VI planning, delivery and evaluation.

Paper ID: 24

Failure to thrive: Understanding why the academic discipline of rural health has failed to develop in New Zealand.

Garry Nixon¹

¹ University of Otago (New Zealand)

Rural Health has not developed as an academic discipline in NZ the way that it has in comparable countries. New Zealand has no rural clinical schools, departments of rural health or senior rural health academic posts.

This presentation explores the issues behind academic rural health's 'failure to thrive' in NZ.

The potential risk factors include the following:

- * A dramatically different understanding of what constitutes 'rural' in NZ, both at an official and a societal level.

- * NZ's medical schools recognise a different set of social accountability priorities reflecting their responsibilities under the Treaty of Waitangi.

- * A trick of history saw the country's oldest and largest medical school established in a city that has seen little population growth in over a century. Much of the clinical teaching is now 'farmed out' to larger urban centres in a regional structure that has seen rural health divided across a multitude of urban-based departments.

- * The depth of the NZ economic downturn in the 1980s and 90s has left a social and infrastructure debt that is taking decades to repay.

It hard to fully explain the extent of the 'trans Tasman rural health gap' but doing so may help navigate the 'catch up' that is now needed.

Paper ID: 26

Social Determinants of Health - What is it and why should I talk about it?

Talia Blythman¹, Elena Rudnik¹, Vicki Martin², Sarah McArthur¹ and Bill Gransbury³

¹ Flinders University Rural Health South Australia (Australia)

² Vicki Martin Child and Family Psychologist (Australia)

³ Angaston Medical Centre (Australia)

Social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. This workshop will present recently published resources developed by the World Health Organisation (WHO) and present practical strategies for health professionals to engage patients in discussions about SDH. The Steps to Better Health (STBH) project developed a hard-copy and electronic tool containing a SDH assessment tool and a cross referenced service directory. Workshop participants will be shown how to use the STBH tool and develop their own locally relevant STBH leadership plan.

Learning Outcomes

1. Improved knowledge of SDH and relevance to the management of patient health
2. Understand the content of the STBH booklet and how to use it engage patients in conversations about SDH
3. Identify opportunities and develop strategies in your practice to promote SDH conversations

This workshop will incorporate:

- * Background to the Social Determinants of Health utilising The World Health Organisation SDH eBook and training materials.
- * SDH indicators in the South Australian context.
- * Explanation of the STBH assessment tool and cross-referenced service directory.
- * A skill development session for participants to administer the STBH assessment tool.
- * Group discussion and small group work to develop leadership plans to promote STBH and SDH in diverse rural settings.

Paper ID: 27

Steps to Better Health - getting rural communities talking about Social determinants of health

Talia Blythman¹, Elena Rudnik¹, Vicki Martin², Sarah McArthur¹ and Bill Gransbury³

¹ Flinders University Rural Health South Australia (Australia)

² Vicki Martin Child and Family Psychologist (Australia)

³ Angaston Medical Centre (Australia)

Introduction

The management of chronic disease required complex interprofessional practices and consideration of social influences upon health care and patient wellbeing. Social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Steps to Better Health (STBH) developed a hard-copy and electronic resource to enable General Practitioners (GPs) and other health professionals to have a conversation with patients and assess 16 key Social Determinants of Health (SDH). This presentation will present an overview of the project and seeks discussion about the next phase and potential the promotion of SDH and STBH into other rural communities.

Methods

The process of the STBH tool development involved interview and survey feedback from health professionals about the usability and perceived outcomes for primary health care consultations.

Results

The survey data will be presented along with an overview of the STBH tool.

Discussion

STBH resources provides an easy to use tool that promotes SDH discussions. Feedback is being sought from service providers about strategies that promote SDH conversations with patients, the applicability of the STBH resources in rural primary health and acute care settings and ideas for the education of health practitioners about SDH.

Paper ID: 28

Creating a culture of diversity and inclusion in an urban longitudinal integrated clerkship

Tal Ziv¹, Laurel DeCou¹ and Nardine Saad Riegels¹

¹ Kaiser Permanente, East Bay and University of California, San Francisco (United States)

Introduction/background: Serving a diverse urban community, Kaiser Permanente, East Bay Medical Center (KPEBMC) is the teaching site for 8 medical students in the Kaiser Permanente-University of California, San Francisco (UCSF) Longitudinal Integrated Clerkship (KLIC). Recognizing challenges facing under-represented in medicine (URM) students, and students' interest in health equity and inclusion, we developed an array of opportunities within KLIC to empower students to engage around diversity and inclusion (DI).

Goals/Aim:

1. To improve URM student wellbeing
2. To recruit URM students to local residency programs and
3. To support all students to understand healthcare disparities and address workplace implicit bias.

Methods: During 2017-18, a DI thread was woven into the KLIC curriculum, specifically through didactics, student invitations to KPEBMC equity conferences and the diversity committee, clinical experiences with an emphasis on health disparities, faculty training, and URM student mentorship. An additional domain in quarterly LIC assessment of medical student performance, patient advocacy, is currently being piloted.

Results: Students widely participated in DI experiences. Impact will be assessed through students' year-end program evaluation on wellbeing and DI (available June 2018) and ongoing URM matriculation into residency.

Discussion: To create a DI thread in our LIC, we capitalized on existing resources in our medical center and affiliated university through a concerted effort to coordinate, highlight and make DI opportunities accessible to students. High attendance and informal feedback are promising; quantitative and qualitative data is pending.

Conclusion: With a multipronged approach, KLIC addresses health equity, diversity, and inclusion as a multifaceted domain of medical education.

Paper ID: 29

Talking together: The development of an Indigenous language resource for medical students

Henrietta Byrne¹

¹ Mobile Language Team, University of Adelaide (Australia)

Introduction/background

This presentation explores the intersection of Indigenous languages and the health and wellbeing of Indigenous peoples. Both qualitative and quantitative literature consistently speak to the importance of language and communication in delivering effective healthcare. Paying attention to communication and language is an especially critical component of addressing the current healthcare inequity faced by Aboriginal and Torres Strait Islander peoples. The benefits of integrating Indigenous language use into health services include increased cultural safety and help-seeking behaviours, however medical students and practitioners who would like to use Indigenous language in their work are often at a loss on how to do so. In this paper, I use the case study of Pitjantjatjara/Yankunytjatjara language resource development for health professionals to demonstrate the ways in which community action which recognises the language & health intersection can provide steps towards addressing Indigenous health inequity.

Aims/objectives

The Mobile Language Team (MLT) at the University of Adelaide is addressing the lack of Indigenous language use in primary health care by developing online, downloadable Pitjantjatjara and Yankunytjatjara language resources for health practitioners and students. The aim of these resources is to encourage medical students and practitioners to engage with Indigenous languages, rather than viewing them as a hindrance. Ultimately, this will allow for more culturally safe and effective health care environments.

Discussion/Conclusion

The benefits for health practitioners and subsequently for their First Nations patients of having access to digital language resources will be discussed. These resources are about encouraging medical practitioners to honour and respect the cultural and linguistic knowledge of Indigenous peoples in the Anangu Pitjantjatjara Yankunytjatjara lands in all its diverse contexts, including health.

Paper ID: 30

The rural-city GP's dispute of the 1990's and beyond

Max Kamien¹

¹ University of Western Australia (Australia)

The Rural Doctors' Association of Australia (RDAA) was formed in 1991. Its main aim was to establish a procedurally-based training program with the end point being a Fellowship in Rural Medicine (FRM) within the Royal Australian College of General Practitioners (RACGP). They were opposed by the city-based members of the RACGP Council who thought that the post nominals FRACGP FRM would undermine the primacy of the FRACGP. The ensuing dispute became bitter and legalistic. The RDAA declared the RACGP to be 'metrocentric' and voted to leave the RACGP and set up the Australian College of Rural and Remote Medicine. The outcome for the RACGP was that it became the only Royal College of Medicine in the British Commonwealth that did not control the training program of its future Fellows.

This talk follows the structure of a Shakespearian tragedy in describing and dissecting the events, analysing the characters and flaws of the protagonists and pointing to the lessons to be learned.

These events occurred in Australia. But the lessons learned are applicable to other countries with medically underserved rural and remote populations and with educational institutions and professional colleges that maintain a rural- urban dissonance that impedes the skills training and competencies necessary for isolated practice.

Paper ID: 31

Fitting Various Pegs Into Uniform Holes: Standardising Learning Across Different Community Settings

Brahm Marjadi¹

¹ Western Sydney University, School of Medicine (Australia)

Partnerships for community-engaged learning at Western Sydney University's Medicine in Context (MiC) program include 80+ community organisations that address Social Determinants of Health and have been vetted to be able to provide suitable learning opportunities for medical students. Due to the wide variation of organisation sizes, types of service, clientele, and supervisors' and staff's backgrounds, students' learning experiences also vary. Therefore, there is a need to strike the appropriate balance between standardising students' learning experiences and making the most of unique opportunistic learning at each organisation.

The MiC curriculum improvement 2014-2017 aimed to improve students' community-engaged learning by scaffolding students' learning around transferable key learning outcomes.

Improvements were simultaneous, multi-pronged and aimed at students, community supervisors and on-campus tutors. A blended learning approach was the mainstay of improvements with online components (on Blackboard Learn and Learning Activity Management System), face-to-face interactions (tutorials, workshops, briefings) and written guidelines. Qualitative evaluation has been conducted for process and outcome, and a quantitative evaluation is underway.

There is a marked qualitative improvement in open discussions between students, community supervisors and academic staff around finding the learning balance at each community placement. Students' answers to weekly tutorial questions and written exam questions indicated a positive overall shift toward deeper learning of transferable insights.

Our multi-pronged curriculum development initiative has improved students' learning in the MiC program. Community supervisors collaborated with MiC academics in setting learning experiences that meet common learning outcomes while maintaining unique experiences specific for each organisation.

Paper ID: 32

Delivering Telehealth services in Rural and Remote communities in Western NSW

Justin Gladman¹ and Jenny Beach¹

¹ Royal Flying Doctor Service (Australia)

Background

The delivery of Primary Health Care (PHC) services in rural and remote communities is hampered by distance and cost, contributing to increased morbidity and lower life expectancy.

The RFDS (Royal Flying Doctors Service) South Eastern Section uses Telehealth services for emergency cases however this has not been used in the context of delivering PHC services. At present these services are dependent on FIFO (fly in –fly out) clinicians.

Purpose

The RFDS will trial telehealth services across 14 remote communities over a 14-month period. The project will examine 5 domains: acceptability, enhancement, cost effectiveness, change management and clinical outcomes. These domains will be evaluated over the course of the project which commenced in May 2018 with the preliminary report due in September 2018. The project initially targets 3 communities that have the technological capabilities to run telehealth facilities. This is underpinned by the need for greater investigation of patient satisfaction and cost effectiveness in using telehealth.¹

Methods

This will be a mixed method study. However, phase 1 will focus on qualitative study that will examine the acceptability of patients and clinicians in using telehealth services². It is the qualitative results that will be presented at the Muster.

Expected Results

It is anticipated that the use of telehealth services within the identified communities will increase the responsiveness to patient care. The telehealth service will run in parallel to face to face clinics, providing a more comprehensive delivery of health care services to rural and remote communities.

Paper ID: 33

Utilizing a research conference to engage researchers distributed across a large geographical area

Lyne Morvan¹, David MacLean¹ and Penny Moody-Corbett¹

¹ Northern Ontario School of Medicine (Canada)

Introduction/Background:

Research is an important component of the social accountability mandate and is at the forefront of the Strategic Plan for the Northern Ontario School of Medicine (NOSM). As part of its campus, NOSM engages with over 90 communities distributed over 800,000 km² which has proven challenging in organizing events to bring researchers together. The purpose of this presentation will be to outline how NOSM utilizes the Northern Health Research Conference (NHRC) as means of providing participants a forum for presenting research, establishing collaborations and creating a network for researchers throughout Northern Ontario.

Aims/Objectives:

The aim of the NHRC is to bring together researchers from a large geographical area and to demonstrate NOSM's continued commitment to health care, research and education as it pertains to the peoples and communities of the north.

Discussion:

Since 2006, NOSM has held 12 conferences in 8 communities across Northern Ontario. In 2006 the first annual NHRC was held in Sault Ste. Marie, Ontario with 71 abstracts being presented. Most recently, in 2017, NHRC was held in Thunder Bay, Ontario and had 76 presentations. It is clear that since its inception the conference has not lost momentum with some conferences seeing upwards of 150 attendees.

Conclusion:

Individuals appreciate the conference for its proximity to their communities and for the chance to develop a greater appreciation and awareness of research related to Northern Health issues. This presentation will highlight statistics of attendance, themes and processes that have made this conference so successful.

Paper ID: 34

Enhancing interprofessional education through family medicine and multidisciplinary teamwork in Phuket, Thailand

Withita Jangiam¹

¹ Vachira Phuket Hospital, Phuket (Thailand)

Background: The Ministry of Public Health in Thailand launched a health promotion project where teams of family physicians provide public health services to their communities. Family physicians with expertise in family medicine are well placed to enhance the knowledge and skills of health care providers working in multidisciplinary teams in order to help more Thai citizens.

Objectives: To enhance family medicine competencies within health care providers working in multidisciplinary teams.

Methods: A new one-year family medicine curriculum was created containing 9 modules: introduction to family medicine, patient-centred medicine, home health care and conducting home visits, caring for the caregiver, family lifecycle, working with community and consultation, referral and communication skills. 38 nurses and public health officers working in multidisciplinary teams undertook the curriculum. A family doctor observed these teams and assessed their care of patients. Health care providers were asked to complete 15 pre and post questionnaires assessing their competency in family medicine.

Results: Health care providers used a holistic approach and had enhanced patient care, communication skills and understanding of their patients.

Discussion: Health care providers developed good competencies in family medicine, in particular enhanced communication skills and use of a holistic approach that increases their potential to work effectively in their communities.

Conclusion: Family medicine should be added to the curriculum of interprofessional education.

Paper ID: 35

Great expectations for small rural medical workforce in Australia

Dylan Raftery¹, Lucie Walters² and Adrian Griscti²

¹ Flinders University (Australia)

² Flinders University Rural Health South Australia, (Australia)

Australia is still suffering from a medical workforce shortage in regional, rural and remote areas despite producing a sufficient number of medical graduates across the country. It has been suggested that medical students spending at least one year of clinical placement in a rural area during their training increases their likelihood of practising rurally. In response to this, the Australian Medical Association (AMA) have suggested increasing the number of medical students required to complete a year of clinical training in a rural area.

While this shortage is reflected throughout all areas outside of a capital or major city, it is particularly prominent in small rural or remote communities and very remote areas (RA4-RA5). We are interested in looking at the proportion of students that spend one year in a rural clinical school (RCS) interested in small rural practice. From here, we will be looking at the factors contributing to this and finding out if there is any difference in these factors when compared to students interested in practising in regional areas (RA2-RA3).

A survey developed by the Federation of Rural Australian Medical Educators (FRAME) will be used to analyse data from 19 RCSs across Australia.

Please come with your ideas of what factors we should consider that might influence career intent for medical practice in small rural towns of less than 5,000 people. This PeArLs will be of interest to program coordinators, clinical academics, students, small town clinicians and community members.

Paper ID: 36

Rural LIC students are more active participants in clinical tasks than their hospital based peers

Lara Fuller¹, Jessica Beattie¹ and Mary Lawson²

¹ Deakin University, Geelong Australia, School of Medicine, Rural Community Clinical School (Australia)

² Deakin University, Geelong Australia, School of Medicine (Australia)

Background: In their third year, medical students at Deakin University (DU) are allocated to one of five clinical schools including four hospital-based clinical schools and the Rural Community Clinical School (RCCS), a comprehensive Longitudinal Integrated Clerkship (LIC) Program. The equivalence of these programs in terms of students' participation in clinical tasks is unknown.

Aim: To compare LIC students' level of participation in surgical condition encounters with their hospital-based peers.

Methods: Students completed an online record of clinical tasks performed during encounters with ten common surgical conditions selected from the curriculum. Tasks include history taking and physical examination, formulation of a differential diagnosis, ordering and interpreting investigations and preparation of a management plan. Students also selected their level of participation in these tasks, ranging from observation to independent performance.

Results: The most commonly logged tasks were history taking and physical examination, followed by preparation of a management plan. A significant difference was observed in the degree of student participation in clinical tasks, with LIC students more likely to actively perform tasks (60% of encounters) compared with hospital-based peers (25%). Observation of tasks was most common for hospital-based students (68% of encounters) compared with LIC students (25%).

Discussion/recommendations: These results provide evidence that rural LIC students are more active participants in clinical tasks and this may impact favourably on their engagement and motivation. Further investigation beyond surgical conditions would inform the generalisation of these findings. The impact of this difference on student's mastery of clinical tasks and learning outcomes warrants investigation. These figures are based on preliminary data collected (approx. 90% complete). Final figures will be available at completion of data collection in July 2018.

Paper ID: 38

Are models of LIC associated with the mental health of rural medical students?

Kay Brumpton¹

¹ Griffith University (Australia)

Introduction/background

We are proposing a research project to assess the mental health of rural LIC students. This oral presentation seeks input and discussion on research design, tools, and potential collaborations.

Psychological distress, suicide prevention and the mental health of medical students is a recognized health priority. Literature supports teaching medical students how to recognize signs of suicide risk and to how to approach a struggling colleague; promoting and implementing effective clinical and professional practices for assessing and treating medical students identified as being at risk; and reviewing structure of training for medical students. As students on rural placement face additional potential challenges of social and geographical isolation, awareness of mental wellness and early treatment support programs are likely to be more important.

Griffith Medical School delivers three types of LIC and traditional block rotation which provide unique comparator groups to determine if the type of LIC and length of rural placement impacts upon mental wellness.

Aims/objectives: Our aim here is to determine if the type of rural medical student placement impacts on student mental health and wellbeing.

Methods: We propose to conduct a cohort study of LIC students using mental health screening self-assessment tools.

Discussion and Conclusion: Information on whether the type of placement and duration of placement impacts on mental wellness will inform program design, delivery and future medical student placement. Resources and programmatic changes can be tailored to student health and well-being.

Paper ID: 39

Gauging the value of a first year community engagement placement in medicine: initial perspectives

Frank Bate¹, Griffiths Dylan¹, Rachel Hall¹, Donna Mak¹, Effie Mangharam¹, Paul Noakes¹ and Kylie Russell¹

¹ Notre Dame University Fremantle (Australia)

In 2018, the University of Notre Dame School of Medicine (Fremantle) commenced a three-year research project designed to investigate a Community Engagement Placement (CEP) for its 103 first year medical students. The aim of the CEP is to facilitate student learning about the determinants of health, and health service needs and priorities of Australian communities living in rural WA. The research is interested in the extent to which academic and community objectives are met. This paper presents the approach, intent and preliminary results from the first year of the study.

Qualitative data from students, staff and participants from the seven communities is collected through focus groups. Quantitative survey data is collected from students and community participants. The study will be conducted over three years and involve multiple cohorts of students and communities.

Data collection commenced in April 2018. Initial feedback suggests that the placement challenged some student pre-conceptions about rural life. Students also developed a sense of connectedness with each other, and to the academic staff who supervised the placement. Descriptive statistics will be presented on students' perceptions of the value of the CEP. These perceptions will be contextualised with viewpoints from University supervisors and participants representing the seven communities involved, providing important clues into how the CEP might be refined over time.

The study aims to make applied and theoretical knowledge contributions to the way in which first year medical students relate to rural communities, and may provide insights into the educational and career choices they make thereafter.

Paper ID: 40

Supporting our Workforce

Tracey Wanganeen¹

¹ Uniting Communities (Australia)

Introduction

StandBy Support After Suicide provides community based suicide postvention support by utilising a casual workforce of regionally based crisis response teams. StandBy Support After Suicide Service employs a dedicated postvention workforce with well over 100 staff spread across Australia. Without the appropriate support the impact of suicide on those left behind can be devastating and long lasting however the majority of research has focused only on the family or friends of the deceased. Those that work with people impacted or bereaved by suicide are also affected by their experiences.

Aims/Objectives

This presentation will outline the support and training StandBy provides to their unique workforce and illustrate learnings about the needs of those working in the area of traumatic loss and suicide bereavement gathered from staff surveys and interviews.

Discussion

The coordinator of the SA County StandBy region will give a case study of the recruitment, training and support provided to an individual team member. And outline which self-care and support processes have been found to be effective.

Conclusion

This presentation will conclude with a summary of key individual, interaction and organisational wellbeing measures StandBy implements to support their workforce.

Paper ID: 41

Impact of Northern Ontario School of Medicine's community engaged distributed medical education

John Hogenbirk¹, Margaret French¹, Oxana Mia¹, Patrick Timony¹, David Robinson² and Roger Strasser³

¹ Centre for Rural and Northern Health Research, Laurentian University (Canada)

² Laurentian University (Canada)

³ Northern Ontario School of Medicine (Canada)

Introduction

Through participation in distributed medical education programs, communities anticipate long-term improvements to recruitment and retention of physicians. In the short term, communities accrue benefits through their participation in training programs.

Objective

To summarize studies measuring the impact of Northern Ontario School of Medicine's (NOSM) community engaged distributed medical education programs on participating communities.

Methods

Tracking studies assess NOSM graduates recruitment into Northern Ontario communities. In 2014, key informant interviews measured the impact of NOSM on communities' physician recruitment activities. Another study used cash flow and multipliers to estimate the economic impact of NOSM on Northern Ontario in 2008 and 2017.

Results

In 2014, of 129 Canadian medical graduates who trained at NOSM, 45% practised in rural and 16% in urban Northern Ontario with an additional 5% in rural southern Ontario. In 2017, there was a similar distribution of practice locations.

In the recruitment impact study, six of eight communities reported historic shortages of family physicians of 30% - 50%, whereas in 2014, five communities had achieved their full complement.

In 2008 and 2017, the economic impact in Northern Ontario was \$67.1 million CAD and \$134 million CAD, respectively.

Discussion

Studies show that NOSM is producing physicians who stay in Northern Ontario. Communities' participation in medical education has changed how communities fund and structure recruitment activities. In addition, there is an economic impact as program money is re-spent within the region.

Conclusion

Communities can realize short to long-term benefits from their participation in community engaged distributed medical education programs.

Paper ID: 42

Building a cohort of community-engaged learners: Findings from the THEnet graduate outcome survey

Sarah Larkins¹, Salwa Elsanousi², Marykutty Mammen³, Charlie Labarda⁴, Fortunato Cristobal⁵, Sara Willems⁶, Jennene Greenhill⁷ and John Hogenbirk⁸

¹ James Cook University (Australia)

² Department of Family and Community Medicine, University of Gezira (Sudan)

³ University of Fort Hare (South Africa)

⁴ School of Health Sciences at the University of the Philippines (Philippines)

⁵ School of Medicine, Ateneo De Zamboanga University (Philippines)

⁶ Department of Family Medicine and Primary Health Care, Ghent University (Belgium)

⁷ Flinders University Rural Health South Australia, Flinders University (Australia)

⁸ Centre for Rural and Northern Health Research, Laurentian University (Canada)

INTRODUCTION

The Training for Health Equity Network (THEnet) is an international community of practice of twelve health profession schools with a social accountability mandate. The schools aim to deliver a fit-for-purpose health workforce and community engagement is a central feature.

AIMS

THEnet Graduate Outcome Study is an international prospective cohort study tracking learners throughout training and ten years into practice. We present the practice intentions of entry and exit cohorts of medical students and their predictors.

METHODS

Data include cross-sectional entry and exit data collected from medical students using standardised questionnaires between 2012 and 2016. Binary logistic regression produced adjusted odds ratios for associations of student characteristics with practice intent.

RESULTS

Findings from 3346 learners from eight THEnet medical schools in six countries are presented. A high proportion of study respondents at these schools come from rural and disadvantaged backgrounds and these respondents are more likely than others to express an intention to work in underserved locations after graduation at both entry and exit from medical school and less likely to intend to emigrate. After adjusting for confounding factors, rural and low income background were the most important predictors of intent to practice in a rural location.

DISCUSSION

This study provides preliminary evidence for the selection and training of a medical workforce motivated to meet the needs of underserved populations. Future analysis will include correlations with placements and actual practice location.

CONCLUSION

Socially accountable schools appear to be successful in nurturing intent of learners to serve in the rural workforce.

Paper ID: 43

Aboriginal cultural awareness: Selfies as learning tools in rural medical education / #campquorn2018

Adrian Griscti¹, Doug Turner¹, Amy Schulz¹, Catherine Nacey¹, Stefanie Lobzin¹ and Jennene Greenhill¹

¹ Flinders University Rural Health South Australia (Australia)

Introduction and Aims:

Education of future health professionals in aspects of Aboriginal cultural awareness is an important way to equip them with an understanding of the significance of culture pertaining to both the health and to the delivery of health care services of Aboriginal people.

Methods:

Medical students from our rural longitudinal integrated clerkship receive a series of tutorials on topics relating to Indigenous cultural awareness and health including discussions on Aboriginal connection to country, aspects of dreamtime and Indigenous inequality. To complement and reinforce this knowledge, our group of 11 medical students were taken on a 3 day Aboriginal cultural immersion trip. This was led by a Nukunu elder onto his traditional lands in the Flinders Ranges, South Australia. The aim of this trip was to expose students to aspects of Aboriginal culture that cannot be taught in a classroom and also to give the students a powerful experiential opportunity. To reinforce the educational value of their experience through reflective learning, the students were set a challenge to take a "selfie" that represented a significant aspect of the trip for them and make a statement using #campquorn2018. These and other photographs were shared amongst the group who had the opportunity to comment further and then used as the basis for a follow-up tutorial to reinforce knowledge.

Discussion and Conclusion:

We have combined traditional and innovative teaching methods to engage our "millennial" cohort of students. This presentation will examine contemporary educational strategies to embed knowledge of this ancient culture.

Paper ID: 44

Physician Preceptor Satisfaction Across LIC and TBR Curricula

Marni Krehnbrink^{1,2}, Kunal Patel^{1,2}, Julie Byerley¹, Heather Tarantino³, Bruce Peyser⁴, Lauren Payne², Kathy Foley² and Robyn Latessa²

¹ University of North Carolina School of Medicine (United States)

² UNC Health Sciences at MAHEC (United States)

³ UNC School of Medicine Charlotte Campus (United States)

⁴ Duke University Medical Center (United States)

By comparing medical student physician preceptors who teach in longitudinal integrated clerkships (LIC) to those who teach in traditional block rotations (TBR) or in both settings (LIC-TBR), we aim to identify differences in satisfaction and analyze factors contributing to satisfaction.

Data were collected through a quantitative, cross-sectional survey of physician preceptors in North Carolina in 2017. Preceptor satisfaction and student influence on various aspects of practice were analyzed with bi-variate chi-square statistics. Progressive logistic regressions were used to create odds ratios of satisfaction across the different curricula.

Results included 338 physician preceptors, including 79 LIC (23.4%), 50 LIC-TBR (14.8%), and 209 TBR preceptors (61.8%). The majority of preceptors indicated satisfaction (91.4%), though LIC preceptors were more likely to indicate being "very satisfied" than either their LIC-TBR or TBR counterparts (53.2%, 40.0%, and 37.3% respectively, $p = 0.05$).

Progressive logistic regressions suggest that those teaching in LIC curricula are almost three times more likely to be "very satisfied" than those in TBR (OR 2.80, 95% confidence interval 1.52-5.15, $p < 0.001$), and that this effect of satisfaction is not seen for those who teach in both settings (LIC-TBR OR 1.11, 95% confidence interval 0.55-2.22, $p = 0.78$; TBR reference, OR = 1.00).

This study of LIC preceptor satisfaction, the largest of its kind to date, showed that satisfaction was significantly higher amongst preceptors who teach in LIC settings. These findings could have practical implications for preceptor recruitment and retention in an era of increasing need for physician preceptors.

Paper ID: 46

Integrating Complementary/Alternative Medicine Treatment Modalities in the Medical School Curriculum

John Litaker¹ and Alexander Moise²

¹ James Cook University, College of Medicine and Dentistry (Australia)

² NOSM, Medical Sciences Division (Canada)

There is a widespread and significant public interest in the use of complementary and alternative medicine (CAM) approaches in disease treatment and prevention. This interest is driven not just by the lower cost or faster access to CAM-based treatments compared to conventional approaches, but also by patient perceptions that CAMs offer increased control of their health, as they explore what they view as a more holistic solution to achieve good health. Importantly, many patients see CAMs as part of the social and historic fabric of society derived from traditional healing traditions, particularly among the indigenous communities of the world. Despite increased resources dedicated to the promotion of integrative medicine in traditional medical schools, there is a need for additional education on the use of CAMs in society, the scientific basis of their effectiveness, and evidence-based information about their use, either separately or concurrently, with conventional medical approaches to care. Here, we first evaluate the extent of training of medical students regarding CAM-based therapies and in recognizing the patient's perception of and use of such therapies. Based on our reviews and surveys, we examine the approaches employed by two community-engaged medical education programs, as exemplified by the Northern Ontario School of Medicine and James Cook University College of Medicine and Dentistry, in the teaching of CAM concepts. Finally, we make several recommendations designed to increase the awareness and integration of CAM treatment modalities in medical school curricula.

Paper ID: 47

Designing a 4-year longitudinal-continuity undergraduate medical education program at a rural site

Jay Erickson¹ and Barbara Doty¹

¹ University of Washington School of Medicine (United States)

Introduction: Designing a 4-year longitudinal-continuity undergraduate medical education program at a unique rural site

Background: This presentation will briefly review 10 years of experience of the University of Washington School of Medicine WWAMI medical education program and its TRUST (Targeted Rural Underserved Track) program. Students in this track have a targeted admissions process which results in matriculation and placement at a unique rural underserved community for 4 years of longitudinal-continuity medical education experience.

Currently 32 WWAMI students out of a class of 270 are admitted into this program yearly. The longitudinal placement in a rural underserved community results in 8-9 months of medical education experience at their unique TRUST community over the 4 years of medical education which begins before medical school and includes a 5-6 month LIC experience in their first clinical year. Students also participate in a rural health curriculum that includes a variety of topics. Early outcomes data will be explored.

Learning objectives:

1. Understand the advantages and challenges of a 4 year rural undergraduate medical education experience at a unique rural site.

Breakout discussion:

1. Discuss the advantages and challenges of longitudinal-continuity placement of a student at a unique rural underserved community.
2. What are the key components that enhance a rural undergraduate medical education program?
3. How do you define success of a rural undergraduate medical education program?

Activities:

20 minutes- Presentation on UWSOM TRUST program

40 minutes- small group to discuss breakout questions

30 minutes- large group discussion of small group outcomes

Paper ID: 48

Conundrum of training full spectrum rural Generalists

Jay Erickson¹ and Barbara Doty¹

¹ University of Washington School of Medicine (United States)

The WWAMI program/UWSOM created and implemented a rural workforce program and LIC (TRUST- Targeted Rural Underserved Track) that strives to create full spectrum rural Generalists (includes operative OB). Over time as obstetrical care has left many rural communities within our states there are fewer rural communities needing full spectrum rural Generalists. The TRUST program has robustly created students, residents and physicians interested in becoming full spectrum rural Generalists. We expect to reach a point in the next 5 years in Montana and Alaska where we will likely fill all available rural full spectrum Generalist workforce opportunities present within our states. While this is good from a rural physician workforce standpoint, it does create some teaching conundrums. 1. Do we continue to recruit students into this rural program/LIC with the expectation that they will have the opportunity to become full spectrum rural Generalists? 2. Do we change our educational model to train students for a different type of practice experience that meets the physician workforce needs of the communities, that may not focus on training rural full spectrum Generalists? 3. Training has occurred in rural communities staffed by full spectrum rural Generalists who practice full spectrum care, do we change the location of our training away from these communities and their focus on training for full spectrum care?

Paper ID: 49

What is the Role of Academia in Social Accountability?

Penny Moody-Corbett¹, Roger Strasser¹, Catherine Cervin¹ and Erin Cameron¹

¹ Northern Ontario School of Medicine (Canada)

Introduction: Northern Ontario is a unique environment with a large geographic area and sparse population that includes diversity in cultures and languages. As a young School, the Northern Ontario School of Medicine (NOSM) focused on ensuring that the undergraduate and postgraduate programs would meet their accreditation requirements in the context of this unique geography. Indeed the School was founded on the mission of "being socially accountable to the needs and the diversity of the populations of Northern Ontario". However, also since its inception NOSM has ensured that the framework of the School is based in a vibrant academic environment that supports research, scholarship and innovation. These dual roles of social accountability and academic culture have been seen to be in conflict and the focus of this session will be to talk about the opportunities and challenges that arise from this dynamic.

Aim: The aim of this session will be to discuss how social accountability to local populations and communities in a geographically distributed and culturally diverse medical school is achieved while striving to establish and maintain a national and international reputation in research, innovation and scholarship.

Questions and issues for discussion: The discussion will focus on topics of understanding what we mean by the terms "social accountability", "academic culture" and "success"? We will explore the questions: What does an academic culture mean in a socially accountable a medical school? What are the academic opportunities and/or challenges within socially accountable medical schools?

Paper ID: 50

A Graduate Program Focused on Training Practicing Physicians in Conducting Quality Research

David MacLean¹, Roger Strasser¹ and Penny Moody-Corbett¹

¹ Northern Ontario School of Medicine (Canada)

The Northern Ontario School of Medicine (NOSM) has recently completed developing its first graduate program, a Masters in Medical Studies (MMS). A unique aspect of this program is that it has been developed specifically for practicing physicians to provide them with the training and tools necessary to conduct socially accountable, community engaged research. To accomplish this goal, students will be required to complete a number of key courses covering content essential for conducting quality research. These include; Introduction to Research in Medical Studies, Independent Study/Advanced Topics and Bioethics and Research Integrity. The curriculum is designed to be delivered utilizing the Distributed Community Engaged Learning (DCEL) model, a distinctive approach to medical education and health research that was developed specifically by NOSM. The DCEL model is an essential component as it is anticipated that the physicians enrolled in the MMS program will be from distributed communities throughout Northern Ontario. In addition, face-to-face workshops will be included to supplement the learning in order to provide physicians from distributed communities an opportunity for small group interactions. The purpose of this presentation will be to outline the key components of the MMS program including admissions requirements, course and curricular content, learning outcomes as well as competencies.

Paper ID: 51

From Angst to Empowerment: Transforming the LIC Assessment Experience for Students and Faculty

Jennifer Adams¹, Nardine Riegels², Anne Frank¹ and Tali Ziv²

¹ Denver Health and Hospital Authority (United States)

² Kaiser Permanente, Oakland California, University of California San Francisco (United States)

Background:

Numerical scales conveniently collect data about student performance, but these data lack the depth and specificity needed for valid assessments. Longitudinal integrated clerkship (LIC) preceptors are uniquely positioned to craft meaningful narratives describing students' skills in multiple domains over time, with a natural opportunity to identify next steps for student growth. Qualitative narrative assessments add depth and validity to numerical scales assessing learners' competence and progress, but require significant faculty development and investment. LIC student-faculty longitudinal relationships can facilitate coaching around the process of assessment to use a growth mindset, transforming student angst to empowerment. This session will provide strategies to direct the student-faculty team assessment dialogue away from anxiety and strain, and toward progress.

Learning Objectives:

1. Train faculty preceptors to provide formative narrative comments, identify student progress and clearly delineate growth areas.
2. Train faculty advisors to frame assessments and coach students as they receive feedback and assessments to mitigate angst around feedback and focus instead on professional development.
3. Create programs to support students in developing a growth mindset with an eye towards lifelong personal and professional development.

Areas for exploration: faculty development, narrative assessment, student wellness, growth mindset, lifelong learning, positive psychology

Activities:

1. Large group introduction to concepts and exemplars from 2 LIC programs (University of Colorado - Denver Health and UCSF - Kaiser Permanente)
2. Small group break-outs to discuss specific assessment tools and application to participants' programs: a. Faculty Development b. Student Advising c. Student Wellness
3. Large group debrief
4. Toolbox resources

Paper ID: 52

Generating Best Precepting Practices in a Joint, Multidisciplinary Faculty Development Workshop

Tara Singh¹, Yamini Saravanan¹, Bianca Shagrin² and David Hirsh³

¹ Harvard Medical School/Cambridge Health Alliance (United States)

² Harvard Medical School, Cambridge Health Alliance (United States)

³ Harvard Medical School (United States)

Physician educators often rely on personal experiences to develop their teaching styles, with minimal formal education about learning theories and best practices of teaching. Additionally, most training programs do not offer physician educators regular, continual training opportunities to improve their clinical teaching skills. The Harvard Medical School (HMS) Cambridge Integrated Clerkship (CIC), is a transformative longitudinal integrated clerkship (LIC) at Cambridge Health Alliance (CHA). Over the past 15 years, there have been limited faculty development sessions.

We created a faculty development workshop to establish a community of educators in the CIC at CHA, to honor and renew enthusiasm in preceptors, and provide opportunities for knowledge and skill improvement in clinical teaching.

We conducted an educational needs assessment of the CIC students and a faculty needs assessment survey. This data was used to design the inaugural, multi-disciplinary, faculty development workshop. Faculty from different disciplines convened for one of two evening sessions to discuss and develop best practices for teaching in a longitudinal clerkship.

Thirty-four of 70 faculty attended the workshop. Faculty participated in small and large group discussions, sharing best practices of clinical teaching for longitudinal preceptors. A summary of practices was emailed to all faculty attendees to edit. The organizers collated this collaborative work of best precepting practices for the CIC.

Collaborative faculty development programs from multi-disciplinary faculty in LICs can lead to rich discussion and development of best practices which may be used to inform teaching and faculty development across institutions.

Paper ID: 53

Workshopping at CLIC-An Integral Step in the Development of a Powerful Community of Practice

Bruce Peyser¹

¹ Duke University School of Medicine, Department of Internal Medicine (United States)

Background

Faculty development workshops have been a popular method for sharing information to support collaboration amongst clinician educators. Recent literature has summarized how to prepare a workshop (1), and O'Sullivan explored what motivated faculty developers within an academic center (2), but there has not been exploration of whether longitudinal learning programs might inspire workshop creation for different reasons.

Objective

The purpose of this pilot is to explore motivations that affect clinician educators who lead workshops at our international conference of teachers and program leaders. What leads an educator to propose a workshop, and what is gained from such an activity? Feedback obtained can then be used to strengthen the workshop experience, for participants as well as workshop leaders.

Methods

Consent for enrollment has been obtained from nearly all of the workshop leaders from the CLIC 2018 Singapore conference. Participants will be sent an invitation to complete an anonymous and brief questionnaire on line. Information will be collated, analyzed, and stored with REDCap.

Results

(None available to date)

Issues for Discussion

The goal here is to more fully comprehend the challenges, the workload, and the risks associated with workshop leadership at CLIC. Conferences. How can we enhance this process to result in more effective workshops that result in enduring change and how can this process strengthen our sense of community of longitudinal educators from around the world?

Paper ID: 54

Teaching the Practice of Longitudinal Care to Undergraduate Medical Students

Bianca Shagrin¹, Galina Gheihman, HBS² and David Hirsh²

¹ Harvard Medical School, Cambridge Health Alliance (United States)

² Harvard Medical School (United States)

The literature suggests that students' care of and work with patients over time motivates patient centeredness, a value that connects to empathy, patient safety, and quality of care. Harvard Medical School's (HMS) Cambridge Integrated Clerkship (CIC) at Cambridge Health Alliance (CHA) was created to align with educational science to benefit student learning as well as to address these patient and health system goals. We believe that longitudinally following patients may support students' learning and the patients' experience of care. In this study, we seek to identify the specific activities of a teacher that promote a student's most effective longitudinal learning and care of patients.

We surveyed sixty faculty members at CHA who work with HMS students clinically in three undergraduate courses, the majority from the CIC. Faculty surveys aim to understand current practices that faculty use to allow students to follow patients over time. Select faculty will participate in focus groups to further elucidate these questions.

In this presentation, we will present survey data and results of qualitative content analysis from the focus groups.

This project intends to improve medical students' experience in clinical courses and to serve the clinical educators who teach in these venues. Ideally, it may also serve patients who receive care in teaching settings. We hope that the findings learned may be disseminated and offer new and transferable benefits within and outside of HMS.

Paper ID: 55

Bubble-wrap, Cling-wrap or None? Students' Cultural Safety during Community-Engaged Learning

Brahm Marjadi¹, Rowena Saheb² and Robyn Preston³

¹ Western Sydney University, School of Medicine (Australia)

² Western Sydney University, Student Counselling (Australia)

³ James Cook University (Australia)

The concepts of cultural safety and competence, students' mental health and wellbeing, and political correctness have been increasingly buzzing in the academic literature as well as in popular media. There is a strong intersect between these concepts in community-engaged learning programs which poses some wicked questions. Students need to learn about their communities in order to better serve them. Yet, some community members may hold strong beliefs that may threaten students' cultural safety and thus their mental health and wellbeing during placements. In campus-based learning students are used to lecturers with cultural competence who teach using politically correct language; but this is not always the case in community-engaged learning.

This session aims to share experiences and discuss how to strike the balance between creating a safe learning experience for students in communities and allowing students to learn the hard realities about the communities. Questions include:

1. When a community has an unfavourable trait that may challenge students' cultural safety, do we:
 - a. Not send students there? ("bubble-wrap approach")
 - b. Send students there but limit their contact with the community? ("cling-wrap approach")
 - c. Send students there for full immersion?
2. Despite having undertaken all necessary preparations, some students may still be ill-prepared for confronting encounters with community members. How do we minimise the negative impacts of those encounters on students without denying them these "growing pains"?
3. What kinds of "hidden curriculum" may influence our selection of community partners when designing community-engaged learning opportunities? Are these hidden curricula justified?

Aboriginal cultural integration for medical students on rural longitudinal placements: a strengths-based approach

Donna Quinn¹, Elsa Barton¹, Doug Turner¹, Darryl Cameron¹ and David Lim¹

¹ Flinders University Rural Health South Australia, (Australia)

Introduction: Rural clinical schools in Australia have an important role in ensuring all medical students develop a comprehensive understanding of Aboriginal and/or Torres Strait Islander health issues. At Flinders University Rural Health South Australia (FURHSA) an Aboriginal cultural integration program for third year medical students on rural longitudinal placements commenced across four South Australia regional sites in 2017. The aim of this program is to develop student's cultural humilities to enhance service delivery to Aboriginal people.

Method: The program progressed with the employment of four Aboriginal health academics located at each of the FURHSA sites who have strong connections with local Aboriginal communities. Extensive ongoing community engagement is a key feature of the program with strong partnerships with Elders and senior community members, community services such as Aboriginal Community Controlled Health Organisations, schools and government funded health services. The program consists of five cultural awareness sessions and a 'Walk on Country' experience.

Results: 39 medical students across the four regional sites were involved in the first year of the programs' operation. A comprehensive evaluation including four focus groups and student feedback on individual sessions was conducted. Students valued the dynamic way of learning which included small group sessions tailored to their learning needs with a combination of traditional tutorials and outside yarning circles. Students were provided with many community engagement opportunities and gained a greater appreciation of Aboriginal cultural values and connection to country that was specific to the local communities.

Discussion/Conclusion: Cultural awareness teaching that is tailored to specific Aboriginal communities in which students are placed, that is delivered by Aboriginal academics, Elders and local service providers offers a unique opportunity for students to gain greater knowledge and respect for Aboriginal cultures to inform their future clinical practice.

Paper ID: 57

Does a socially accountable curriculum transform students into fit-for-purpose graduates?

Robyn Preston¹, Torres Woolley¹, Amy Clithero², Salwa Elsanousi³, Shambhu Upadhyay⁴ and Karen Johnston^{1,5}

¹ James Cook University (Australia)

² University of New Mexico Health Sciences Center (United States)

³ University of Gezira (Sudan)

⁴ Patan Academy of Health Sciences (Nepal)

⁵ THEnet (Australia)

INTRODUCTION Addressing the mal-distribution of health workforce through socially accountable health profession education is one strategy gaining momentum for the achievement of Universal Health Coverage. The Training for Health Equity Network (THEnet) is an international collaboration of 12 medical schools and a Physician Assistant Program that aim to produce work ready graduates, fit to serve in identified areas of health need.

AIMS/OBJECTIVES This presentation describes THEnet's Competencies Plus study, initial experiences of its ongoing implementation at 4 THEnet schools in 4 countries, and preliminary findings from one school. The study aims to assess how work-ready and fit-for-purpose medical and physician assistant graduates are in their first year after graduation.

METHODS (if relevant) A survey with later frequency analysis was used to obtain the views of a cross-section of health professionals who supervise or work closely with THEnet graduates.

RESULTS (if relevant) A total of 174 supervisors of THEnet school graduates have been recruited to the study to date. Schools are at various stages of data collection and analysis. Preliminary findings from 70 participants indicate that >90% of participants rate James Cook University interns as above average for 'overall performance', 'work readiness at commencement', overall clinical skills' and 'commitment to health equity'. This study will provide empirical evidence on the competencies and skills of graduates of socially accountable health profession programs. Findings will be used to inform the continued development of socially-accountable health profession education.

CONCLUSION OR ISSUES FOR DISCUSSION It is expected that this project will involve collecting surveys from approximately 50-100 appropriate health professionals from hospitals and/or training centers within the country that have employed at least 5 THEnet medical or PA graduates in the last 2 years. It is likely that the results of this study will inform the methodology for a larger study with participating THEnet medical schools.

Paper ID: 58

Harmony in the Bush: Innovative Training for Personalised Aged Care in Rural Australia

Abraham Kuot¹, Prue Mellor¹, Vivian Isaac¹ and Jennene Greenhill¹

¹ Flinders University Rural Health South Australia (Australia)

In long-term aged care facilities, many residents with neurocognitive disorders experience behavioural and psychological symptoms of dementia (BPSD) such as agitation. BPSD are complex, stressful, costly aspects of care, and associated with diminished quality of life, and a high workload for care staff. Non-pharmacological interventions attract growing attention in caring for people with dementia, due to limited efficacy of the use of antipsychotic medications. Harmony in the Bush Study is an innovative project that aims to co-design and implement evidenced based behavioural interventions with music in managing individual BPSD outcomes. Aged-care staff education and training in the intervention is of paramount importance to the success of the project. However staff training in a residential home environment is complex. This presentation aims to illustrate the process of our innovative training of aged care staff in a large multi-site study involving five Australian rural aged care facilities. The project incorporates over two years longitudinal quasi-experimental design including behaviour measurements, surveys, interviews, and focus groups in the five facilities to evaluate the model's effectiveness in different kinds of health services; small, large, public and private. Process and output evaluation of the staff training program from the first three participating facilities will be presented. The training enables researchers to identify key drivers of personalised care intervention, and implement a new personalised model of care incorporating the Progressively Lowered Stress Threshold principles and personalised music/art programs for people living with dementia in the five facilities.

Paper ID: 59

Time for Action: Addressing gender inequities in health workforce education

Robyn Preston¹, Bjorg Palsdottir², Amy Clithero³, Lyn Middleton⁴ and Simone Ross⁵

¹ James Cook University (Australia)

² THEnet: Training for Health Equity Network (United States)

³ University of New Mexico Health Sciences Center (United States)

⁴ THEnet (South Africa)

⁵ College of Medicine and Dentistry, James Cook University (Australia)

Background

Gender inequities abound in health workforce education (HWFE) around the globe. These range from policies and practices that limit employment opportunities for women, their full and equal participation, gender related salary disparities to bottlenecks in career progression. Women also face challenges related to combining career and child-rearing as well as sexual and gender-related harassment, violence, and discrimination in workplace cultures that mirror dominant societal norms and values. Transformation of health workforce education environments requires intervention on multiple levels. This PeArL will build on an action plan developed at 2018 TUFH-The Network conference.

Objectives

Share and receive feedback on a solution-oriented action plan that includes multi-level strategies to increase gender equity and support women's leadership in HWFE.

Discussion including questions/issues for exploration

What are the key individual, institutional and systemic barriers and strategies to gender equity in HWFE?

What are the global challenges women in health workforce education (HWFE) face?

What are the key individual, institutional and systemic barriers to gender equity in HWFE?

How can we promote and develop our solution-oriented action plan that includes multi-level strategies to increase gender equity and support women's leadership in HWFE?

How can we promote and develop a network focusing on gender issues in HWFE for engaging with identified local, national, and global HWFE interest groups in shaping, implementing, and disseminating the action plan.

Paper ID: 60

Developing Curriculum for Socially Accountable Health Professional Schools

Simone Ross^{1,2}, Robyn Preston¹, Amy Clithero³ and Eric Lachance⁴

¹ College of Medicine and Dentistry, James Cook University (Australia)

² Training for Health Equity Network, New York (United States)

³ School of Medicine, University of New Mexico (United States)

⁴ Faculté de médecine et des sciences de la santé, Université de Sherbrooke (Canada)

Introduction/Background: The Training for Health Equity Network's (THEnet) is a growing global community of practice comprising 12 health professional schools with explicit social accountability mandates to address the priority health needs of the communities they serve. THEnet has created an online toolkit to assist schools embed social accountability values and competencies in their teaching, research and service. Online modules recently developed focus on how to develop a socially accountable health professional education curriculum and how to track graduates. These modules are readily available online (www.thnetcommunity.org).

Learning Objectives: * Devise techniques to map the existing curricula with a specific focus on social accountability, including evaluating the curricula with community priority health needs and desired graduate attributes * Identify new opportunities for topics/modules/courses that encompass social accountability competencies * Critically reflect on what works and apply appropriate resources, including THEnet modules to further their work Issues/areas for exploration Work through the socially accountable health professional education curriculum module. Focus will be on identifying community health priorities, how to map the curricula for these priorities, and to develop curriculum for these priorities. Discuss and review the online THEnet tools, how to adapt the tools for context, and consider how to integrate social accountability learning into an already full curricula.

Participants will be encouraged to reflect on the learning students require to become a graduate who addresses priority health needs.

Activities: The format will comprise of group discussion, presentations and group work; with substantial opportunities for interaction and sharing of ideas and experiences.

Paper ID: 61

Monetizing medical student-driven impacts in rural communities: A social-return-on-investment tool

Monsie Guingona¹, Torres Woolley², Fortunato Cristobal³, John Hogenbirk⁴, Simone Ross⁵ and Andre-Jacques Neusy⁶

¹ School of Medicine, Ateneo de Zamboanga University (Philippines)

² James Cook University (JCU) (Australia)

³ Ateneo de Zamboanga University, Mindanao (ADZU) (Philippines)

⁴ Centre for Rural and Northern Health Research, Laurentian University (Canada)

⁵ College of Medicine and Dentistry, James Cook University (Australia)

⁶ Training for Health Equity Network (United States)

Introduction

The worldwide shortage and mal-distribution of health professionals arising from a mismatch between training and workforce needs highlights the importance of health institutions being focused on producing graduates with the appropriate skills and willingness to provide healthcare in underserved regions.

Community-engaged medical education (CEME) involves training institutions working with local, underserved rural towns to implement student placements where most needed. CEME students undertake a range of clinical, public health and community development activities; all planned with meaningful input from the community. Previous studies have confirmed these CEME student activities lead to social, health and economic benefits to people in these communities; however, no study has yet monetized these benefits.

Aims/objectives

The Training for Health Equity Network along with partner schools (institutions listed above) have developed and tested a social-return-on-investment (SROI) tool, processes and program logic model that monetizes the range of clinical, public health and community development impacts to rural towns arising from CEME student activities.

Discussion including questions/issues for exploration

This PeArL will:

- Discuss the range of social, economic and health outcomes in several underserved rural Philippines communities arising from CEME student placement activities
- Discuss methodologies that identify, quantify and monetize these outcomes, such as the real-world application of SROI principles to medical education, complexity-aware data collection strategies, and 'willingness-to-pay' and 'productivity lost/gained per health outcome' monetizing strategies.
- Provide opportunities for the audience to learn with and from each other about CEME student-driven activities and the community outcomes they create, and how these can be identified and monetized.

Paper ID: 62

A Longitudinal Clerkship Model in an Academic Medical Centre

William Heddle¹, Paul Worley², Jordan Li¹, Tina Noutsos¹ and Gayle Robertson¹

¹ Flinders University (Australia)

² Australian Government Department of Health (Australia)

In January 2017 a Longitudinal Integrated Clerkship (LIC) was introduced for all third year Flinders University Doctor of Medicine (MD) students. For the students placed at the large metropolitan tertiary hospital, Flinders Medical Centre (FMC), this replaced Traditional Block Rotations (TBR). LIC's at Flinders University have been offered to rural students since 1997. In 2012 a plan was made for all Year 3 (of 4) MD students to undertake a LIC. From 2013-2016 pilot LICs for 8 students per year were run at FMC, an Academic Medical Centre where 100 of 160 year 3 MD students do their clerkship. The change required detailed discussion with students and faculty. The results of the pilots and the staffing structure determined the final model. Students are placed with 2-3 supervisors per semester. A longitudinal Academic Program (half a day per week) engages all 100 in the same "flipped classroom" learning of core elements of applied clinical knowledge, supplemented with tutorials run by clinical educators to ensure curriculum coverage independent of placement. Formal clerkship in all disciplines are not experienced by all students in Year 3 with additional placements in year 4 to supplement their Year 3 programs. The program has been well received by students and supervisors with good academic results in 2017. Twenty years after the first rural LIC all year 3 MD students now have a LIC.

Paper ID: 63

Acute bedside education in country hospitals - Is there room for more than one discipline?

Stefanie Lobzin¹, Adrian Griscti¹, Vanessa Ryan¹, Sandra Crockett¹, Peter Burns¹, Sarah Boyd¹ and Elena Rudnik¹

¹ Flinders University Rural Health South Australia (Australia)

Ward rounds have been used as valued teaching opportunities for students undertaking acute clinical placements for decades. Commonly, students will interact with their supervisors at the bedside, in isolation from students of other disciplines who are on placement in the same hospital. There is a general shortage of clinical placement opportunities in Australia and we need to consider ways that clinical educators can work with more students, including students from other disciplines, whilst providing high quality learning experiences. Interprofessional learning is often overlooked but this could offer a solution, particularly in country hospitals that often have medical and health students working in close proximity. With increased student learning opportunities comes increased student satisfaction, and an increased potential for the student to return to the rural environment as a practitioner.

The aim of this PeArLs is to discuss how teaching at the acute patient bedside can involve students from more than one discipline whilst meeting their learning needs and increasing their Interprofessional Practice (IP) capability.

1. How can clinical educators frame their teaching to appropriately address the learning goals of more than one discipline at the same time?
2. What are the key elements required in the bedside teaching interaction that will develop our upcoming workforce interprofessional practice capability and how can this be integrated into them?
3. What are the benefits and concerns for the practitioner, students, patients and their families of teaching more than one discipline during a single teaching interaction/patient round?

Paper ID: 64

L'offre active des services de santé en français : pourquoi et comment la mettre en pratique

Diane Quintas¹

¹ Réseau du mieux-être francophone du Nord de l'Ontario (Canada)

Le Réseau du mieux-être francophone du Nord de l'Ontario (Réseau) a lancé la nouvelle formation interactive en ligne sur l'offre active des services de santé en français.

Les modules ont été inspirés des priorités établies par le Commissariat aux services en français de l'Ontario, ainsi que par le Cadre de référence pour la formation à l'offre active des services de santé en français et la Boîte à outils pour l'offre active du Consortium national de formation en santé (CNFS) et divers autres partenaires provinciaux et nationaux.

Cette formation vise à sensibiliser les gens qui travaillent et étudient dans le domaine de santé à la valeur de l'offre active de services de santé en français. La formation est gratuite et est offerte en français et en anglais. La réussite de la formation permet d'acquérir des crédits d'apprentissage continu par l'entremise de certains collèges et ordres professionnelles.

La formation est composée d'une série de six modules :

1. Excellence de service centré sur le patient
2. Équité et sécurité
3. Compétences culturelles
4. Recrutement et rétention des ressources humaines bilingues
5. Environnement de travail et culture organisationnelle
6. Engagement communautaire

Cette initiative est financée par Santé Canada, dans le cadre de la Feuille de route pour les langues officielles de 2013-2018 : éducation, immigration, communautés ainsi que par le Réseau local d'intégration des services de santé (RLISS) Centre-Toronto.

Pour en apprendre davantage sur la formation interactive en ligne sur l'offre active des services de santé en français, veuillez consulter www.formationoffreactive.ca ou www.activeoffertraining.ca.

Paper ID: 65

Can Change Begin with a RIPLE? Relational InterProfessional Longitudinal Education

Tara Singh¹, Allisyn Brady², Aliza Stern³, Janice John² and David Hirsh⁴

¹ Harvard Medical School/Cambridge Health Alliance (United States)

² Cambridge Health Alliance (United States)

³ Boston University (United States)

⁴ Harvard Medical School (United States)

Collaborative practice improves population health outcomes and management, but educators have yet to define the most effective shared educational structures. The US's Institutes of Medicine endorse interprofessional education (IPE) and nationally, leaders call for new innovative IPE models. No "gold standard" exists in the literature for maximizing the goals and benefits of IPE. We propose creating and evaluating a new model of IPE-- relational interprofessional longitudinal education (RIPLE), a longitudinal clerkship interweaving medical and physician assistant (PA) students. We hypothesize that meaningful longitudinal co-practice transforms the ways that medical and other professional students learn, feel, and ultimately exhibit teaming and interprofessionalism.

We will evaluate whether RIPLE fosters benefits that the LIC literature reports and extends the benefits to serve PA and medical students. We will evaluate if this educational model of early extended co-practice advances interprofessional teamworking and ultimately the care of patients.

We will launch a six-month pilot project in 2019. We consider several questions: What are the milestones of IPE competencies and what longitudinal experiences facilitate these milestones? How should we assess learner milestones/competencies in this 2-profession model? And evaluation? How should we design interprofessional faculty development to support the RIPLE?

We welcome ideas to advance work on RIPLE and the evaluation thereof. Following classic PeArLs rules, we will provide a brief outline of our work and questions, step back and learn from the wisdom of the assembled, and then close with our thanks, thoughts, and take home steps.

Paper ID: 66

Stretching Beyond an LIC: A Longitudinal Post-Clerkship Course in Social Medicine

Michelle Cleeves¹, Margaret Tomcho¹ and Jennifer Adams¹

¹ Denver Health and Hospital Authority (United States)

Background:

The University of Colorado's Denver Health LIC is based at an urban affiliate where students spend their principal clinical year caring for the underserved. Upon completion, students have diminished access to the hospital system, LIC patients and mentors.

Aims:

Develop a longitudinal post-clerkship experience allowing LIC students to engage in mentored scholarly work and in-depth learning of social medicine.

Methods:

A needs assessment demonstrated 100% of students with high interest in participation; scholarly areas of interest were QI, community engagement, and medical education. The Longitudinal Social Medicine Elective was implemented and encompasses a mentored project, longitudinal patient care, student project presentations, service learning, and didactics.

Outcomes:

The inaugural class of five students completed this elective. Students were highly productive in scholarly output; obtained several grants and many presented their work at local and national meetings. Social medicine didactics such as Medical-Legal Partnerships, Trauma-Informed Care, and Implicit Bias were rated highly. Participants rated the course as providing skills and knowledge that would prepare them to be leaders and advocates for the underserved at 4.6 on a 5-point Likert scale. 100% rated themselves highly committed to serving vulnerable populations; and many were highly interested in ultimately practicing at Denver Health.

Discussion:

Students produced meaningful projects that served the community and supported professional development through scholarship. Dedication to the underserved and understanding of social medicine were reinforced. Students reported high levels of commitment to working with underserved populations in the future, fulfilling a workforce pipeline curricular goal of this LIC program.

Paper ID: 67

Community Action Project: Medical students leading health improvement projects via society engagement

Sonia Kumar¹, Ravi Parekh¹ and Shivani Tanna¹

¹ Imperial College London (United Kingdom)

The UK health-service faces increasing levels of health inequality and rising demand from a diverse, ageing and multi-morbid population with limited resources. Within this context, there is a growing evidence base and consensus for medical schools to recognise their responsibility of improving the health of their local population and integrate this within their medical curriculum.

At Imperial College, social accountability has become a key theme within our Learning & Teaching strategy. We have piloted a novel assessment, the "Community Action Project" (CAP) in year-3 of the undergraduate medical course. This project involved 50 medical students during their 8-week community medicine attachment. Students were asked to identify an area of health need within their local primary care population, engage relevant community stakeholders, design and lead an intervention and evaluate the project. Key areas of assessment of their work included: sustainability, community stakeholder engagement and leadership.

The aim of this research is to explore the impact of the CAP on medical students, patients, the community and the wider health-service.

We will conduct focus groups (May 2018) with the students who have completed the CAP, exploring its impact on the student and their perceived wider impact. Focus group data will be analysed through qualitative thematic analysis.

This research is currently in progress and we will share examples of the projects, and key themes emerging from the focus group analysis.

We will discuss the potential benefits, barriers and solutions associated with incorporating such community-focussed and student-led health improvement projects sustainably within a medical curriculum.

Paper ID: 68

The Trojan Horse: Medical students as the hidden army for the UK health service?

Andy McKeown¹, Ravi Parekh¹ and Sonia Kumar¹

¹ Imperial College London (United Kingdom)

The UK health-service faces unprecedented demand from an ageing, multi-morbid and diverse population with limited resources. Addressing this requires future doctors to take a generalist, empathetic and resilient approach to undifferentiated and complex clinical presentations. Imperial College has piloted a novel longitudinal integrated clerkship (LIC) with a service-learning, apprenticeship model to inspire these qualities within our students. This course provides the potential for an authentic learning experience, demonstrating students as a highly skilled underutilised resource for the health-service. This study explores students' experiences of the LIC, its impact on them and their perceived impact on patients. In 2016-17, 24 volunteer year-5 medical students were placed on a year-long primary care LIC for one day a week. They followed a diverse caseload of patients across primary and secondary care, taking an active role in their management, with weekly facilitated tutorials. Students' experiences and the impact on them and their patients were explored through focus groups. Students also completed multiple inventories which included assessing: students' empathy, tolerance of ambiguity and resilience. Focus group analysis demonstrated students developed a patient-centred and generalist approach, with an increased understanding of medical complexity and ability to navigate the healthcare system. Importantly, students felt they had an integral and meaningful role in their patients' care. There was no significant difference in final assessments between the cohorts. Data from the inventories is currently being analysed. This LIC presents medical students as a highly skilled underutilised resource for the health-service, preparing patient-centred, critical thinking generalists for our future population.

Paper ID: 69

Opportunities and Obstacles in a Longitudinal and Integrated Rural Pharmacy Placement

Maurianne Reade¹, Taylor Geertsema², Melanie Sanderson², Frances Kilbertus¹, Ken Barss¹, Kaitlin Bynkoski² and Diane Meehan³

¹ Northern Ontario School of Medicine (Canada)

² University of Waterloo (Canada)

³ Northeastern Manitoulin Family Health Team (Canada)

Background

With the emergence of the Doctor of Pharmacy (PharmD) program in Ontario, pharmacy students have the opportunity to participate in advanced clinical training, through role-emerging placements, to prepare for the evolving world of pharmacy. Longitudinal integrated placements enable learning through the development of continuous relationships with patients, practitioners and the community.

Aims

The documented benefits of longitudinal placements for medical students are anticipated to be transferable to role-emerging placements for PharmD Learners.

Discussion

The University of Waterloo has developed Community of Practice clinical rotations to immerse pharmacy students in the healthcare system within 14 communities across Ontario. On Manitoulin Island, a rural community in Northern Ontario, the University of Waterloo School of Pharmacy and the Northern Ontario School of Medicine have supported the development of a longitudinal and integrated learning program for pharmacy learners. This program links the formal curriculum with experiential workplace learning to facilitate the development of professional identity, autonomy, comprehensive patient care abilities and inter-professional collaboration. The placement involves student participation in hospital, medical clinics, First Nations health centres, long-term care and community pharmacy settings. The learning experience includes the opportunity to explore traditional Anishnabek culture. The pharmacy students will follow patients longitudinally, refine their patient care abilities and develop ongoing relationships with healthcare providers all while living within the local community.

Conclusions

The researchers will explore learning, including opportunities and obstacles, of a rural longitudinal, integrated pharmacy learning experience.

Paper ID: 70

Franco Doc: Un modèle de formation orienté vers les besoins des francophones minoritaires

Aurel Schofield¹, Danielle Barbeau-Rodrigue² and Philippe Leblanc³

¹ Association of Faculties of Medicine of Canada (Canada)

² École de médecine du Nord de l'Ontario (Canada)

³ Association of Faculties of Medicine of Canada (Canada)

L'Association des facultés de médecine du Canada, en partenariat avec la Société Santé en français, le Consortium national de formation en santé et Médecins francophones du Canada, a lancé le projet Franco Doc. Le but de ce projet est d'assurer le développement et le renforcement des ressources médicales francophones en milieu minoritaire en ciblant les étudiants francophones et francophiles dans les facultés de médecine anglophones en lien avec les besoins des communautés francophones minoritaires.

L'approche novatrice du projet Franco Doc a été la création d'un comité de liaison faculté-communauté qui a pour but d'améliorer l'éducation médicale dans un contexte de responsabilité sociale. Des activités d'apprentissage ont été développées; sur le lexique médical en français, sur la connaissance des défis d'accès aux services et sur le concept d'offre active de service de santé en français en milieu minoritaire et des activités de réseautage avec des cliniciens francophones de leur région.

Ces activités ont permis aux étudiants en médecine de mieux comprendre les enjeux affectant les communautés francophones en situation minoritaire et de pouvoir mieux interagir avec leurs patients francophones une fois en pratique. Les liens créés avec les communautés francophones ont permis de bien saisir les spécificités de ces groupes. Ce modèle pourrait être dupliqué pour d'autres groupes linguistiques minoritaires. Le modèle comprend des leçons apprises qui informeront la deuxième phase du projet et servira de modèle phare pour d'autres initiatives similaires qui mettent en partenariat des instituts de formation et des communautés en situations minoritaires. Les discussions sur le modèle incluront des détails sur les façons d'adapter le modèle selon divers contextes

Paper ID: 71

Reflections on relationships between Indigenous theatre and rural health professions education

Maurianne Reade¹, Joahna Berti², Erin Cameron¹, Frances Kilbertus¹ and Marion Maar¹

¹ Northern Ontario School of Medicine (Canada)

² Debajehmujig Storytellers (Canada)

Introduction

The authors will consider the relationships between a professional Indigenous theatre group (Debajehmujig Storytellers) and rural health professions educators at the Northern Ontario School of Medicine (NOSM). Collaboration between NOSM faculty and Debajehmujig began in 2009 around the concept of mutual benefit for acting interns and health professions learners.

Aims

The authors will review the breadth of humanities projects that have been developed. As well, reflections on the collaborative relationships that enabled these projects will be shared.

Discussion

Our initial collaborative projects involved engaging simulated patient scenarios, with actors, in a wilderness medicine setting. All participants had an element of "performance delivery" and shared the need to "keep the audience safe." The relationships and trust that have grown since this initial engagement have fostered the ability to explore more complex and challenging collaborations around mental health, missing & murdered Indigenous women, photovoice research and knowledge translation on healthy relationships, and Indigenous perspectives on death and dying. The work of the actors is identity-based, connected to their unique perspectives and lived experiences.

For faculty, the projects with Debaj actors represent opportunities to be community-engaged in education and research. For Debaj, the opportunity to impact local and regional health care delivery for Indigenous peoples through increased cross-cultural understanding is deeply significant.

Conclusion

The authors will explore how collaborative relationships between educators and artists enhances learning, and how this collaboration can be transferred throughout NOSM's Distributed Community-Engaged Learning model to foster art and inclusive cultural perspectives within medical education in Northern Ontario.

Paper ID: 72

Culinary Medicine Labs: A Northern Ontario School of Medicine (NOSM) Pilot

Lee Rysdale¹, Ashley Hurley¹, Michelle Dumont¹, Nicole Selman¹, Cara Green¹, Vincent Ng¹, Heather Feldmann¹ and Saara Rizzo¹

¹ Northern Ontario School of Medicine (Canada)

Background

Culinary Medicine Labs (CMLs) are commonly used in American medical schools as strategy to address the challenges of integrating nutrition into the curriculum.

Aims

The Northern Ontario Dietetic Internship Program (NODIP) partnered with two medical student groups to pilot and evaluate an interprofessional model involving Registered Dietitians (RDs), dietetic interns and medical students to determine the perceived need and potential for enhanced nutrition curriculum at NOSM.

Methods

Four CMLs were piloted in 2017-18; each two-hour session was facilitated by two RDs and two dietetic interns. Medical students were recruited through word of mouth, posters and student newsletters. Participation was voluntary and outside the school schedule. Written evaluations were completed at the end of each session. All responses were anonymous; results were collated to guide future sessions and potential integration into the formal curriculum. Research ethics waivers were received from Laurentian and Lakehead Universities.

Results

Overall, there over 35 participants including one physician faculty. Evaluations showed increased personal nutrition knowledge and food skills, and planned behaviour change related to nutrition care as physicians.

Discussion

While participating students were highly positive and requested more frequent sessions, future CMLs would require dedicated NODIP resources and funding including faculty stipendiaries. Suitable space and adequate equipment on campus and integration into the formal curriculum would increase access and participation for all students.

Conclusion

This innovative and experiential approach provided new concepts and strategies around nutrition care as physicians. Future sessions could enhance the nutrition curriculum and the roles of RDs in medical education.

Paper ID: 73

Advancing Indigenous Cultural Competency: The Northern Ontario Dietetic Internship (NODIP) Experience

Lee Rysdale¹ and Denise Raftis¹

¹ Northern Ontario School of Medicine (Canada)

Background

The Truth and Reconciliation Commission Calls to Action (December 2015) advocates for cultural competency training of all healthcare professionals. Yet, there is a gap in the dietetics profession considering the diverse practice settings of Registered Dietitians (RDs), how integral food-related beliefs and behaviours can be in a given culture, and how strongly they can influence health.

Aims

With almost half (40%) of Ontario's Indigenous population residing in Northern Ontario, the Northern Ontario Dietetic Internship Program (NODIP) aims to develop, implement, and evaluate curriculum to enhance cultural self-efficacy.

Methods

As a mandatory component of NODIP, cultural curriculum includes self-directed and facilitated learning activities and intentional, focused placements. Both generic and food/nutrition specific competency resources have been developed and evaluated along with placement and final program evaluations. Building on five core generic competencies developed and validated for allied health learners, additional food and nutrition domains were validated with a national sample of RDs (n=120) who work in and/or have an interest in Indigenous health. National consultations also took place to inform integration of this curriculum across Canadian dietetic internships.

Discussion

Core cultural competencies including food and nutrition domains have been validated. Annual evaluations inform curriculum tools and resources including an online learning module (Qualtrics®) allowing for increased learner interactivity and improved tracking of uptake and evaluation results. Preceptor training has been piloted using a variety of strategies.

Conclusion

This competency curriculum appears to increase cultural self-efficacy; more than 10% of NODIP graduates are working in Indigenous health across Canada.

Paper ID: 74

Strategies to accelerate future physician nutrition competence in medical schools

Lee Rysdale¹ and Denise Raftis¹

¹ Northern Ontario School of Medicine (Canada)

Background

Despite growing evidence of the efficacy of nutrition counselling by Medical Doctors (MDs), multiple factors have kept it outside the purview of clinical medicine including a lack of graduate knowledge and confidence due to inadequate education in medical schools. Canadian medical students including those at the Northern Ontario School of Medicine (NOSM) want more nutrition education, which led to an interdisciplinary Culinary Medicine Lab (CML) pilot this past academic year. The CML was grounded in the experiential learning theory using teaching kitchens which are affiliated with numerous medical schools across the US and more recently the University of Toronto in Canada.

While participating NOSM students were highly positive and requested more frequent sessions, future CMLs require dedicated resources and funding; suitable space and adequate equipment on campus; and, integration into the formal curriculum to increase access and participation for all students.

Other strategies to integrate nutrition in medical education include online self-directed modules, open source resources, medical student-led community nutrition and cooking classes as well as hands-on cooking seminars with case studies in nutritional strategies for chronic diseases.

This PeArLs session aims to explore how nutrition can be integrated into the curriculum to ensure medical graduates are adequately equipped to address the significant number of diet-related conditions such as obesity, diabetes, heart disease and some cancers.

Discussion questions include:

What are some best practice models that are working?

What resources/supports are needed for implementation success/fidelity?

Are there any reported outcome measures?

Paper ID: 75

Leadership collaboratif socialement responsable en contexte minoritaire francophone

Emmanuelle Careau¹, Anne-Claire Museux², Elise Milot³ and Frédérique Beaudemont⁴

¹ Faculté de médecine de l'Université Laval (Canada)

² Réseau de collaboration sur les pratiques interprofessionnelles (RCPI) (Canada)

³ Faculté des Sciences sociales de l'Université Laval (Canada)

⁴ Réseau Santé en français de la Saskatchewan (Canada)

Introduction : La responsabilité sociale (RS) est cette capacité à s'indigner face aux iniquités, à s'engager dans le changement et à se sentir imputable de nos actions. Elle nécessite de créer des partenariats entre les différents acteurs concernés par une problématique sociale. Le leadership collaboratif, à la fois compétence individuelle et processus partagé, doit être mis à contribution dans la structuration de l'action collective visant à répondre à ces problématiques. Au Canada, un de ces enjeux concerne les communautés francophones en situation minoritaire qui vivent malheureusement plusieurs iniquités à l'égard de l'accessibilité à des soins et services de santé de qualité. Il a donc été proposé de développer une trousse pédagogique portant sur le leadership collaboratif dédié aux agents de changements travaillant avec ces communautés.

Objectifs : Les objectifs de la trousse pédagogique sont :

- 1) Comprendre le sens/la pertinence du leadership collaboratif compte tenu des défis actuels en matière de responsabilité sociale;
- 2) Distinguer le leader collaboratif (compétence) et le leadership collaboratif (processus) afin d'utiliser chacun de manière optimale et complémentaire;
- 3) Initier des processus collaboratifs visant l'exercice d'une responsabilité sociale accrue.

Méthodes et résultats : La trousse s'articule en 6 sections illustrant différentes étapes de planification et de réalisation d'une démarche collective. Elle contient des propositions d'activités concrètes pouvant être utilisées auprès des communautés francophones en situation minoritaire. La trousse a été pré-testée auprès de professionnels de la santé de la Saskatchewan.

Conclusion : Cette trousse, dans sa version finale, sera présentée.

Paper ID: 77

Socioeconomic diversity in medical learners. Can NOSM admissions scores drive equitable intake?

Miriam Cain¹, Robert Barnett² and Owen Prowse¹

¹ Northern Ontario School of Medicine (Canada)

² Laurentian University, School of Rural and Northern Health (Canada)

Introduction: In Canada, there is a movement afoot to assess and increase diversity in medical practitioners. Though gathering this information from medical students may seem an excellent idea, it is difficult in practice for many reasons. The Northern Ontario School of Medicine (NOSM) employs a method called 'context scoring' to evaluate applicant exposure to rural and remote practice setting in the North. The tool uses census information from Statistics Canada to derive an exposure measure from demographics. As such, it is possible that NOSM context scoring could be used to evaluate the socioeconomic (SES) diversity in the NOSM student body.

Aims: Evaluation of the NOSM context scoring tool as a measure of socioeconomic diversity in the student body.

Methods: SES data will be aggregated from the 2016 census and entered into ARCGIS 10.1 to allow for geospatial analysis. Successful applicants to the NOSM Undergraduate program from 2015-2017 (n=192) will be geocoded as well using postal code information. This will allow for the comparison of context score and SES variables assigned to community; specifically average income, highest level of education, and unemployment rate. Multiple regression will be used to define any relation between context and SES. Range of SES exposures will also be analyzed.

Results: Pending.

Discussion: NOSM context scoring is designed to measure rural and remote exposure, and successful applicants are by definition a biased sample given that 92% come from Northern Ontario. Comparison of SES diversity range among the student body and comparison geographies will be discussed.

Conclusion: Pending.

Paper ID: 78

La Faculté de médecine de l'Université Laval: L'excellence en responsabilité sociale

Emmanuelle Careau¹, Nadine Martin¹, Marie-Claire Bérubé¹ and Julien Poitras¹

¹ Faculté de médecine de l'Université Laval (Canada)

Introduction : En août 2017, la Faculté de médecine de l'Université Laval est devenue la première faculté francophone à être reconnue pour la responsabilité sociale (RS) par le programme ASPIRE-to-Excellence de l'AMEE. Dans notre faculté, la RS est plus qu'un standard à atteindre pour l'agrément, elle est tissée dans notre planification et notre fonctionnement, de l'admission au curriculum, en passant par la recherche. D'ailleurs, à cet égard, une instance dédiée a été créée, le Vice-décanat à la responsabilité sociale (VDRS), pour soutenir de façon transversale l'ensemble de la faculté à l'égard des activités touchant la RS.

Objectifs : Présenter la stratégie mise de l'avant pour formaliser une instance dédiée à la RS et structurer ses activités intra- et inter-facultaires.

Méthodes et résultats : Par l'organisation de directions associées au VDRS, plusieurs activités ont été menées afin de : favoriser l'implication citoyenne ; investir notre rôle social d'agent de changement ; soutenir l'effort philanthropique ; s'engager en santé mondiale ; s'assurer de la diversité des cohortes étudiantes ; former des futurs professionnels socialement responsables ; offrir un milieu de vie stimulant qui encourage la santé et le bien-être. Plusieurs projets structurants ont été implantés pour investir la RS dans l'ensemble de notre mission universitaire (formation, recherche, services à la collectivité).

Conclusion: La formalisation d'une instance dédiée a été une stratégie très porteuse pour soutenir de façon transversale la RS et investir notre rôle dans l'Aspire Academy.

Paper ID: 81

Une vision unifiée de la responsabilité sociale pour soutenir la planification collective

Emmanuelle Careau¹, Ahmed Maherzi², Marie-Claire Bérubé¹, Christian Bourdy², Réjean Duplain², Paul Grand'Maison³, Eric Lachance³ and Saleem Razack⁴

¹ Faculté de médecine de l'Université Laval (Canada)

² Faculté de médecine de l'Université de Montréal (Canada)

³ Faculté de médecine et des sciences de la santé, Université de Sherbrooke (Canada)

⁴ Faculty of medicine, McGill University (Canada)

Introduction : La responsabilité sociale (RS) devrait être plus qu'un standard d'agrément à atteindre, elle devrait être mise de l'avant, dans la planification et le fonctionnement de toute la Faculté, de l'admission au curriculum, en passant par la recherche. De plus, elle amène les facultés à agir en concertation avec plusieurs partenaires. Or, l'adhésion à une vision unifiée à l'égard de la RS permettant l'engagement dans une démarche collective socialement responsable amène de multiples défis. Cet atelier illustrera comment un Comité interfacultaire québécois sur la responsabilité sociale en santé (CIQ-RESOsanté) porté par l'Université Laval, l'Université de Montréal, l'Université de Sherbrooke et l'Université McGill a abordé ces enjeux lors d'un symposium provincial.

Objectifs :

- 1) Reconnaître les défis liés à l'adoption d'assises communes permettant une planification stratégique collective abordant la RS
- 2) Expérimenter une stratégie pédagogique structurée permettant la co-construction d'une vision commune à l'égard de la RS
- 3) Identifier les facteurs facilitants et les obstacles dans la réalisation de cette stratégie

Discussion : Cet atelier permettra aux participants de mieux structurer leur démarche à l'égard de la RS en s'assurant que les partenaires s'entendent sur des assises communes. L'expérience des quatre universités québécoises pourra inspirer d'autres Facultés désirant s'engager dans une démarche collective. Les participants pourront expérimenter une activité spécifiquement développée à cet égard et discuter des implications dans leurs propres milieux.

Activités : Présentation de la démarche adoptée par le CIQ-RESOsanté. Expérimentation en petits groupes de l'activité pédagogique Buller" pour la RS ! Discussions en grands groupes.

Paper ID: 82

Defining 'Northern' through quantitative grounded theory, big data mining, and geospatial analysis.

Robert Barnett¹ and Nancy Young¹

¹ Laurentian University, School of Rural and Northern Health (Canada)

Introduction:

Currently, there is no single definition of the terms 'northern' and 'rural' in Ontario though typically these terms are applied to standardized geographic areas used for administrative or electoral processes. Health care services in Ontario determine northern status through boundaries based upon hospital utilization patterns, while rural area can be determined through distance to different levels of service, inter-community workforce commuting and population size. Regardless of the definition used, northern Ontario healthcare is known to be different than the provincial norm with home care, ambulatory care and hospital care are all accessed differently than the provincial norm.

Aims:

To incorporate what relationships may exist between socioeconomic status, population demographics and other characteristics of place into a theory of rurality and the northern healthcare via a doctoral dissertation.

Methods:

Our proposed method entails utilizing geographic information systems to create rolling aggregations of key demographic and inpatient health utilization via kernel analysis, or a surface structure. Data mining techniques will then be married to Quantitative Grounded Theory (QGT) methods as proposed by Glaser (2008) for theory building directly from quantitative datasets will be utilized to explore creation of new theories of rural and northern in the context of Ontario.

Results:

Pending.

Discussion:

The above study direction will be discussed along with its strengths and limitations. Proposed analysis techniques and their implications on rural and remote analysis will be examined along with potential utilization of grounded theory, data mining and geographic information systems in rural healthcare management.

Conclusion:

Pending.

Paper ID: 83

Thinking about "Design Thinking": Novel Faculty Development for LICs

Tara Singh¹, Yamini Saravanan¹, Bianca Shagrin², Nora Osman³ and David Hirsh⁴

¹ Harvard Medical School/Cambridge Health Alliance (United States)

² Harvard Medical School, Cambridge Health Alliance (United States)

³ Harvard Medical School, Brigham & Women's Hospital (United States)

⁴ Harvard Medical School (United States)

Faculty desire innovative, interactive, and engaging faculty development sessions to transform teaching practices. The "design thinking" model, used in business and engineering, can engage faculty to co-create effective approaches to longitudinal teaching. Principles of design thinking stimulate creative inquiry and drive empathetic and relational teaching practices. Design thinking also addresses barriers to effective teaching, fosters dedicated exploration of possible solutions, and creates strategic implementation of interventions. Participants in this process actively share learning and commitment to improved teaching. Clinical faculty may then incorporate this co-created set of teaching practices into the clinical environment. We describe a Cambridge Health Alliance hospital-wide, multidisciplinary faculty development workshop, modelled as a "think tank," using principles from design thinking. In this workshop, participants will 1. Define design thinking using hands-on activities (15 minutes); 2. Use the design thinking framework and apply it for faculty development (5 minutes); 3. Engage in a simulation of a faculty development "think tank" (20 minutes); 4. Evaluate the faculty development think tank format in large group discussion (20 minutes); 5. Apply design thinking techniques in small groups to practice principles (20 minutes); 6. Take back implementable ideas to home institutions (10 minutes).

Paper ID: 84

Training medical students in health coaching skills: a socially accountable way forward?

Arti Maini¹ and Sonia Kumar¹

¹ Imperial College London (United Kingdom)

Health-coaching involves a clinician mindset shift from expert to enabler, re-thinking power dynamics, based on the belief that people are resourceful with internal strengths and capabilities.

This study explored the impact of training medical students in health-coaching skills.

We piloted health-coaching training for six cohorts of Year 3 medical students from September 2016-June 2018 as part of a 10-week community pilot. Students were allocated primary care placements in settings with diverse populations. Focus groups with students explored impact of this training.

Thematic analysis found that health-coaching skills training had a positive impact on student attitudes and skills in using a person-centred coaching approach (based on a mutually respectful, non-judgemental relationship) with people from often very different backgrounds. Students also felt better able to empower people to identify steps within their control to address health and lifestyle issues. Students felt motivated through adding value in clinical encounters by facilitating these empowering conversations. There was positive impact on students' own professional development, including increased levels of self-reflection, self-awareness, solution-finding and motivation, and ability to apply coaching principles to situations involving leadership and teamwork.

These findings suggest that training medical students in health-coaching can develop a mindset and skills to hold empowering conversations with people, including those from marginalised groups. The shift in the balance of power in conversations may contribute to the development of a more socially accountable relationship between a medical school and its local community, enabling a more effective shared exploration of community needs and how best to address these.

Mobilisation des facultés de médecine francophones pour la responsabilité sociale

Ahmed Maherzi¹, Emmanuelle Careau², Joel Ladner³, Dominique Pestiaux⁴, Paul GrandMaison⁵, Jose Gomes³, Michel Roland⁴ and Charles Boelen³

¹ Faculté de médecine de l'Université de Montréal (Canada)

² Faculté de médecine de l'Université Laval (Canada)

³ Réseau international francophone pour la responsabilité sociale en santé (France)

⁴ Réseau international francophone pour la responsabilité sociale en santé (Belgium)

⁵ Réseau international francophone pour la responsabilité sociale en santé (Canada)

Introduction : La responsabilité sociale (RS) des facultés de médecine (FM) est l'obligation d'orienter, en partenariat avec divers acteurs, la formation, les recherches et les services vers les principaux problèmes de santé de la communauté, région et/ou nation qu'elles ont comme mandat de servir. L'inclusion des principes de RS dans les normes d'agrément constitue une étape essentielle et un tournant dans le fonctionnement de nos facultés : de l'obligation morale, cela est devenue une obligation académique. Mais comment aller au-delà d'une simple réponse à une obligation individuelle d'établissement en investissant collectivement notre rôle social d'agent de changement ?

Objectifs : Présenter la démarche adoptée par le Réseau international francophone pour la responsabilité sociale en santé (RIFRESS) regroupant 61 Facultés de 23 pays.

Méthodes et résultats : Considérant les actions menées dans plusieurs facultés francophones du Nord (Québec, France, Belgique, Roumanie) et du Sud (Tunisie, Haïti, Madagascar, Bénin, Sénégal) de 2012 à 2017, le RIFRESS propose de :

1. Mieux définir la population de référence desservie;
2. Documenter les besoins prioritaires de santé en collaboration avec les communautés et les autres acteurs clés de la santé
3. Planifier des actions structurantes investissant les trois volets de la mission universitaire adaptés aux besoins identifiés
4. Évaluer leur impact selon le modèle Conception, Production, Utilisabilité

Conclusion : La concrétisation de la démarche suppose la formalisation au sein des facultés d'une structure de la RS qui travaillera transversalement avec toutes les instances facultaires et encouragera les partenariats intra- et inter-universitaires.

Paper ID: 86

Démarche pour concrétiser une norme d'agrément en lien avec la responsabilité sociale.

Ahmed Maherzi¹, Serge Quérin¹, Christian Bourdy¹, Réjean Duplain¹, Joanie Cyrenne-Tourigny¹ and Hélène Boisjoly¹

¹ Faculté de médecine de l'Université de Montréal (Canada)

Introduction : Les programmes canadiens d'études médicales de premier cycle (M.D.) doivent satisfaire aux normes du Comité d'agrément des facultés de médecine du Canada. Depuis juillet 2016, un élément sur la responsabilité sociale (RS) des facultés de médecine a été ajouté stipulant qu'une faculté de médecine s'engage à répondre aux préoccupations prioritaires en matière de santé des populations qu'elle est responsable de servir .

Objectif : nous rapportons par ce travail la démarche que nous avons entreprise pour concrétiser cette nouvelle norme d'agrément en lien avec la RS.

Méthodes et résultats : La Faculté de médecine de l'Université de Montréal avait déjà fait la preuve de son engagement en matière de RS par diverses actions, notamment en créant en 2005 un campus délocalisé en Mauricie visant à encourager la rétention des médecins en région. En septembre 2017, la doyenne a créé un Bureau de la RS incluant un directeur et un comité de réflexion et d'action d'une vingtaine de membres, qui se réunit mensuellement. Un sous-comité de l'agrément a veillé à formuler les premières propositions du comité sous forme de réponses à un questionnaire d'agrément qui étaient exigées en avril 2018. Cette contrainte a permis d'orienter les discussions du comité principal vers des actions concrètes et réalistes qui seront menées au cours des mois et des années à venir, en collaboration avec divers départements, directions et comités de la Faculté.

Conclusion : L'intégration des principes de RS dans les normes d'agrément constitue une étape essentielle qui va transformer progressivement le fonctionnement de nos facultés.

Paper ID: 87

Le dilemme de publications en matière de santé lié aux barrières linguistiques et à l'iniquité

Danielle Barbeau-Rodrigue¹ and Pascale Dettwiller²

¹ École de médecine du Nord de l'Ontario (Canada)

² SA Health (Australia)

Au MUSTER 2014, un petit groupe plurilingue a discuté de l'iniquité des publications scientifiques unilingues anglophones produisant une perte de connaissances au sein d'autres groupes linguistiques.

L'anglais est considéré la langue franche de la communauté scientifique étant tellement commun que dans certains pays où on ne parle pas l'anglais (Allemagne, France, Espagne, Russie et Chine), les publications savantes en anglais sont plus nombreuses que celles produites dans leur langue d'origine. Dans les Pays-Bas, un des exemples les plus flagrants, le ratio s'élève à 40 publications en anglais pour chaque publication en néerlandais.

Les langues européennes perdent leur place comme langues savantes en faveur de l'anglais. La tendance vers la bi-alphabétisation, à la fois en anglais et dans la langue d'origine de l'auteur scientifique, peut être considéré comme la diglossie. Cette asymétrie peut avoir des répercussions sérieuses sur le monde universitaire.

Les participants pourront :

- Définir l'équité dans le domaine de la publication scientifique en matière de santé
- Explorer le biais linguistique de la bibliométrie.
- Comprendre les barrières et outils linguistiques dans le cadre de la diffusion des connaissances en matière de santé.

L'étude de cas du contexte canadien démontre combien l'anglais joue encore un rôle dominant.

Les connaissances provenant de la recherche traditionnelle présentées dans une langue autre que l'anglais, n'ont pas, en soi, une valeur scientifique moindre. De fait, les soins de qualité, sécuritaires, culturellement appropriés, et axés sur le patient, exigent le partage des résultats de recherche visant la publication dans d'autres langues que l'anglais.

Paper ID: 89

Hiding in Plain View...How Socially Accountable are We for Those with Invisible Dis/Abilities?

Jo Beyers¹ and Erica DiRuggiero²

¹ NOSM, Sudbury (Canada)

² University of Toronto (Canada)

One in seven people lives with a dis/ability, upwards of 90% are "invisible". People with dis/abilities (PWD) experience systemic barriers to health and health care services, bias, stigma, and discrimination in their daily lives. PWD are less likely to engage in health promoting behaviours and experience poorer health outcomes compared to those without dis/abilities, largely due to unjust, avoidable, and socially constructed health inequities.

WHO reports that PWD are more than twice as likely to report finding health care provider skills inadequate to meet their needs and four times more likely to report being treated poorly. While social accountability and diversity have traditionally focused on race, gender, and locality, there has been limited attention given to dis/ability diversity, despite PWD as the world's largest minority group.

Yet dis/ability is so much more than wheelchair ramps. As a social justice issue, dis/ability needs to be embedded in all facets of medical education - from curriculum, to PWD learner admissions, and a medical school workforce reflective of the people it ultimately serves. WHO therefore recommends that dis/ability education be integrated into health-care professional training. With calls such as "nothing about us, without us" from advocacy groups, cultural competency training for PWD is critically needed. To ensure effectiveness, theoretical models of dis/ability, ableism, and intersectionality must also become an integral part of education and training.

The aim of this session is to discuss, gain insight and share reflections, evidence-informed practices, programs, and strategies which explicitly build dis/ability into medical education settings.

Paper ID: 90

An Australian Study of Rural Medical Students; are LIC students more patient centred?

Zelda Doyle¹, Jennene Greenhill², Amanda Barnard³, Andrew Dean⁴, David Hirsh⁵ and Lucie Walters²

¹ Lithgow Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

² Flinders University Rural Health South Australia (Australia)

³ Australian National University College of Health and Medicine (Australia)

⁴ Ballarat Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

⁵ Harvard Medical School (United States)

Background/Aim:

The literature demonstrates qualitative and quantitative data that establish the benefit of the longitudinal integrated clerkship (LIC) model in medical training. In Australia, institutions have implemented these models predominately in rural areas. This project applied both the Patient-Practitioner Orientation Scale (PPOS) and the Tasks of Medicine (TOMS) questionnaire as part of the national survey of medical students who completed rural clinical placements of one year or more in 2015. The study aimed to determine if LICs affect student perceptions.

Method:

We scanned surveys and cleaned data to compare PPOS and TOMS scores by the type of LIC programme in each rural clinical school as well as general descriptors

Results:

Results demonstrate significant differences in PPOS and TOMS between LICs and block rotations. We consider these results in the context of demographic differences between student cohorts in the rural clinical schools.

Discussion:

The LIC approach may account for some of the significant differences found in the orientation scales. LICs immerse students in rural communities and students form long-term relationships with patients, their supervisors, other team members, and the community itself. Some rural clinical schools simply translate the block rotation model into rural areas.

Conclusion:

We conclude that it is not only where students learn but also how students learn that makes a difference and assists medical students to become more patient-centred. More work is needed to determine what components of LIC and block rotations influence students' responses to these validated measures.

Paper ID: 91

Rural clinicians experiences of the intersection between access and quality in rural medicine

Ella Cockburn¹, Laura Grave¹, Jill Konkin², Ian Couper³, David Campbell⁴, Ruth Stewart⁴ and Lucie Walters¹

¹ Flinders University Rural Health South Australia (Australia)

² University of Alberta, Edmonton (Canada)

³ Faculty of Medicine and Health Sciences Stellenbosch University (South Africa)

⁴ James Cook University, Thursday Island, Queensland (Australia)

Background:

Many rural and remote communities across the world suffer from the maldistribution of health professional personnel and resources. For this reason, rural doctors often find themselves in positions where they are pushed to the limits of their scope of practice to provide the medical care that is needed by their community. When acting outside of their comfort zone, it is not naïve practice, nor the exhibition of blatant disregard for patient safety; it is an act of courage. More specifically, it is what we call “clinical courage”.

The purpose of this research is to examine the lived experience of “clinical courage” by rural physicians.

Methods:

At an international rural medicine conference in 2017, doctors who practiced rural/remote medicine were invited to participate in the study. Twenty-seven semi-structured interviews were conducted exploring the doctor’s experiences of pushing the boundaries of their scope of practice. Initial analysis of the material using a hermeneutic phenomenological frame, sought to uncover the meaning of clinical courage to the participants.

Results:

Transcripts were initially analysed individually by each member of the research team and then co-analysed using an iterative process to identify core concepts.

Conclusion:

Deepening the understanding of “clinical courage” could inform rural health professional training and ongoing professional development.

Paper ID: 92

Implementation Science: Improving Equitable Interventions by our Rural Medical Education Workforce

Jo Beyers¹ and Erica DiRuggiero²

¹ NOSM, Sudbury (Canada)

² University of Toronto (Canada)

In Canada, billions are spent on health care yet investments in rigorously assessing what interventions work for whom and under what contextual circumstances still fall short. Efforts to learn from successful (and failed) interventions - also known as implementation science - are key to improving our population's health. Many interventions found to be effective in health services research involving optimal patient conditions (eg studying highly motivated patients in a teaching hospital or university setting) fail to translate into meaningful patient care outcomes in rural, remote and resource constrained contexts.

Public health core competencies include being skilled at evidence-informed decision-making (EIDM) which encompasses the tenets of implementation science. At its core, implementation science attempts to re-direct the emphasis from one of internal validity (ie where we know that something can work) to external validity (ie finding out which populations it works for and how best to make it work for those populations). Barriers to implementation arise at multiple levels of health care delivery: the patient, family, the provider team or group, the organizational, community, system and broader policy levels. Many conceptual and theoretical frameworks/models exist to identify, describe and understand the contexts in which programs/policies are implemented.

In order to improve the equitable delivery and scale up of health care interventions in rural and remote communities our workforce must have strengthened EIDM capacity which includes implementation science skills. This session will describe learnings from implementation research that highlights the importance of context. Global health and rural clinical and community-based studies will be showcased.

Paper ID: 93

« Lost in Translation » : contrer la perte de sens et de contexte dans les publications scientifiques

Pascale Dettwiller¹ and Danielle Barbeau-Rodrigue²

¹ SA Health (Australia)

² École de médecine du Nord de l'Ontario (Canada)

Fortes de nombreuses années d'expérience au sein de leur communauté respective ainsi qu'en milieu universitaire, les facilitatrices exploreront et développeront avec les participants une approche visant un modèle de publications et de diffusion de connaissances équitables dans un monde où la langue anglaise est majoritaire et acceptée comme la langue franche. Le biais dans les publications tendant à exclure les malades ne parlant pas l'anglais couramment pose une question supplémentaire à l'iniquité qui examine la validité et la transférabilité des résultats à d'autres populations.

Les participants pourront :

- Comprendre les défis du manque d'équité dans les pratiques de publications scientifiques actuelles .
- Explorer des questions spécifiques et connexes dans le contexte de la justice sociale et la responsabilité sociale ayant trait aux soins de santé
- Identifier des stratégies et meilleures pratiques menant à l'amélioration du transfert de connaissances et la communication dans le secteur de la santé

Les participants réfléchiront sur leurs propres expériences et partageront des stratégies qu'ils ont adoptées pour surmonter cette iniquité et ce biais des résultats, et ce, dans le contexte de la justice et la responsabilité sociale.

Format de discussion suivant le nombre de participants : les participants, en petits groupes, auront l'occasion de réfléchir sur des questions précises. Par la suite, tous les commentaires seront rapportés au grand groupe, en vue d'encadrer un exercice de développement de stratégies ayant pour but de mener au changement et d'améliorer le transfert de connaissances et la communication entre les divers partenaires du secteur de la santé.

Paper ID: 95

Student Research in Rural Areas - Building a Rural Theme into an MD programme.

Zelda Doyle¹, Joe McGirr², John Dearin¹, Andrew Dean³, Catherine Harding² and Alexa Seal²

¹ Lithgow Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

² Wagga Wagga Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

³ Ballarat Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

Background:

The University of Notre Dame Australia, School of Medicine, Sydney (SoMS), has recently transitioned to offering an MD degree for its medical course. This programme change has seen students required to undertake 120 hours of research over 3 years in one of ten pre-defined themes. One of these themes, Rural Medicine, is co-ordinated through the rural clinical schools. The program provides a potential pathway for students to develop their interest in rural practice in preparation for undertaking clinical years learning in a rural location.

Discussion:

This presentation will demonstrate the development of sustainable research projects for the MD program within the rural clinical schools. By dividing the research up into interest areas such as Health Services, Community, Workforce, and Policy we have developed processes and key contacts which allow for the development of self-sustaining research projects. We intend to outline both the process we undertake to support and encourage research within our communities, and how we are developing this self-sustaining research, which allows for ongoing interaction between students and local rural communities.

Paper ID: 96

Factors influencing Rural Practice: A survey of University of Notre Dame, Australia SoMS Graduates.

Zelda Doyle¹, Leeanne Schaefer², Jennifer Stokes³ and Joe McGirr⁴

¹ Lithgow Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

² Ballarat Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

³ (Australia)

⁴ Wagga Wagga Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

Background

Rural communities have an acknowledged shortage of doctors, which is associated with poorer health outcomes in these communities.

The Australian government has introduced a number of strategies at university level to address this shortage including the introduction of rural clinical schools (RCS), rural training hubs, mandated percentages of rural origin (RO) students for enrolment in medical courses and rural rotations. Evaluation of these strategies is important and a graduate tracking study has been undertaken at the University of Notre Dame Australia, School of Medicine, Sydney (SoMS).

Aim

To determine the impact that RO and RCS have on the work location of SoMS graduates

Method

School databases were utilised to determine tracking factors for the first six graduating cohorts (2011 - 2016). The Australian Health Practitioner Regulation Agency (AHPRA) database, was used to determine current location of practice via postcode.

Analysis of known factors which may influence rural practice was undertaken via binary logistic regression.

Results

It was found that both RO (2.8 (1.5 - 5.1)) and RCS (2.1 (1.1 - 4.1)) increased the odds of rural work independently of each other. The combination of RO and RCS increased the odds of rural work significantly (6.4 (2.9 - 13.9) $p < 0.005$).

Conclusion

Both RCS and RO have an influence on rural work, but their cumulative impact is significantly greater. There may be other factors which influence rural work which will need further investigation.

This study will continue to update and track graduates to determine any lasting effects of RO and RCS on rural workforce.

Paper ID: 97

Building Community Research in Rural Areas: From Little Things, Big Things Grow

Zelda Doyle¹, John Dearin¹ and Joe McGirr²

¹ Lithgow Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

² Wagga Wagga Rural Clinical School, School of Medicine, Sydney, University of Notre Dame, Australia (Australia)

Background:

The Lithgow Rural Clinical School is one of three rural clinical schools which form part of the University of Notre Dame Australia, School of Medicine, Sydney (SoMS). Located approximately three hours west of Sydney, it is serviced by a 42 bed GP run hospital, and is at the far west of the Nepean Blue Mountains Local Health district. Within the hospital campus, there is also an aged care facility, specialist consulting rooms and community and allied health teams.

Making research an integral part of the medical and allied health communities, can be perceived as difficult in smaller rural areas, particularly those areas which do not have a research base or culture from which to build. This presentation aims to show how one small rural clinical school has started building that research culture within what is essentially a research naive medical and allied health community.

Utilising a case study approach we intend to show how we have established the concept of "what if" research within the medical and allied health communities, and how we are working with different groups to encourage and promote research, to help develop a research culture within the hospital campus and the greater community.

Paper ID: 98

'Lost in Translation': how can we avoid the loss of meaning and context in scientific publishing?

Danielle Barbeau-Rodrigue¹ and Pascale Dettwiller²

¹ École de médecine du Nord de l'Ontario (Canada)

² SA Health (Australia)

At MUSTER 2014, a small plurilingual group emerged and discussed the inequity of monolingual publications in English and subsequent the loss of knowledge and information from and to other linguistic groups.

English is considered the 'lingua franca' of the scientific community and is so prevalent that in some non-English-speaking countries (Germany, France, Spain, Russia and China), English-language academic papers significantly outnumber publications in each country's own native language. In the Netherlands, one of the more extreme examples, this ratio is an astonishing 40 publications in English to 1 publication in Dutch.

European languages are being displaced as academic languages in favour of English. The tendency to biliteracy, writing in both English and in the academic authors' native language, can be defined as diglossia. This asymmetry can have serious effects and repercussions on academia as a whole.

After attending this session, the participants will be able to:

- Understand the challenges due to the lack of equity within current scientific publishing practices.
- Explore linguistic bias and challenges of diglossia.
- Understand the impact (barriers/enablers) of language on scientific knowledge dissemination.

The case study in the Canadian context will illustrate how the English language still plays a dominant role.

Knowledge produced via traditional research methods yet presented in a language other than English, does not diminish its scientific value. In fact, in the interest of ensuring quality, culturally appropriate patient-centered care, sharing research results for the benefit of all by publishing additionally in languages other than English is not only unavoidable but preferable.

Paper ID: 99

Contextual Learnings from researchers on socially accountable community engaged medical education

Andre-Jacques Neusy¹, Torres Woolley², John Hogenbirk³, Fortunato Cristobal⁴, Amy Clithero⁵, Salwa Sanousi⁶, Jusie Lydia Siega-Sur⁷ and Carole Reeve⁸

¹ Training for Health Equity Network THEnet (United States)

² James Cook University (Australia)

³ Centre for Rural and Northern Health Research, Laurentian University (Canada)

⁴ Ateneo de Zamboanga University, Mindanao (ADZU) (Philippines)

⁵ University of New Mexico Health Sciences Center (United States)

⁶ University of Gezira School of Medicine (Sudan)

⁷ University of the Philippines Palo Leyte-School of Health Sciences (Philippines)

⁸ College of Medicine and Dentistry, James Cook University (Australia)

Background

Educating a fit-for-purpose health workforce is central to reducing health disparities and achieving health equity. Health professionals must acquire additional competencies not delivered by traditional teaching curriculums. In response, community-engaged education programs have emerged, characterized by: close partnership between university, local communities and health delivery system; early clinical immersion; and longitudinal integrated clerkship in communities blended with hospital rotations. Evidence is growing on the impacts and outcomes of this approach on graduates and the communities they serve. THEnet, a collaborative of 12 socially accountable health professional schools across six continents, created a research group that carries out multi-institutional comparative research on outcomes, impact and return on investments associated with community-engaged health professional education (CEHPE). Facilitated by THEnet, this workshop aims to engage Muster participants in sharing their research topics, successes and failures in order to contribute to the larger research agenda.

Learning objectives

1. To understand the research landscape on CEHPE and identify priority research agenda and gaps.
2. To understand major research methodology limitations and problems encountered by researchers investigating the CEHPE approach.
3. Facilitate future research collaboration and cross-contextual learning amongst participants.

Issues

Research topic priorities on CEHPE and the strengths and limitations of related methodologies

Activities

The workshop, facilitated by THEnet representatives, will be divided in two parts; each involving small group discussions followed by a plenary discussion of the feedback. Part 1 will discuss research topics and gaps, while Part 2 will discuss strengths and limitations to approaches in understanding the topics and gaps identified.

Paper ID: 100

Community Based Participatory Curriculum Development: The Planning Circle

Ghislaine Pilot-Attema¹, Robert Baxter², Jennifer Fawcett³, Kristy Cote¹, Christina Graves³, Claudette Chase³ and Paul Capon⁴

¹ NOSM (Canada)

² Eabametoong First Nation (Canada)

³ Northern Ontario School of Medicine (Canada)

⁴ Matawa First Nations Management (Canada)

Introduction: The Northern Ontario School of Medicine (NOSM), Matawa First Nations Management (MFNM), and Eabametoong First Nation (EFN) collaboratively established a new residency stream in response to the physician needs of EFN. The clinical and academic curriculum is grounded in specific community health care requirements and values traditional and western medicine. The curriculum supports Indigenous ways of knowing, while ensuring integration with the College of Family Physicians framework. The development of this curriculum is a collaborative effort by all stakeholders.

Aims/Discussion: Using Community Based Participatory Research methods as our guiding framework, curriculum for the residency stream is being co-created by all parties. By incorporating Community Based Participatory Curriculum Development (CBPCD) as a guide, EFN, MFNM, and NOSM strive to create teachings that satisfy the requirements of the College and the medical school, but also teachings which recognize the health needs of Eabametoong First Nation and learning required for a resident to become a successful community physician. This method of curriculum development is a unique model for residency programs, and represents an attempt to level power structures between medical schools and the communities their trained physicians serve.

Conclusion: As part of our co-created curriculum, all parties have engaged in developing curriculum using a planning circle. Members of EFN, MFNM and NOSM will gather in community to continue the dialogue on curriculum proposed to date. This presentation will focus on the perspectives of the planning circle from MFNM, EFN and NOSM and look at challenges and successes of the planning circle.

Paper ID: 101

Medical student presentations on local health issues: A novel way to promote community engagement

Prabhat Lamichhane¹, Lara Fuller², Erik Martin¹, Phuong Uyen Tran³, Colleen Stephens² and Colin Bell¹

¹ Deakin University, Geelong Australia, School of Medicine (Australia)

² Deakin University, Geelong Australia, School of Medicine, Rural Community Clinical School (Australia)

³ Bankstown-Lidcombe Hospital (Australia)

Introduction: To achieve learning objectives in public health medicine, third year Deakin University medical students give a three-minute oral poster presentation describing an evidence-based solution to address a local public health issue. Since 2016, in addition to student peers and Deakin academic staff, community members were invited to locally held presentations.

Aims/objectives: To pilot 'Speak out about health', a novel learning activity designed to enhance social accountability and community engagement in Deakin's Rural Community Clinical School (RCCS) program.

Methods: In 2016, the first 'Speak out about health' session was held in Southwest Victoria and community members were invited to attend. Following its success, in 2017 the initiative was expanded to six other RCCS townships.

Results: Sessions were well attended with between 10 and 40 participants including GP supervisors, mayors and health service CEO's. Community members actively engaged with the issues raised and the students' proposals. In one case a student's presentation on dental health and water fluoridation prompted the local councillor in attendance to take steps towards introducing water fluoridation in the town.

Discussion: Locating students' presentations in their community appears to have enhanced learning outcomes for students and increased engagement of the community in student activities. More formal evaluation of the outcomes of these presentations for students and their communities is planned.

Conclusion: Assessment presentations by medical students in public community fora are an innovative way of promoting social accountability and community engagement and have the potential to result in tangible community health benefits.

Paper ID: 102

Walking Together with Community

Ghislaine Pilot-Attema¹, Robert Baxter², Jennifer Fawcett³, Christina Graves³, Kristy Cote¹, Claudette Chase³, Paul Capon⁴ and Samuel Senecal³

¹ NOSM (Canada)

² Eabametoong First Nation (Canada)

³ Northern Ontario School of Medicine (Canada)

⁴ Matawa First Nations Management (Canada)

The Northern Ontario School of Medicine, in partnership with tribal councils and First Nation communities, have created unique learning opportunities at both the undergraduate and postgraduate level. NOSM and 43 Ontario First Nations and organizations have successfully partnered to bring an innovative curriculum module for undergraduate students. The module places all first-year medical students in an Indigenous community for an immersive four-week cultural experience. NOSM, Matawa First Nations Management (MFNM), and Eabametoong First Nation (EFN) collaboratively lead a residency stream in family medicine at the postgraduate level. This stream is built on foundational principles of equal partnership which include respect for the immemorial, constitutional, treaty and international rights of Indigenous Peoples. Our goal is to share knowledge and experiences of both of these partnerships to help inform other respectful and culturally safe partnerships and relationships.

Learning objectives:

1. Describe NOSM's Indigenous Affairs Unit Principles of Community Engagement in Undergraduate Medical Education (UME) along with NOSM, Eabametoong First Nation, and Matawa First Nations Management's unique tri-party residency stream in Postgraduate Medical Education (PGE).
2. Reflect on guiding principles created for both UME and PGE, and how they are translated into practice.
3. Reflect on Nation-to-Nation relationships which incorporate respectful partnerships where culture is interwoven into care for others and the education of medical learners and residents.

Paper ID: 103

Gathering Collective Wisdom: How is Indigenous Content Best Integrated in Residency Programs?

Ghislaine Pilot-Attema¹, Christina Graves², Claudette Chase¹, Robert Baxter³, Paul Capon⁴ and Jennifer Fawcett²

¹ NOSM (Canada)

² Northern Ontario School of Medicine (Canada)

³ Eabametoong First Nation (Canada)

⁴ Matawa First Nations Management (Canada)

PeArLs Session : The Northern Ontario School of Medicine (NOSM), Matawa First Nations Management (MFNM), and Eabametoong First Nation (EFN) collaboratively established a new residency stream in response to the needs of a remote First Nation community in northern Ontario. From the selection of the residents to the creation of the curriculum, all three partners are collectively involved in the process. This stream is built on foundational principles of equal partnership including respect for the immemorial, constitutional Treaty and international rights of Matawa First Nations and other Indigenous peoples. Identify how NOSM/MFNM/EFN can move forward with Indigenous content that is weaved into postgraduate programs using established best practices and the collective wisdom of session participants. By listening and learning from others in the field, we hope to tap into that knowledge to guide us as we continue to build on this residency program. We hope to have a collaborative discussion with participants to listen and build a network of educators in Indigenous culture, health and education. How is Indigenous content best integrated into existing residency programs? What are the challenges with integration? How much prior knowledge are we to assume our residents have? As we move forward with this residency program into other communities, how do we balance educational experiences that are community tailored with overall knowledge on living and working with Indigenous communities?

Paper ID: 104

Developing health professional education faculty in the Pacific

Louise Young¹, Sinead Kado² and Linda Sweet³

¹ College of Medicine and Dentistry, James Cook University (Australia)

² College of Medicine, Nursing and Health Sciences, Fiji National University, Suva, (Fiji Islands)

³ College of Nursing and Health Sciences, Flinders University (Australia)

Background

Since 2006, students from Pacific island nations have been sent to Cuba to train as doctors in a health system that emphasizes community and primary health care. They are now returning as interns to their home country. It has been found that they are not well prepared for hospital work as interns, and their supervisors had little experience supervising and educating interns. Faculty development for this role was required.

Method

This paper reports outcomes from a series of health professional faculty development workshops that have been undertaken in the Pacific, including Solomon Islands, Kiribati, Vanuatu, Palau and Fiji. These workshops aimed to upskill clinical supervisors with contemporary knowledge, skills and attitudes for learning and teaching in clinical settings.

Results

The presentation will describe the theoretical basis for the workshops, demonstrate the action research cycles applied, as well as the topics and skills covered. Outcomes from the workshops, including participant feedback will be described. A main outcome was the increase in teaching confidence as well as the development of educator skills. Recommendations for faculty development in other low resource countries will be discussed.

Discussion and Conclusion

One-week workshops are effective for developing faculty educator skills for clinical supervisors in Pacific Island nations. Core concepts such as learning as opposed to teaching, and active rather than passive learning were readily adopted by participants. A week-long workshop for developing a positive teaching culture and supervisor skills as educators, is currently the best fit for the Pacific in the light of clinicians' workloads and the availability of experts to teach. Although longitudinal training has been shown to be more beneficial, it will require local faculty to be trained to deliver this training for faculty development to be sustainable.

Take home messages

Week-long workshops are effective in increasing capacity in health professional education in low resource settings and where there is no previous teaching culture.

Paper ID: 105

Health system and community impacts from socially-accountable medical education in the Philippines

Torres Woolley¹, Fortunato Cristobal², Carole Reeve^{1,3}, Jusie-Lydia Siega-Sur⁴, Simone Ross^{1,5}, Andre-Jacques Neusy⁶ and Servando 'Ben' Halili²

¹ James Cook University (JCU) (Australia)

² Ateneo de Zamboanga University, Mindanao (ADZU) (Philippines)

³ Flinders University (Australia)

⁴ University of Philippine Manila, School of Health Sciences, Leyte (UPM-SHS) (Philippines)

⁵ Training for Health Equity Network, Belgium (THEnet) (Australia)

⁶ Training for Health Equity Network, Belgium (THEnet) (Belgium)

Introduction: Socially-accountable health professional education (SAHPE) institutions specifically develop student selection, curriculum and extended community-based student training strategies to produce graduates competent in locally-required skills and dedicated to strengthening local health systems. SAHPE institutions also have a social mission: to improve the health of community members equitably across all socio-economic, ethnic and cultural divides. However, very little published literature exists around the impact of SAHPE graduates on local health workforce and communities.

Aims/Objective: Undertake an impact evaluation (PIMS) to identify and quantify health workforce and community impacts from SAHPE students and graduates across multiple rural Philippines communities.

Methods: Two Philippines and two Australian 'SAHPE' medical schools developed and tested an impact evaluation involving both quantitative (graduate outcomes survey, maternal and child health community survey) and qualitative (case study) methodologies across two Philippines regions.

Results: Local health system and community impacts from SAHPE students and graduates included:

- increased health workforce recruitment and retention in rural and/or lower socio-economic areas
- "fit-for-purpose" students and graduates whom improve health equity and coverage, and can treat & prevent common health issues
- strengthened health services, social cohesion, health infrastructure, improved child & maternal health outcomes - often in communities which had not previously received them

Discussion: PIMS provided evidence that Philippines SAHPE institutions shape and train their students and graduates to have significant and wide-ranging impacts across local health systems and communities - fulfilling the concept of universal access to health.

Conclusions: Appropriately-designed impact evaluations can successfully evaluate the health workforce and community impacts from SAHPE programs.

Paper ID: 106

Does the rural pipeline influence rural general practitioner (GP) practice location and retention?

Jessica Ogden¹, Scott Preston¹, Riitta Partanen² and Remo Ostini²

¹ General Practice Training Queensland (Australia)

² The University of Queensland Rural Clinical School (Australia)

Background

There is currently a shortage of Australian-trained GPs in rural and remote locations of Australia. Research into factors influencing a GP's decision to practise rurally suggests that doctors with a rural background are more likely to practise in rural areas. Other influential factors include rural exposure during undergraduate medical training and vocational GP training. Given the implementation of recent government initiatives to increase recruitment and retention of rural Australian GPs, through supporting the increase of rural clinical exposure in undergraduate and postgraduate medical education, there is a need to synthesize the existing evidence and communicate this to policy-makers.

Aims

Summarise the quantitative evidence for the association between rural pipeline factors (rural background, rural clinical exposure during medical school and vocational training) and rural practice by systematically reviewing national and international published and unpublished reports.

Method

A systematic literature search was conducted for studies providing a clear and quantitative comparison of rural and urban GPs with and without a history of rural pipeline factors, including studies examining the relative importance of these factors in rural practice/retention.

Results

Following a systematic search and formal screening of search results against eligibility criteria, 26 observational studies involving a quantitative analysis of rural pipeline factors and rural practice were identified. Quality assessment of observational studies identified the majority of evidence ranged from satisfactory to very good quality.

Conclusion

Major findings of the review following synthesis of quantitative data will be discussed, including evidence of association between rural pipeline factors and rural practice.

Discussion

Implications of review findings will be discussed.

Paper ID: 107

Sky High Hopes: Supporting Aboriginal student plans to complete secondary school

Elsa Barton¹, Jessica Howard¹, Doug Turner¹, Jacob Jeffery¹ and Elena Rudnik¹

¹ Flinders University Rural Health South Australia (Australia)

Intro:

Aboriginal Australians experience disproportionately poor health outcomes despite multilevel initiatives to close this gap. The social determinants of health play a significant role in this disparity. Education as a determinant needs special attention as Aboriginal students have significantly lower rates of secondary completion. Whilst reviews have outlined the barriers and enablers for rural students accessing university, little literature is available regarding the Aboriginal Australian secondary school completion experience.

Aims/Objectives:

To investigate: (1) Barriers for Aboriginal secondary students to complete secondary school (2) Indicators of further study intention and unclear post school plans.

Methods:

Recruitment involved regular school visits, cultural activities and Aboriginal health expo attendance. Longitudinal semi-structured interviews with individual Aboriginal secondary school students explored experiences and further training intentions. Interviews were recorded, transcribed, and thematically analysed independently by three researchers. Ongoing consultation with Aboriginal Elders and Aboriginal health services informed interpretation.

Discussion:

Initial consultation and recruitment practices have generated positive interest and concern about Aboriginal student education. Initial findings will be presented at the Muster that address the feedback from students and the interpretation of barriers from a researcher and Aboriginal community perspective.

Conclusion:

Understanding barriers for Aboriginal student completion of secondary school requires a whole of community approach. This research is important as it specifically engages intergenerational members of the Mount Gambier Aboriginal community with the purpose of making recommendations and strategies to increase the numbers of Aboriginal students completing secondary school.

Paper ID: 109

Social Network Analysis of Rural Medical Networks after RCSWA

Denese Playford¹ and David Atkinson¹

¹ RCSWA (Australia)

Background

It is known that attracting new medical graduates to rural settings is difficult in all parts of the world, resulting in striking differences in distribution between the urban and the rural medical workforce. The Australian experiment with "Rural Clinical Schools", where pre graduate medical students live in a rural longitudinal integrated clerkship for one academic year, is having clear flow on rural workforce effects. But the impact of these new graduates on the social dimensions of the rural medical workforce has not been examined. Social Network Analysis is able to visualize and measure these dimensions.

Methods

Participants were medical graduates of the Rural Clinical School of Western Australia (RCSWA) from the 2001 - 2014 cohorts, identified as being in rural work in 2017 by the Australian Health Practitioner Regulation Agency. Social Network Analysis was used to examine the relationships between site of origin and of work destination. Data were entered into UCInet 6 as tied pairs, and visualized using Netdraw. UCINet statistics relating to node centrality were obtained from the node editor.

Results

124 of 709 graduates were in rural practice. Social Network Analysis measures showed that they were strikingly distributed across rural Australia, and that their practice was strongly focused on the North, with a clear centre in the very remote Western Australian town of Broome. Women were strongly recruited, and were widely distributed; they formed the majority of graduates in the Broome.

Discussion

Social Network Analysis showed the new concentration of medical workforce in the remote north of Western Australia. Positive social relationships appear central to this re-organisation. The RCSWA LIC appears to be a form of "weak tie": the School attracts students to rural nodes with which they had no or little prior contact. The multiple activities that comprise the social capital of the most attractive remote node demonstrate the distinctive workforce effects of being a "bridge, broker and boundary spanner" in Social Network Analysis terms. Social Network Analysis helps describe the "RCS phenomenon".

Paper ID: 111

The influence on distributed clinical training sites of undergraduate student placements.

Susan van Schalkwyk¹, Julia Blitz¹, Ian Couper¹, Marietjie de Villiers¹, Jana Muller¹, Guin Lourens¹ and Ben van Heerden¹

¹ Faculty of Medicine and Health Sciences, Stellenbosch University (South Africa)

Community-based education is a common strategy to improve the relevance of education and increase graduate retention in underserved communities. The Stellenbosch University Faculty of Medicine and Health Sciences offers differentiated experiences in five undergraduate health professions programmes, which include clinical involvement at multiple district and community health facilities.

We aimed to understand the views of key roleplayers at these facilities about the contributions made by students.

We analysed qualitative data obtained during interviews held at eight purposively selected public health care facilities. The facility manager, one clinical supervisor and one other clinician were invited to participate, leading to 24 individual, semi-structured interviews. We generated in-depth information on their perspectives of student contributions to their facilities.

Students' contributions coalesced around their influence on the facility and its staff, on patient care, on local communities served, and on clinical supervisors. Students are seen to foster interpersonal and collaborative approaches to care, lighten the workload, encourage adoption of evidence-based practices, and improve quality of health care.

This study shows clearly that students have a positive effect on health care services, moderated by critical factors such as clinicians involving students in everyday practices of the clinical team and enabling the pursuit of their learning outcomes. To achieve this, issues need to be addressed such as the nature of the students, space and time, and adequate supervision.

Provided certain conditions exist, students in distributed clinical training sites make an important contribution to health care. Regardless of the situation, students add value to the health service.

Paper ID: 112

Insights into rural and remote GP training and supervision in Queensland

Louise Young¹, Raquel Peel¹, Carole Reeve¹, Bunmi Malau-Aduli¹, Belinda O'Sullivan² and Richard Hays¹

¹ College of Medicine and Dentistry, James Cook University (Australia)

² School of Rural Health, Monash University (Australia)

Many rural and remote communities are struggling to attract and retain GPs while experiencing poorer population health outcomes and burden of disease. Therefore, the provision of a reliable rural GP workforce is vital.

Registered Training Organisations provide high quality training experiences for GP registrars. A collaborative project between JCU and Monash University aimed to identify aspects of GP training which impact registrars' experience. Perspectives were obtained from GP registrars, supervisors, and practice managers. This presentation focuses on training and supervision aspects in rural and remote north-west Queensland.

A mixed methods study was undertaken and both quantitative and qualitative data were collected. A modified survey based on the adapted Critical Access Hospital Community Apgar Questionnaire was used to collect data about perceptions of rural GP training and supervision with the highest rated factor being medical quality and the lowest rated being scope of practice.

Semi-structured interviews were then used to gather additional information about training and supervision experiences. Interviews were thematically analysed and primary themes relating to attractors and barriers for workforce training and supervision, and impact of rural remote practice were elicited. Attractors included lifestyle, rural medicine, scope of practice, services and incentives while barriers included workforce factors, lifestyle, location, services and incentives.

Rural remote GP training experiences contribute a variety of attractors and barriers which impact on a positive training experience for registrars. Identification of these factors make it possible to tailor training accordingly and foster a positive rural experience that may translate to a future reliable workforce.

Paper ID: 114

The social impact of medical students on a rural community of practice

Hayley Purcell¹ and Vanessa Ryan²

¹ Flinders University (Australia)

² Flinders University Rural Health South Australia (Australia)

Background:

It is well established that Longitudinal Integrated Clerkships (LICs) offer many benefits for medical students, General Practitioners (GP), patients, and the wider community, including: improved student performance and confidence; symbiotic learning between GP and student; GP enjoyment; improved quality of patient care; and increased recruitment to the rural health workforce. However, there is little evidence for the impact of medical students on the rural community of practice.

Aims:

This project aims to examine whether these benefits can be seen in a specific rural medical clinic in the Murray Mallee region of South Australia, and the impacts medical students have had on this community of practice. As the existing literature focuses on the experiences of GPs, students, and patients; this study will focus on the whole community of practice, and whether the experiences of other clinical and administrative staff are similar to that of the GPs. This project aims to contribute to existing knowledge and evidence for the positive benefit of including medical students in communities of practice.

Methods:

Focus groups involving members of the administrative, clinical, and General Practitioner staff of a clinic in the Hills Mallee Fleurieu (HMF) region of the Parallel Rural Community Curriculum (PRCC) will be used to examine the social relations in the community of practice, and how they are affected by the inclusion of medical students.

Conclusion:

This presentation will discuss the importance of communities of practice to the success of LICs, and explore in more detail the aims and objectives of this project.

Paper ID: 115

Open Your Mind to the Influence and Value of Law in Your Practice

Patricia Carlisle¹

¹ University of Adelaide (Australia)

Law in medicine is often considered an obscene expletive, only spoken in the most derogatory of ways. The myth remains that the application of law to clinical practice relies upon not "being sued" and the misunderstanding that it doesn't matter until a mistake is witnessed. Curiously, however, and a truth that is rarely acknowledged, is that most aspects of clinical practice in the healthcare setting are underpinned by the law and its derivatives: Codes, Legislation, Policies, Procedures, and Regulations. A cursory overview of some essential topics in health law: consent, confidentiality, coroners matters, mandatory reporting and privacy, are foundational to a medical practitioner's armoury of theoretical and clinical knowledge. None more so than in the smaller and less funded rural communities whose ready access to such education is less appreciated. A Rural Medical Education Programme that fails to understand the rightful place of law in the education of medical practitioners fails to appreciate the centrality of law in clinical medical practice. The association of medicine with law will remain an obscene expletive until we dare to embrace the value of each highly regarded profession, medicine and the law, and appreciate their respective positions that work together to enhance a consumer centred framework of care. A concern remains that a knowledge of the law and its derivatives will continue to be entrenched in the myths and misunderstandings inherited and dispersed from hospital corridors and stylised television dramas.

Paper ID: 117

Franco Doc: A model to develop French-speaking human resources in Francophone minority communities

Danielle Barbeau-Rodrigue¹, Aurel Schofield² and Philippe Leblanc³

¹ École de médecine du Nord de l'Ontario (Canada)

² Association of Faculties of Medicine of Canada (Canada)

³ Association of Faculties of Medicine of Canada (Canada)

The Association of Faculties of Medicine of Canada in association with community partners launched the Franco Doc project. Having identified the need to provide better access to health care for French-speaking Canadian in official language minority communities, Franco Doc was launched to address this problematic.

The goals of Franco Doc were to identify and mobilize Francophone and Francophile students, prepare and equip them for work in the community and recruit them for placements in official language minority communities.

By working in partnership with community partners, Franco Doc helped to facilitate alliances among faculties of medicine, community health networks and other organizations to set up a liaison committee between each faculty and the community in order to encourage them to maximize the recruitment and facilitate the integration of French-speaking health care professionals in these communities. By placing the communities at the center of the initiative, it allowed communities to take an active part in educating learners and education establishment about their realities and for faculties to respond appropriately.

The Franco Doc project discovered that approximately 200 French-speaking medical students enter the Canadian medical schools each year. Our 14 liaison committees and working with those student and are putting together learning activities and networking event to provide those new students with a better understanding of medical terminology and the reality of access to health care in minority community. The model of the project could be duplicated and used for other communities in need as well.

Paper ID: 118

School Based Approach to Community Engagement in Young Medical Students, a Preliminary Report

Piyaon Numpaisal¹ and Seekaow Churproong¹

¹ Institute of Medicine, Suranaree University of Technology (Thailand)

A rural community-based medical program commenced at Suranaree University of Technology, Institute of Medicine to address the insufficient number of doctors working in rural areas. Early and continuously expose to rural communities is a key success of this program. There are many community engagement tools to draw on, but these are often complex and not suitable for first and second year medical students. Schools are a central part of the community in rural areas, providing education and recreation. A school-based approach to community engagement was trialled with students in their second year of medicine. . . Students were given a school-based activity and divided into groups of 10-12. Each group explored a health promotion problem affecting children and teachers at the local school. Projects included; scabies eradication, dengue fever prevention, dental caries management and childhood obesity. Students worked collaboratively with local health personnel and key stakeholders in the community. Preliminary evaluations reported positive feedback from students, who reported greater understanding of health promotion principles and community culture and norms. In conclusion, a school-based approach is a practical tool for community engagement that can enhance learning in young medical students.

Paper ID: 119

Barriers to Health Education Programs in Remote Communities - Padstow, South Africa

Nicola Robinson¹, Myra Hales¹ and James Burgess¹

¹ Flinders University (Australia)

Introduction

In the remote community of Padstow, South Africa, communicable and non-communicable health concerns are exacerbated by the rurality and resource-poverty of the village. Community health workers (CHWs) are lay people from this community, who work to support healthcare services. CHW-delivered community education programs may benefit Padstow village by increasing health literacy. Barriers to implementing such a program are many and varied, and will be discussed in this presentation.

Aims/Objectives

The project aims to develop an understanding of the barriers to remote community education utilising CHWs, whilst also improving health literacy and empowering community members to engage with their health.

Methods

The initial needs analysis consisted of interviews with key community members. A screening event was held to gather data regarding common conditions. Data analysis demonstrated a high prevalence of undiagnosed hypertension and limited community knowledge. A targeted program aimed at community hypertension screening and education was therefore developed and delivered. Post-delivery evaluation was conducted through interviews and reflections, which were thematically analysed to determine the major barriers associated with the implementing the program.

Discussion

Ethical and logistical matters were identified as barriers. Ethical issues comprised of confidentiality, increasing resource demand, mediation with community members, and sustainability. Logistical issues included village mapping, ensuring patient comprehension, the political climate, and community events.

Conclusion

Understanding the barriers to implementing CHW targeted health education programs will improve development of such programs. Prior knowledge of potential logistical and ethical issues will increase education efficacy, improving community health outcomes.

Paper ID: 120

Franco Doc: A training model geared towards the needs of Francophone minority communities

Aurel Schofield¹, Danielle Barbeau-Rodrigue² and Philippe Leblanc³

¹ Association of Faculties of Medicine of Canada (Canada)

² École de médecine du Nord de l'Ontario (Canada)

³ Association of Faculties of Medicine of Canada (Canada)

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The Franco Doc project discovered that approximately 200 French-speaking medical students enter the Canadian medical schools each year. Our 14 liaison committees and working with those student and are putting together learning activities and networking event to provide those new students with a better understanding of medical terminology and the reality of access to health care in minority community. The model of the project could be duplicated and used for other communities in need as well.

Paper ID: 121

OUCH! (Ownership, Understanding, Curiosity, Healing): Helping students overcome "very bad days"

Galina Gheihman¹ and Cynthia Cooper²

¹ Harvard Medical School (United States)

² Massachusetts General Hospital (United States)

Introduction/Background

Medicine demands excellence, precision, and confidence. This "culture of perfection" is introduced during training and reinforced by explicit and implicit messaging. Medicine is also a field where conflict, difficult emotions, imperfect interactions, and bad outcomes are frequent; a career that inevitably includes "very bad days." Trainees without strategies to address and recover from "very bad days" may resort to self-blame, avoidance, and depersonalization--maladaptive strategies that undermine students' performance, wellbeing, quality of patient care, and team relationships.

Overcoming obstacles and negotiating team dynamics is especially important in the LIC setting, where students develop longitudinal relationships with patients, preceptors, and teams.

We believe medical students can and should be equipped with formal training on overcoming personal obstacles and conflicts they will encounter during training. We offer OUCH! (Ownership, Understanding, Curiosity, Healing) - a practical framework to guide trainees through a reflective and constructive process to overcoming these challenges.

Learning Objectives

Participants will be able to

1. Describe common training conflicts and share their own experiences of "very bad days;"
2. Apply the OUCH framework to a case and reflect, inquire, and create an action plan to move forward;
3. Tailor the OUCH framework to challenges faced by trainees at their school.

Activities/Areas for Exploration (90 mins):

1. Review of common training conflicts
2. Small-group sharing of personal "very bad day" experiences
3. Discuss/analyze sample case study and apply OUCH framework
4. Large-group discussion of case, the OUCH framework, and opportunities to guide/support students overcoming "very bad days."

Paper ID: 122

Practical Tools to Promote Medical Students' "Everyday Resilience"

Galina Gheihman¹, David Sloane², Nora Osman², Tara Singh³, Rachel Hathaway³ and David Hirsh¹

¹ Harvard Medical School (United States)

² Brigham and Women's Hospital (United States)

³ Cambridge Health Alliance (United States)

Introduction/Background

Burnout appears to be a rising epidemic among practicing physicians and medical students alike. While longitudinal clinical experiences offer students valuable learning opportunities, they also expose medical students to the challenges inherent to engaging and caring for patients - humans who are suffering. The literature also notes the demands of working in remote settings and with underserved populations. Students need adaptive skills to cope with these stressors. Developing resilience and coping skills can help increase students' wellbeing and efficacy during times of adversity and stress in training.

This workshop introduces participants to the concept of "Everyday Resilience." Participants will partake in the training themselves and then learn to train their students. The workshop will be interactive and involve hands-on application of two "resilience tools" ("Breaking Down Easy" and "My Resilience Practice"), large group discussion, and time to reflect on resilience as a daily practice.

Learning Objectives

Participants will be able to

- Define resilience and its role as a protective factor against burnout
- Apply two practical, easy-to-use tools to promote resilience as a daily practice
- Propose opportunities to teach and promote resilience among medical students

Activities/Areas for Exploration (90 min):

1. Define resilience and review data on burnout in medicine
2. Application of two resilience tools and small group discussion:
 - a. "Breaking Down Easy"
 - b. "My Resilience Practice"
3. Large group discussion: reflection on applying tools, and identifying opportunities to teach resilience among medical students at participants' home institutions
4. Wrap-up and takeaways

Paper ID: 123

Feedback in the era of pass-fail, self-driven, longitudinal curricula

Galina Gheihman¹, Josephine Fisher¹, Cynthia Cooper², John Flanagan¹, Henrike Besche¹, Eli Miloslavsky², Bianca Shagrin³ and David Hirsh¹

¹ Harvard Medical School (United States)

² Massachusetts General Hospital (United States)

³ Cambridge Health Alliance (United States)

Introduction/Background

The empirical sciences of learning are driving medical schools to create curricula that promote self-directed learning just as student assessment is shifting to pass-fail models and high-bar criterion referencing. Models promoting competency-based education and testing-for-learning abound. With such shifts, medical educators must balance formative "assessment for learning" and summative "assessment of learning" to support and document students' progression.

Feedback to students drives students' learning, yet remains challenging. Feedback may even undermine learning if perceived as judgment by students. Mechanisms of feedback have not kept pace with changes in curricular stance, structure, and pedagogy. Programs continue to struggle with developing a safe feedback culture.

In this PeArLS session, we invite participants to think creatively about opportunities to give students appropriate and valuable feedback that is timely, relevant, specific, and actionable.

Aims/Objectives

Participants will be able to

1. Define high-value feedback in new educational structures;
2. Describe how feedback should be adapted in novel curricular and assessment contexts;
3. Identify innovative solutions, mechanisms, and opportunities for offering student feedback and promoting a feedback culture in this new era

Questions/Issues for Exploration:

1. How should feedback change to meet new curricular models?
2. In self-guided learning, how do we ensure timely, specific, actionable, and relevant feedback? How do we now balance formative and summative feedback? What tools exist to help?
3. How do we assess the quality of the feedback we provide students?
4. How might novel student feedback mechanisms be implemented (e.g. peer-to-peer feedback, patient feedback, using technology, etc.)?

Paper ID: 124

Community Partnerships: A Collaborative Selection Process for a Remote First Nations Program Stream

Robert Baxter¹, Paul Capon², Claudette Chase³, Jennifer Fawcett³, Catherine Cervin³, Kristy Côté³, Ghislaine Attema³ and Christina Graves³

¹ Eabametoong First Nation (Canada)

² Matawa First Nations Management (Canada)

³ Northern Ontario School of Medicine (Canada)

Introduction

The Northern Ontario School of Medicine (NOSM), Matawa First Nations Management (MFNM), and Eabametoong First Nation (EFN) collaboratively established a new residency stream in response to the needs of a remote First Nation community in Northern Ontario. The stream is built on foundational principles of equal partnership including respect for the immemorial, constitutional, Treaty and international rights of Matawa First Nations and other Indigenous Peoples.

Aim

NOSM, MFNM, and EFN developed a selection process that is equally driven by community determination of the best physician candidate for their community, and meeting NOSM's requirements for residency program entry. Collaboration ensured respect for both community and NOSM requirements for a successful residency match.

Discussion

File review and interview questions were co-created and designed around holistic spiritual, social, physical, and mental attributes of the medicine wheel. The selection process is completed in two phases where phase one includes NOSM representatives and EFN community members who interviewed and short-listed candidates to move to the second round. The second phase was comprised of EFN community representatives who interviewed candidates on-site in EFN to showcase the community and ensure candidates were provided a realistic preview of residency training and community life.

Discussion

The selection process is significant because NOSM, MFNM, and EFN collaborated at all junctures in the process, and the community (EFN) made the final decisions for community suitability. This unique process demonstrates collaboration and community self-determination. Discussion will focus on lessons learned and the successes and challenges with this approach.

Paper ID: 125

Quality improvement, systems thinking, and delivery science: what do medical students need to learn?

Galina Gheihman¹, Anjala Tess², John Flanagan¹, Henrike Besche³, Maren Batalden⁴, Yamini Saravanan⁴, Lindsay Mazotti⁵ and David Hirsh¹

¹ Harvard Medical School (United States)

² Beth Israel Deaconess Medical Center (United States)

³ Harvard Medical School (United States)

⁴ Cambridge Health Alliance (United States)

⁵ University of California, San Francisco (United States)

Introduction/Background

Health systems and medical schools proclaim the importance of developing students' skills in quality improvement (QI), systems thinking, and delivery science. Graduate medical education in the US now requires such training and accordingly undergraduate medical curricula are increasingly emphasizing these topics.

To address this emerging need, Harvard Medical School (HMS) is considering the development of a new advanced integrated science course (AISC). This AISC will integrate classroom-based learning with field- and clinical-based experiences. Year long LICs such as HMS's Cambridge Integrated Clerkship are also leveraging students' longitudinal relationships with patients and preceptors to introduce concepts of QI, systems thinking, and delivery science. The new Kaiser Permanente School of Medicine aims to train students in these domains over a four-year longitudinal curriculum. These programs highlight three examples of integrating QI, system thinking, and delivery science content into medical curricula - what other ideas, methods, and opportunities exist?

Aims/Objectives

Participants will be able to

1. Describe the importance of QI and delivery science training
2. Highlight three examples of integrating QI and delivery science content in medical school curricula
3. Discuss additional opportunities to introduce this training to medical students

Questions/Issues for Exploration:

1. What topics/skills should medical students learn and practice in quality improvement, health systems, and delivery science?
2. What are other schools doing to build students' knowledge and skills in QI and delivery science?
3. How can we leverage longitudinal clinical experiences to augment and reinforce classroom-based learning of QI and delivery science?

Paper ID: 126

Comparison of *Toxoplasma gondii* prevalence in humans on Kangaroo Island and mainland South Australia

Annabelle Askew¹, Henry Rodriguez¹, Vanessa Ryan², Patrick Taggart³, Chris Lease⁴ and Elena Rudnik²

¹ Flinders University (Australia)

² Flinders University Rural Health SA (Australia)

³The University of Adelaide (Australia)

⁴SA Health (Australia)

While in the Parallel Rural Community Curriculum (PRCC) medical students in their penultimate year live and learn in a rural community. The program aims to immerse students in rural and remote medicine and this experience often translates into graduates of this program returning to work in rural environments. Throughout the Doctor of Medicine course students complete a compulsory supervised research project or select postgraduate coursework. This presentation will discuss the multifaceted teamwork required to bring an innovative research project to a remote part of South Australia (SA). The *Toxoplasma gondii* (*T. gondii*) seroprevalence project is a comparison of the seroprevalence of *T. gondii* between Kangaroo Island (KI) and rural SA. There is little data exploring *T. gondii* in Australian human populations but preliminary animal studies have shown a higher prevalence of *T. gondii* on KI compared to mainland SA. The prevalence data is significant as it will provide preliminary data on a public health issue that can have real benefits for the communities in which the students are based for the year. The innovative nature of this project coupled with the multiple geographically distributed stakeholders has presented a challenging path for the students, supervisors and GP practices to negotiate. The experience has highlighted many learning opportunities about research, community engagement and geographic dispersion, many of which were not anticipated when the research question was developed three years ago. This presentation will introduce the project and discuss the complexities of collaboration encountered when bringing together multiple stakeholders.

Paper ID: 127

Défis, perspective, expérience : la responsabilité sociale dans une université en zone post-conflit.

Gyavira Mushizi Barhageranya¹ and Andre-Jacques Neusy²

¹ Université Officielle de Bukavu (UOB) (Congo, The Democratic Republic of the)

² Training for Health Equity Network THEnet (United States)

Contexte

L'Université Officielle de Bukavu (UOB), située dans la capitale de la province du Sud Kivu République Démocratique du Congo est la seule université gouvernementale de la région servant une population de 6 million récupérant d'un conflit responsable de plus de 4 million de morts (98% des décès attribués aux maladies et malnutrition). Sa faculté des sciences de la santé comprenant une école de médecine, de santé publique et de pharmacie, durement éprouvée par des années de guerre est engagée dans un difficile processus de reconstruction. Pour répondre à sa responsabilité sociale d'adresser les besoins de santé prioritaires de sa population, elle fait face à d'immenses défis au niveau de son infrastructure et équipement d'enseignement, formation du corps enseignant et sites de formation clinique.

Objectifs

1. Compréhension des défis rencontrés par une faculté de médecine avec peu de ressources pour concrétiser le principe de responsabilité sociale dans un environnement post-conflit
2. Sensibiliser la communauté académique internationale aux besoins de partenariats académiques ciblés
3. Compréhension partagée sur le rôle des partenaires académiques dans le renforcement des capacités de l'UOB

Discussion comprenant des questions/problèmes à explorer

Quelles sont les stratégies essentielles pour aligner le curriculum avec les besoins en tenant compte des réalités du terrain ?

Comment renforcer le développement du corps professoral ?

Comment renforcer les infrastructures et matériels d'enseignement et d'apprentissage exploitant les technologies de l'information (e-Learning et e-Health) ?

Comment aligner les priorités souvent compétitives des différents acteurs locaux, les prestataires de service, les ONG et les donateurs internationaux pour soutenir le développement de l'éducation médicale à l'UOB ?

Paper ID: 128

A Call for Change Agents: The role of medical students in clinical and educational transformation

Galina Gheihman¹, Marni Krehnbrink², Yamini Saravanan³, Bruce Peyser⁴, Alexandra Bocharnikov⁵, Joshua Onyango², Aarti Thakkar⁵, and David A Hirsh^{1,3}

¹ Harvard Medical School (United States)

² UNC Chapel Hill School of Medicine (United States)

³ Cambridge Health Alliance (United States)

⁴ Duke University Medical Center (United States)

⁵ Duke University School of Medicine (United States)

Introduction/Background

Medical educators design longitudinal integrated clerkships (LICs) to address gaps in health professions education and care delivery. An unexpected outcome of the rise of these models is medical students' advocating for novel, expanded, value-added roles for themselves on healthcare teams. LIC students advocate for their patients, heed the call to improve health professions education, and work to improve the health care system by identifying quality improvement opportunities and proposing creative solutions. This workshop will serve as a "think tank" to animate possibilities for students' advocacy, learning, and leadership in the future of education and care delivery transformation.

Learning Objectives

Participants will be able to

1. Describe the foundational principles of LIC programs
2. Recognize the transformative roles of LIC students within healthcare teams at three US medical schools
3. Consider opportunities for students' advocacy, learning, and leadership in educational and care delivery redesign

Areas for Exploration/Activities (90 min):

1. Introduction: Define principles of the LIC training model
2. Panel: LIC students share their experiences and highlight transformational student-led advocacy initiatives, research projects, and curriculum reform
3. Small groups:
 - a. Creating opportunities for students to play active roles in advocating for patients
 - b. Creating opportunities for students to participate in medical education curriculum development and research projects
 - c. Using principles of the LIC training model to transform education and care delivery structures
4. Large group:
 - a. "Speed round" sharing of ideas on value-added roles for medical students
5. Wrap up and key takeaways

Paper ID: 129

Students Use Design-Thinking and Quality Improvement Tools to Care for High-Risk Patients

Yamini Saravanan¹, Galina Gheihman², Tara Singh¹, David Hirsh² and Maren Batalden¹

¹ Harvard Medical School/Cambridge Health Alliance (United States)

² Harvard Medical School (United States)

Longitudinal integrated clerkships (LICs) bridge medical training with the needs of patients and communities. In LICs, students learn to diagnose, treat, prognosticate, advocate, and care for patients by considering multiple contextual factors: patients' experience of illness and preferences, the scientific basis of disease, the clinical evidence base, social determinants of health, health systems factors, and national policies related to health and healthcare. In the United States, "complex" and "high-risk" patients with co-comorbid medical and psychiatric illnesses, have increased utilization rate and less satisfaction and engagement with care.

We describe an innovative curriculum within Harvard's Cambridge Integrated Clerkship (CIC). Using design-thinking and Quality Improvement tools, students learn to approach complex/high risk patients with compassionate curiosity. Students develop medical and psychosocial narratives to describe the drivers of a patient's current health and healthcare. Using visual tools (bone analysis or journey map), students work in small groups with faculty to identify opportunities to improve patients' care and/or engagement. Students then collaborate with their patients to develop a shared-care plan, including the patient's priorities and capacity. Curriculum assessment involves student and faculty reflections and patient experiences (patient satisfaction, coordination of care, patient engagement) and clinical outcomes.

This curriculum (1) develops students' skills to collaboratively care for and with complex patients and (2) uses patient experience and outcomes to inform the medical curriculum.

Paper ID: 131

The Birth of SLICC (Students for Longitudinal Integrated Clerkships and Curricula)

Galina Gheihman¹, Alexandra Bocharnikov², Aarti Thakkar², Joshua Onyango³, Bruce Peyser⁴ and David Hirsh¹

¹ Harvard Medical School (United States)

² Duke University School of Medicine (United States)

³ UNC Chapel Hill School of Medicine (United States)

⁵ Duke University School of Medicine, Department of Internal Medicine (United States)

Background: In 2007, leaders formed CLIC to provide resources and a supportive community for institutions running or implementing longitudinal integrated clerkships (LICs). In 2017, student members of CLIC founded SLICC, Students for Longitudinal Integrated Clerkship and Curricula, the student arm of this community of educators and researchers.

Aims: SLICC aims to connect students involved in LIC curricula or longitudinal clinical programs internationally. This network provides peer-to-peer and alumni support, access to shared resources, ideas, and mentors, as well as research and educational opportunities.

Methods: SLICC was founded at CLIC 2017 and has continued to evolve. SLICC communicates through Facebook, open teleconference calls, and shared online documents. The network has recruited students and alumni internationally and is working to streamline organizational processes, seek financial support, and identify research and advocacy opportunities.

Results: SLICC currently represents 10 international LIC medical school curricula and 4 student-led longitudinal care groups. SLICC has student representation on the CLIC committee and also represents the student voice in the restructuring of the CLIC website. SLICC is promoting student participation at CLIC 2018 and will host student-centered events at the conference. SLICC's first collaborative student-led medical education research project is now underway. Future opportunities include developing international clinical and scholarly exchanges.

Discussion/Conclusion: SLICC supports students embarking on non-traditional, longitudinal forms of clinical training and those seeking medical education reform. SLICC demonstrates undergraduate medical students are capable of self-directed leadership and organization. The network cultivates community, fosters innovation, and promotes student advocacy for educational transformation and health care reform.

Paper ID: 132

Sensitivity to psychosocial factors: a comparison between two different clerkship programs in Taiwan

Hsin-Mei Pan^{1,2}, Yaw-Wen Chang¹ and Shih-Chung Huang³

¹ Tri-Service General Hospital,

² National Defense Medical Center (Taiwan)

³ Kaohsiung Armed Forces General Hospital (Taiwan)

Introduction

The biopsychosocial model has been considered as a holistic health care approach in clinical practice. From the perspective of medical education, we expect students involved in longitudinal integrated clerkship (LIC) and rotation-based clerkship (RBC) all become sensitive to the influence of psychosocial factors on illness. However, we notice that the RBC puts more emphasis on biomedical model and disease-based clinical knowledge while the LIC highlights the importance of patient-centeredness and the continuity of clinical care.

Aims

To understand whether there is a difference in the sensitivity of identifying the psychosocial factors of illness between students in two different programs: the RBC and LIC at the terminal stage of the students' first-year clerkship.

Methods

Six LIC and six RBC students are interviewed with a semi-structured, in-depth interview framework. A general inductive approach is applied in the analysis.

Result

LIC enables participants to develop sensitivity to the psychosocial factors on illness.

Discussion

The LIC students are asked to foster close and continuous contact with patients, from which the students learned patient's experience of illness. This experience enables the LIC students to learn from the patients' narratives and to recognize the influence of psychosocial factors on illness. The RBC students are asked to complete the assigned ward routine and have less opportunity to interact with the patients; therefore, the RBC students have less sensitivity to the psychosocial factors on illness.

Conclusion

The RBC should be modified to enable the students to develop sensitivity to the psychosocial factors on illness.

Recruit and Retain in northern Iceland

Sigurður Sigurðsson¹, Hildigunnur Svavarsdóttir¹, Bjarni Jonasson¹ and Roger Strasser²

¹ Akureyri Hospital Iceland (Iceland)

² Northern Ontario School of Medicine (Canada)

Akureyri Hospital is a small hospital serving rural areas in the northern part of Iceland. A long-standing challenge has been to recruit and retain physicians in the hospital needed to provide services in the local and surrounding communities. This is not isolated to Iceland but a global problem.

The participation in EU funded programs *“Recruit and Retain”* and then *“Recruit and Retain - Making it Work”* has led to new and innovative focus to solving the problems relating to the recruitment of health care personnel. The transnational cooperation between five nations in the rural Nordic and arctic areas has led to innovative interventions to tackle the lack of specialized health care personnel in rural and remote areas.

- An engagement from the municipality to underline the importance of the social aspect of recruitment is important especially to foreigners as well as Icelanders.
- An understanding of professional isolation and measures to counteract is an important factor in retention.
- Participating in educational programs of physicians in the specialist training has given the Akureyri Hospital opportunity to be more recognized in its target groups of physicians.
- Regular visits to medical schools in Iceland and abroad has opened up channels to larger numbers of possible candidates.
- Regular visits to Icelandic physicians abroad have been greatly appreciated.

Although not all physicians positions have been filled the situation in Akureyri Hospital has improved considerably. For example five new specialists in orthopedics and general surgery have been recruited that before relied on inconsistent locums. The result so far encourages for further use and development of the business model for other health care professions.

Paper ID: 135

Animating EPAs through LICs: Deliberate Design of Structure and Function

Ellen Cosgrove¹, David Hirsh², Robert Englander³, John Dalrymple², Anne Pereira⁴, Gary Shen⁵, Edward Simanton⁵ and Corrin Sullivan⁵

¹ University of Nevada Las Vegas School of Medicine (United States)

² Harvard Medical School (United States)

³ University of Minnesota Medical School (United States)

⁴ University of Minnesota School of Medicine (United States)

⁵ UNLV School of Medicine (United States)

Entrustable Professional Activities (EPAs) offer faculty the means to make competency-based decisions based on observing medical students in authentic patient care experiences. The EPA assessment framework connects closely to and benefits from continuity of learner-teacher relationships. The longitudinal design of education affords faculty "time to trust" and may support opportunities for and evaluation of student competency. The purpose and structure of longitudinal integrated clerkships (LICs) emphasize continuity and the progression of students' developmental learning under extended supervisor-supervisee relationships. This session considers how longitudinal design may inform our use of EPAs in longitudinal and non-longitudinal contexts alike. Faculty will engage in discussion to consider how to structure and foster observational experiences and developmental evaluations to assess student performance through EPAs.

Learning Objectives:

By the end of the session, participants will be able to

- list the features and guiding principles of a longitudinal integrated clerkship (LIC);
- correlate the EPA model of assessment to the LIC model of clinical education; and,
- define ways to incorporate EPA assessment (approaches/methods and outcomes) into educational design within and beyond LICs.

Session Plan:

Plan

1. Introduction of Topic - EPAs & LICs
2. Facilitated small group discussion at tables
3. Open mic - Controversies and next steps
4. Key themes from the discussion - invitation to join informal, online working group to address and refine issues identified in the session.

Paper ID: 136

From Conception to Inception: Scaling Up the LIC from Pilot to Whole School

Ellen Cosgrove¹, David Hirsh², Robert Englander³, John Dalrymple², Anne Pereira⁴, Gary Shen⁵, Edward Simanton⁵ and Corrin Sullivan⁵

¹ University of Nevada Las Vegas School of Medicine (United States)

² Harvard Medical School (United States)

³ University of Minnesota Medical School (United States)

⁴ University of Minnesota School of Medicine (United States)

⁵ UNLV School of Medicine (United States)

The training of modern physicians requires new models of clinical education that produces specialist and generalist clinicians capable of working effectively with teams in ambulatory settings. Longitudinal Integrated Clerkships (LICs) create student participation in the comprehensive care of patients over time, the continuity of learning relationships with patients and their clinicians, and meet the majority of the expected core, clinical competencies across multiple disciplines simultaneously. This session offers the lived experiences from leaders at three schools to trigger a discussion of perceived barriers and actual solutions to clinical education redesign.

Participants will engage in facilitated small and large group discussions to consider the growing model of structural redesign of clinical education, culminating in the LIC. Discussants will guide participants to deliberate about practical means to implement and scale LICs (or other such restructuring) so as to transform student learning relationships and outcomes.

The LIC Continuity Model

- Patient Panel
- Longitudinal Preceptors
- Faculty Advisors/Mentors
- Continuity with peers
- Continuity with site/system/community
- Developmental curriculum

Learning Objectives:

By the end of the session, participants will be able to

- list the essential features of a longitudinal integrated clerkship, LIC;
- describe the rationale for and guiding principles, goals, and growth, of LICs;
- describe perceived barriers to scaling LIC models; and,
- develop steps to address perceived barriers to creating and scaling LICs or other innovations in the structure of clinical education.

Session Plan:

Plan

1. Introduction of Topic - The LIC Model - Planning, Development, Evaluation & Execution with brief examples of three institutions
2. Facilitated Round table Discussions of perceived barriers and overcoming barriers to developing LICs or other innovative redesigns of clinical education
3. Open mic - Facilitated discussion of controversies, solutions, and next steps
4. Final thoughts/wrap-up - invitation to join informal, online working group to address and refine issues in the LIC model

Paper ID: 137

Ethical Professionalism development through Longitudinal Integrated Clerkships in Taiwan: A qualitative study

Chaoheng Kao^{1,2}, Yan-Di Chang^{1,2}, Yaw-Wen Chang² and Wen-Hui Fang^{1,2}

¹ Medical student / Tri-Service General Hospital (Taiwan)

² National Defense Medical Center, Taipei (Taiwan)

Purpose

In recent years, medical disputes have been a critical issue in Taiwan. The main reasons are because doctors show indifference or non-understanding towards patients. Thus, it is important to establish a training environment for medical students that promote empathy. This pilot study investigated whether Longitudinal Integrated Clerkships (LIC) strengthen ethical professionalism in medical students.

Method

Medical students from National Defense Medical Center who participated in the half-year LIC program between 2015 and 2018 were interviewed. We asked if students going through LIC were more willing to care for their patients and if they could communicate more effectively. The interviews consisted of three aspects: motivation to sign up for the program, self-reported changes in clinical practice, and clinical abilities after going through the LIC.

Results

LIC students reported increased professionalism in terms of altruism, ethics, cultural sensitivity, and humanistic care. They were less afraid of and more willing to take care of their patients after factoring in their level of self-motivation before LIC. Also, we notice that students who attend LIC get more confident when facing patients as an intern.

Discussion

The main features of LIC are continuity in clinical learning, education, and patient care. Thus, they provide medical students with ample chances to strengthen their professionalism through more contact with and care of their patients. Whether we can create a proper environment for medical students to learn in their clerkship, it still depends more data and time to approve it.

Conclusion

Participating in LIC may improve students' motivation to understand, communicate with, and take care of patients. However, further studies are needed to confirm if and in what ways students' clinical abilities are improved. Besides, difference for students who attend in LIC or RBC should be clarified. Follow-up is also required to reassess ethical professionalism in the students.

Paper ID: 138

Rural health research innovations in sparsely populated areas: finding true (mid) North

Heidi Hodge^{1,2} and Dean Carson³

¹ Flinders University Rural Health South Australia, and

² Charles Darwin University (Australia)

³ Charles Darwin University (Sweden)

Small rural communities are often overlooked in favour of larger regional centres to participate in rural medical education and research programs. These are the very communities who stand to benefit from access. A small but growing number of rural health research ventures are emerging in sparsely populated areas. These have the potential to host non-clinical placement programs utilising non-GP supervisors, and offer an alternative approach to participate in globally important research from small and rural non-campus locations.

We explore such two case studies: the Centre for Rural Medicine (Storuman, Sweden), and the Mid North Knowledge Partnership (Burra, South Australia). Their emergence and evolution is discussed, and the influence of rural geography on shaping the potential transferability of their operating models to other small rural places.

A qualitative approach is utilised, with semi-structured field interviews conducted in situ with persons identifying as having some connection (employed, and external) with the Centre for Rural Medicine, and the MNKP. A social network analysis will also be undertaken, to explore the connectivity and engagement of each venture.

Lessons from the Centre for Rural Medicine and the MNKP contribute to the development of rural UCE scholarship more broadly, with implications for non-rural ventures. The cases highlight the need to fit the place while reaching beyond the place, to secure critical mass and extended knowledge co-creation and transfer.

Paper ID: 139

The UK's first comprehensive Longitudinal Integrated Clerkship: an early evaluation

Maggie Bartlett¹, Fiona Muir¹, Neil Merrylees¹, James McMillan¹ and Kara Knight¹

¹ University of Dundee School of Medicine (United Kingdom)

Introduction: Dundee University School of Medicine established a pilot for a 40 week long comprehensive Longitudinal Integrated Clerkship (LIC) in 2016. Year 4 students are invited to volunteer for one of ten places which are shared between National Health Service (NHS) Highland (the north of Scotland) and NHS Dumfries and Galloway (the south-west of Scotland) which are both largely rural and sparsely populated areas by UK definitions. We evaluated the clerkship by exploring students' and staff perceptions and experiences.

Method: We used an exploratory educational case study in which data were collected via focus groups and semi-structured interviews from 7 students, 4 Health Board staff and 21 General Practitioners, and reflective audio-diaries kept by all students. Analysis was thematic, the themes being identified from the data.

Results: Students perceived their experiences as very positive in terms of learning, feeling part of their practice teams and the extent to which they were engaged with their communities. They recognized how the LIC aligned with current Scottish Government health care policies. Access to secondary care learning linked to their patients was sometimes problematic within the National Health Service, but students and their GP tutors have found creative ways of managing the issues.

Conclusion: Though still in its early days, the Dundee LIC seems to be successful in delivering community oriented medical education which aligns with evidence from international literature. There is a need to adapt existing models used in North America and Australia to the context of the UK National Health Service.

Paper ID: 140

Challenges and perspectives: social responsibility of a university in a post-conflict environment

Gyavira Mushizi Barhageranya¹ and Andre-Jacques Neusy²

¹ Universite Officielle de Bukavu (UOB) (Congo, The Democratic Republic of the)

² Training for Health Equity Network THEnet (United States)

Background:

The Bukavu State University (UOB), located in the capital of South Kivu province Democratic Republic of Congo is the only government university in the region serving a population of 6 million recovering from a conflict responsible for more than 4 million deaths (98% deaths attributed to diseases and malnutrition). Its faculty of health sciences including a school of medicine, public health and pharmacy, hardened by years of war is engaged in a difficult process of reconstruction. To meet its social responsibility to address the priority health needs of its population, it faces immense challenges in terms of its infrastructure and teaching equipment, faculty training and clinical training sites.

Objectives:

1. Understanding the challenges faced by a medical school with few resources to implement the principle of social responsibility in a post-conflict environment
2. To sensitize the international academic community to the needs for targeted academic partnerships
3. To share understanding of the role of academic partners in building the capacity of the UOB

Discussion including questions / issues to explore:

What are the essential strategies for aligning the curriculum with needs, taking into account realities on the ground?

How to strengthen faculty development?

How to strengthen infrastructure and teaching and learning materials exploiting information technologies (e-Learning and e-Health)

How to align the often-competitive priorities of different local actors, service providers, NGOs and international donors to support the development of medical education at UOB?

Paper ID: 141

Engaging with Communities: the Challenges of Power and Process

Roger Strasser¹, Walter Flores², Heidi van Royen³, Jusie-Lydia Siega-Sur⁴ and Bjorg Palsdottir⁵

¹ Northern Ontario School of Medicine (Canada)

² Center for the Study of Equity and Governance in Health Systems (Guatemala)

³ The Human Sciences Research Council (South Africa)

⁴ University of the Philippines Manila School of Health Sciences, Palo, Leyte (Philippines)

⁵ THEnet: Training for Health Equity Network (United States)

Background

Engaging with the communities that academic institutions serve to define and address needs, is at the core of social accountability (SA) in health workforce education. SA efforts are frequently driven by the goal of achieving health equity, ensuring that marginalized communities are represented in the health professions and that they receive the care they need. Power relationships, including within universities, are at the core of accountability. Fueled by structural inequality, poverty and social exclusion, marginalized communities often lack the knowledge and capacity to claim or advocate for their needs or rights. In this workshop Dr. Roger Strasser, Professor Heidi van Royen, Professor Jusie-Lydia Siega Sur and Dr. Walter Flores will draw from their extensive experiences in successful community engagement and share their lessons learned.

Objectives

By the end of the workshop, participants will be able to:

1. Describe effective strategies to engage communities in the design, implementation and evaluation of education, research, and service activities.
2. Outline the role of power, privilege, and structural inequality in creating conditions for self-empowerment and active engagement in the communities that education and research institutions serve.
3. Develop mechanism and processes to maintain authentic and productive engagement and relationships with communities.

Issues

Key elements of success and challenges in implementing community engagement strategies in health workforce education

Activities

Presentations on four different dimensions of community engagement are followed by a facilitated Q&A and small group discussion on key elements of successful community engagement.

Paper ID: 142

Deans' Perspectives: How can we sustain leadership for Social Accountability in medical education?

Roger Strasser¹, Jabu Mbokazi², Paul Worley³, Fortunato Cristobal⁴ and Bjorg Palsdottir⁵

¹ Northern Ontario School of Medicine (Canada)

² Walter Sisulu University Faculty of Health Sciences (South Africa)

³ Australian Government Department of Health (Australia)

⁴ Ateneo de Zamboanga University, Mindanao (ADZU) (Philippines)

⁵ THEnet: Training for Health Equity Network (United States)

Introduction

The WHO's Global Strategy on Human Resources for Health: Workforce 2030, recommends social accountability (SA) standards and strategies in health professions education. Training a fit-for-purpose workforce to strengthen health systems and reduce inequities, requires education institutions to engage with organizations and individuals in mutually beneficial partnerships and implement complex change efforts. This calls for leadership approaches that mobilize teams of people - officials, faculty, clinicians, communities, students - to tackle health challenges and create the conditions for individual, institutional, systems change. The leaders of the education institutions who are members of the Training for Health Equity Network (THEnet) provide such leadership, with impressive impact on education and service delivery, locally and globally. However, like elsewhere, leaders leave. Recently, leaders from several THEnet schools have left or are leaving their positions soon. Given that change is complex and often fragile, and that SA and community engagement approaches are still not seen as mainstream, SA advocates worry about the sustainability of institutional SA efforts when visionary leaders leave.

Learning objectives:

1. Describe the key elements of success and challenges of institutionalizing SA
2. Explore different approaches to leadership transition to ensure sustainability of SA within institutions
3. Engage in discussions in how to create conditions for success in recruiting SA leaders and sustaining such leadership

Issues/areas for exploration

Leadership transition and institutionalization of SA

Activities

Moderated discussion with current and past deans of SA medical schools, followed by small group and then panel discussions on creating conditions for success and sustainability

Paper ID: 143

ROBO-FRIEND for Healthy Ageing in Rural Communities

Mohammad Hamiduzzaman¹ and Jennene Greenhill¹

¹ Flinders University Rural Health South Australia (Australia)

A third of elderly people living in rural areas of Australia report that they have poor health and psychological well-being. The causes relate to social and geographical isolation and a lack of social support and there are limited opportunities for social activities. This public health research aims to increase the quality of life and social connections for elderly people in the Riverland. The project will simply a social robot that is programmed to promote health and well-being with an emphasis on social connections and health literacy. By focusing on the social aspects of human-robot interactions, this project is designed to implement and evaluate the application of social robot. There are three strategies in this 'ROBO-FRIEND - Flinders Rural Initiative for Effective Networking and Development' project: 1) programming a robot with a 'rural heart'; 2) organise face-to-face human-robot interactions; and 3) evaluate the effectiveness of the robot. A non-randomised design will be used to compare pre- and post-intervention measures based on eight weeks 30-minutes interactions. Each session will consist: of interactive communication about healthcare; exercise and we will be assessing people's recreations. Methodological triangulation using quantitative and qualitative methods will be employed to understand the implications and possible future applications of human-robot interactions. This project needs your feedback and we are seeking collaboration to change healthcare behaviours of rural elderly people and connect them to community members and service providers.

Paper ID: 146

WA Wheatbelt Medical Immersion Programme: Student observations of community health.

Andrew Harper¹, Bret Hart¹, Sadhana Bose¹, Mohammad Billah¹, Tess Corbett¹ and Lucy Irvine¹

¹ Curtin Medical School (Australia)

Second year undergraduate Curtin Medical School students together with first year graduate Notre Dame medical students participated in the first WA Wheatbelt Immersion Programme in March 2018.

For Curtin Medical Students, the educational objectives in general were to identify social determinants of health and understand health needs pertinent to the rural community. This paper reports on and analyses Curtin students' observations of rural community health with a focus on social accountability and responsiveness to unmet needs.

Following a series of pre-programme orientation sessions, students were guests of their billeted Wheatbelt communities for four days. Their role as participant observers was to inquire into the psychosocial and physical context of health as it was presented to them. Every student participated in presenting their observations to the faculty upon their return.

Observations of experiences, feelings, relationship to previous knowledge and learning, and future career applications and interpretation will be presented under the headings of: 1. Place, 2. People, 3. Morbidity and determinants, 4. Process of managing health, 5. Resource distribution, 6. Community resourcefulness, 7. Needs and priority for social accountability.

Three issues are outstanding. The Wheatbelt region is disadvantaged by inequitable distribution of resources. This inequity is matched by incredible resourcefulness of country people. Medical education has a great opportunity to become a constructive, evidence-based advocate for change and for promotion of social accountability of medicine to rural Australia.

Paper ID: 147

A Pathway to Indigenous Healing in Medical School Curriculum: A Northern Ontario Case Study

Darrel Manitowabi¹

¹ Northern Ontario School of Medicine (Canada)

Introduction/background

Since time immemorial the Indigenous peoples of northern Ontario, Canada, have practised a healing system specific to their environment, cultural worldview and social relationships. Colonial processes such as government policies, assimilative educational initiatives and the rise of biomedicine as the dominant medical system, either erased, restricted, or curtailed Indigenous-healing practices. Recent social movements have challenged the colonial history in Canada, and there is some reception to Indigenous healing in society and medical school curriculums.

Aims/objectives

The following presentation is a case study of previous research and my lived experience with the Anishinaabe/Ojibwa Indigenous healing system and its integration in a clinical setting and the medical school curriculum in the Northern Ontario School of Medicine. My focus is first to provide a brief overview of Anishinaabe healing, its integration in Aboriginal Health Access Centres in the province of Ontario, and my approach to providing this information in an introductory lecture to first-year medical school learners. Secondly, I self-reflect on the complexities of Anishinaabe healing that are absent from the literature and university and the medical school curriculum such as the duality of medicine (good vs bad).

Discussion

My central argument is the presentation of Anishinaabe healing is constrained by the unequal power relationship with non-Indigenous peoples, which leads to a tendency to emphasise tolerance of indigeneity rather than a complete and complex picture.

Conclusion

In effect, the practice of Anishinaabe healing, like biomedicine, could be subject to compromised ethics and professionalism, and education needs to reflect this reality.

Paper ID: 148

Social impact of a rural clinical school on its community

Marnie Connolly^{1,2}, Robyn Preston², Sarah Larkins², Roger Strasser³ and Angelo D'Amore⁴

¹ Monash University

² James Cook University (Australia)

³ Northern Ontario School of Medicine (Canada)

⁴ Monash University (Australia)

INTRODUCTION:

In 2002, Monash University, School of Rural Health – Bairnsdale (MRH-B) was established under the Commonwealth Government's Rural Clinical School (RCS) programme to address rural medical workforce shortages. Medical students placed in East Gippsland, Victoria, undertake a longitudinal programme in a General Practice setting. Apart from seeing community members within the healthcare context, students integrate into the region's community activities such as sporting clubs, choirs and church groups.

Symbiotic relationships have been developed between community groups, stakeholders, and healthcare workers, in the region. These relationships are essential to the presence and continuation of the MRH-B.

To date there has been no comprehensive research study addressing what the social and economic impacts an RCS has on small communities in Australia.

AIM:

To explore the social and economic impact of an RCS on its community.

METHODS:

A mixed methods approach, utilising questionnaires and semi-structured interviews, is currently underway to understand stakeholder perceptions and expectations related to the social impact of MRH-B on the East Gippsland Community.

RESULTS:

The preliminary findings from 31 interviews conducted so far, suggest MRH-B is a catalyst to supporting regional education activities, health service workforce and community profile.

DISCUSSION:

Understanding why relationships exist and what the community expectations are, will provide opportunities to support medical education and strategic directions for a rural medical school. Additionally, further research examining the economic contributions, by the rural medical school, will provide insight to the economic growth within the region associated with the establishment of a RCS such as MRH-B.

Burnout among rural hospital doctors in the Western Cape, South Africa

Francois Coetzee¹, Andrew Liebenberg², HOFFIE Conradie³ and Johan Coetzee⁴

¹ Stellenbosch University (South Africa)

² Division of Family Medicine, Faculty of Medicine and Health Sciences, Stellenbosch University (Canada)

³ Ukwanda Centre for Rural Health, Faculty of Medicine and Health Sciences, Stellenbosch University (South Africa)

⁴ Department of Anaesthesia and Critical Care, Faculty of Medicine and Health Sciences, Stellenbosch University (South Africa)

Background:

Burnout among doctors negatively affects health systems and ultimately, patient care.

Aim:

To determine the prevalence of burnout among rural Western Cape hospital doctors and to compare the findings with those of previous South African studies.

Methods:

The Maslach Burnout Inventory was distributed to 42 doctors in seven hospitals in the Overberg district. Burnout comprises three components: emotional exhaustion (EE), depersonalisation (DP) and personal accomplishment (PA).

Results:

Response rate was 85.7%. Clinically significant burnout befell 81% of respondents. High burnout levels on all three subscales were present in 31%. Burnout rates were similar to those of a previous study of doctors in the Cape Town Metropolitan district hospitals (Table 1).

Burnout score range	Overberg (N =36)	Cape Town metropole (N =132)	p	95% confidence interval of difference
High for EE or DP†	29 (81%) 65% to 90%	100 (76%) 68% to 82%	0.659	-12% to 17%
High for EE and DP	18 (50%) 35% to 66%	55 (42%) 34% to 50%	0.449	-9% to 27%
No high level for any category	4 (11%) 4% to 25%	21 (16%) 11% to 23%	0.602	-10% to 15%
Low level for all three (EE and DP and PA)	0 (0%) 0% to 1%	6 (5%) 2% to 10%	0.343	-5% to 10%

Data are presented as number, (percentage), 95% confidence interval of the percentage

P = p value for Fisher exact test.

† Clinically significant degree of burnout

Discussion:

An approximately 50% prevalence of severe degrees of burnout was present in both rural and metropolitan district hospital doctors as manifested by high scores for both EE and DP. Conversely proportions of moderate and low degrees of burnout were low. A previous study concluded that substantial after-hour duties, an excessive workload and a perceived lack of management support impacted negatively on rural hospital doctors. Healthcare authorities need to address the problem urgently, implementing programmes to prevent burnout of which adequate staffing and improved work environment are of prime importance.

Paper ID: 150

Embedding the medical curriculum into rural settings: the experience of Broome Learning on Country

Rachel Hall¹, Frank Bate¹ and Donna Mak¹

¹ Notre Dame University Fremantle (Australia)

Introduction:

In 2017 the University of Notre Dame Fremantle medical school initiated a pilot program, Broome Learning on Country (BLOC) to provide pre-clinical rural exposure in addition to its program of current compulsory community-based placements. BLOC provided seventeen second-year students with opportunities to engage with the standard pre-clinical curriculum for six weeks in the country, to explore whether learning could effectively occur in a regional setting. It also aimed to build local capacity, deepen students' appreciation of Indigenous and rural issues, and stimulate interest in rural practice.

A key challenge was to provide a staff and resource-intensive pre-clinical curriculum, covering all domains, including basic sciences, requiring delivery of anatomy and pathology laboratories and a range of both physical and electronic resources.

Data showed that students successfully completed BLOC without being academically disadvantaged, and enjoyed the experience. What is unclear is whether this program, offered to a number of merit-select students, attracts students already interested in rural practice, or if it stimulates rural interest.

Objectives:

1. Understand the challenges and possible solutions involved in relocating a pre-clinical curriculum to a regional setting
2. Consider ways to facilitate an interest in and understanding of rural work placements.

Discussion:

1. How can we use non-clinical rural pre-clinical placements to increase students' understanding of rural issues and interest in rural practice?
2. How can we maximise the impact of these placements? Are there benefits in billeting with local families rather than hosting with a university? What strategies could enhance community-engagement to foster rural understanding and vision?

Paper ID: 151

What is good student support in Longitudinal Clerkships; what is the role of the administrator?

Amy Schulz¹, Jacqui Michalski¹, Bernie Hobbs¹, Kiara Hoffmann¹, Leesa Walker¹ and Meredith Peters¹

¹ Flinders University Rural Health South Australia (Australia)

For over 20 years, Flinders University has conducted successful Longitudinal Integrated Clerkships (LICs) through its Parallel Rural Community Curriculum (PRCC). The program offers 3rd year medical students the opportunity to complete a year of training in a rural community. The LIC generally attracts independent learners and provides students with a 'hands on' clinical experience.

A successful Program Administrator needs to possess an array of skills in leadership, management, budgeting and pastoral care. Exceptional organisational skills and an eagerness to adapt and relate to the needs of a modern student can ensure a successful and independent student group.

During this PeArL session, Program Administrators will discuss the role of the Administrator and present the current model of student support, which is inclusive of creating and sustaining robust stakeholder relationships, student pastoral care, scheduling academic teaching opportunities and enhancing the overall LIC experience. The information gathered will form the basis of a review of the current student support model.

Aims/objectives:

- To explore what constitutes good student support from a diverse audience
- To explore the role professional staff have in supporting students in other programs and different models of delivering this.
- To explore the benefit and sustainability of different models of support.

Questions:

1. What does the modern student seek from the Program Administrator?
2. What are the obstacles and how can we overcome them?
3. What model should the Program Administrator look to implement in the future?

This presentation will appeal to Program Administrators, student support staff, Academic Co-ordinators and students engaged in longitudinal placements.

Paper ID: 152

Systematic review literature searching in socially accountable health professional education

Leila Mohammadi¹, Carole Reeve², Torres Woolley³, Simone Ross², Servando Halili⁴, Fortunato Cristobal⁴, Jusie Lydia J Siega-Sur⁵ and Andre-Jacques Neusy⁶

¹ Prideaux research centre, College of medicine and public health, Flinders University (Australia)

² College of Medicine and Dentistry, James Cook University (Australia)

³ James Cook University (JCU) (Australia)

⁴ School of Medicine, Ateneo De Zamboanga University (Philippines)

⁵ School of Health Sciences, University of Phillipines (Philippines)

⁶ Training for Health Equity Network (United States)

To produce a systematic review, researchers are required to find, appraise, synthesise and interpret all available relevant, high quality research literature relating to a particular research question. There are enormous implications in terms of findings and conclusions if the search fails to uncover key papers on the topic. Search strategies for systematic reviews aims to maximise the sensitivity and to reduce the bias, therefore transparency and replicability are the main criteria for systematic searches. Clinicians/clinical educators are less skilled to conduct a comprehensive reproducible search strategy for systematic reviews. This would be a challenge especially within health profession education (HPE) complex context.

This presentation demonstrates a collaboration between an expert medical librarian and a HPE research team to conduct a systematic review on the impact of socially-accountable health professional education. It also details the systematic approach and methodology we used to conduct the literature searching for a complex research question on social accountability in HPE.

We started with a scoping search in a few databases to identify Mesh Terms and textwords before we design the main search strategy. Then a detailed search was constructed in Medline (OvidSP) and translated into databases from a variety of disciplines such as health, education, policy and social sciences. We used Endnote to manage citations and PRISMA flowchart to report the number of results.

Literature searching is a critical part of conducting a systematic review. Expert searchers need to be part of the research team and effectively communicate with the researchers, from developing the research question through to the publication. This case shows a real life example of collaboration between search experts and HPE research team which led to a successful systematic review publication.

Paper ID: 153

University-Community Engagement does it work? A case study from Flinders Northern Territory

Pascale Dettwiller¹

¹ SA Health (Australia)

Background

Flinders Northern Territory Medical Program in Katherine has a relationships with a women's group 'Banatjarl Wumin's Group'. This women's group is composed of Jawoyn women who have positions as 'Elders' and 'Traditional Owners' in the local community, who have an aspiration to educate and pass on their knowledge 'before it is too late'. To the medical students in placement in Katherine, they explain the importance of understanding Aboriginal spirituality and the importance of working with the local healers. This paper will expose how the FNT Katherine Rural Clinical School fulfils this key performance indicator; achievements; programs; evaluation and community impacts.

A participatory evaluation was undertaken with the Women's Group and by subsequent groups of students to weigh the impact the partnership.

Four key learning points were highlighted by the study on how:

- Working with the community to build a stronger, more integrated and supportive community;
- Enhancing collaboration and coordination between partners;
- Demonstrating the commitment of the University to participation and involvement in the educational, cultural and social life of the community; and,
- Evaluating the quality of teaching and learning by educating students as responsible and reflective professionals who are able to act critically, ethically, socially and responsibly in a variety of educational contexts they are exposed during the duration of the course.

Conclusion

This is the start of a two-ways learning and teaching process and a genuine, strong community-campus partnership between the group and the Flinders' Katherine site for a genuine and sustainable community engagement.

Paper ID: 154

Using Aboriginal perspectives to inform culturally appropriate palliative care in oncology

Darryl Cameron¹

¹ Flinders University Rural Health South Australia (Australia)

Recent epidemiological data demonstrate that Aboriginal and Torres Strait Islander people have a similar prevalence rate of cancer as non-Indigenous Australians; however, there is a higher incidence of cancers that are preventable, more likely to be diagnosed late, less likely to receive culturally appropriate oncological and palliative care, and have a higher mortality rate. To address this cancer mortality gap, the National Aboriginal and Torres Strait Islander Cancer Framework 2015 lists seven priorities areas of work to reduce the disparities for Indigenous Australians with cancer.

Methods: This study identified case studies of rural Indigenous palliative care as primary data source and contextual analysis as analysis technique to understand the Ngarrindjeri cultural perspective of oncological palliative care.

Results and Conclusion: It is argued that Aboriginal and Torres Strait Islander people need to be engaged meaningfully to foster ownership, effective and accurate data collection, and a whole of system approach to planning and implementing culturally appropriate palliative care in oncology is necessary.

Paper ID: 155

Can clinical courage be expressed through visual art?

Lilian Fellner¹ and Lucie Walters²

¹ Flinders University (Australia)

² Flinders University Rural Health South Australia (Australia)

Background

Many rural and remote communities have limited access to medical resources, and rural doctors often find themselves in the position of working at the edge of their competence to provide their communities with the best possible care. This may be anything from performing a procedure you have not done for several years, to delivering your best friend's baby, to having the courage to do nothing at all. We call the concept of working at the edge your comfort zone "clinical courage".

Ella Cockburn and Laura Grave, medical students at Flinders University, interviewed clinicians to ascertain the nature of clinical courage in 2017. We now wonder whether the concept can also be visually expressed.

We are looking to have an interesting discussion about these ideas.

Objectives

We are trying to identify what it is that drives people to work at the edge of their scope of practice in the rural setting. We want to explore this through visual art.

Discussion

Have you ever worked outside your comfort zone? If so, we would like to hear from you, especially if you are also interested in art.

Please come to this session prepared to draw out the meaning of clinical courage through art.

Paper ID: 156

Experiential Learning from Border: The Learning Reflection of Medical Students in Community Hospital

Rungnapha Siriphonphaibool¹, Duangnapa Sirisophon¹ and Supachai Nathongchai¹

¹ Somdejphrajaotaksinmaharaj Hospital Medical Education Center (Thailand)

Introduction

As part of the sixth year Somdejphrajaotaksinmaharaj Hospital Medical Education Centre undergraduate medical program, students are placed for two weeks at Umphang Hospital for their *Community and Family Medicine 3* topic. Umphang Hospital is a 60-bed community hospital which services rural and remote local villages between Thailand and Burma.

Aims

To evaluate the experiential learning of medical students on rural work-integrated learning.

Methods

Qualitative descriptive analysis of students' written reflection and in-depth interviews with 15 students was conducted in 2017.

Results

Medical students learned of public health communication, roles in community, out-patient clinical management, domiciliary consultation and evidence-based medicine.

Discussion/Conclusion

There is evidence that community-based training will support medical students in the acquisition of clinical knowledge.

Paper ID: 157

End-of-life Essential Education

Kim Devery¹, Deb Rawlings¹ and Deidre Morgan¹

¹ Flinders University (Australia)

Introduction

One Australian will die every 3 minutes and 17 seconds and of these 52% will die in acute hospitals – it is estimated that up to 50% of these deaths are expected. In line with an ageing population these death rates are projected to increase. Clinicians report that it is often easier to continue treatments than to talk with patients and families about the end of life. Fear, denial and unrealistic expectations by clinicians can lead to a cascade of invasive treatments or referrals that result in poor end-of-life care.

Aims

End of Life Essentials_(EOLE), provides evidence-based, peer-reviewed and online education and resources to enhance the quality of end-of-life care in Australian hospitals. EOLE has been developed from the Australian Commission on Safety and Quality in Health Care's 2015 *National Consensus Statement: essential elements for safe and high quality end-of-life care*.

Results

To date, over 6,000 clinicians have completed the online education. End-Of-Life Essentials and the webpage has attracted over 150,000 visits to access evidence based and peer reviewed resources. We asked all clinicians/learners what they could change in their practice tomorrow to improve the quality of end-of-life care

Discussion

We provide a summary of the top three themes – emotional insight, listening effectively, and goals, needs and expectations of the patient. These results clarify clinicians' responses to important national policy by articulating, from their perspective, the clinical opportunities around quality end-of-life care and the Consensus Statement. With the introduction of the 2nd edition to the National Safety and Quality Health Service Standards the results are valuable to organisations and policy makers who are wanting to change health care outcomes.

Paper ID: 158

Addressing complex problems in community-engaged medical education - being and belonging

Ian Couper¹ and Paul Worley²

¹ Faculty of Medicine and Health Sciences, Stellenbosch University (South Africa)

² Prideaux Centre for Research in Health Professions Education, Flinders University (Australia)

Introduction

As educators working with multiple partners in developing community-engaged learning, we operate in a very complex environment. Small obstacles easily become wicked problems that appear to have no solution. Approaching such issues is not simply a matter of acquiring new techniques or using better tools, but critically also about having a sense of who we are (understanding how we see ourselves and our own values) and who we are connecting with, in order to find a shared way forward.

Learning objectives

1. Explore the place of personal understanding and values in addressing wicked problems.
2. Discuss some techniques used in complex situations, arising from the adaptive action and symbiosis models.
3. Reflect on principles for communicating ideas for impact, in community and academic environments.

Areas for exploration

The workshop will explore the interaction of our own journeys (inner space) in relation to the context we are facing (outer space), and how they impact on each other. Using techniques from established models, we hope to gain shared insight regarding how our sense of being and belonging can make a difference.

Activities

The workshop will involve small group discussions around the key objectives listed above, after a brief input from the facilitators on each. Participants are encouraged to bring a complex problem they face as a basis for discussion. The aim is not to find solutions but rather to reflect on how we might reframe our perspectives on the issues.

Paper ID: 159

Up-scaling: 8 to 250. How do we develop distributed learning for an entire medical school class?

Francois Coetzee¹, Ian Couper¹ and Karl Klussman²

¹ Stellenbosch University (South Africa)

² Worcester Rural Clinical School (South Africa)

Background

Stellenbosch University is at the beginning of developing a new curriculum for the training of medical students. This program will accept learners that are pre-graduate and will consist of 6 years of training, of which the last year will use an apprenticeship model. The plan is to start the new curriculum in 2020 and the aim is for the whole class of 250 students to shift from the central teaching hospital into distributed health facility-based training sites during their final year.

Stellenbosch University has 7 years of experience with the training of students in a longitudinal integrated clerkship (LIC) in two neighbouring health districts. This program has expanded slowly from 2 students placed for a yearlong LIC in one site, to 8 students in 3 sites, and is planning for 14 students in 5 sites in 2019.

Our question to the group:

How do we upscale and transform the current LIC, maintaining high quality learning and support from well-equipped clinicians, in an under-resourced environment?

Paper ID: 160

Team supervision - linking the learning in General Practice; a synergistic process

Emma Kennedy¹, Chris Harnden¹, Ahmed Al-Sudani¹ and Nadun Rubasinghe¹

¹ Flinders University (Australia)

The context of General practice is key for learning in medicine as the medical curricula embrace medical learning across community and acute sectors. General practitioners and the patients, have increasing involvement in learning and teaching clinical medicine both at undergraduate and postgraduate levels. In this context the clinical imperative of patient centred medicine has synergy with learner centred teaching, and therefore the supervision models for supporting quality health care in General Practice are likely to be synergistic with supporting quality learning and teaching.

This workshop will demonstrate the team supervision model through role play of representative examples of supervision. These examples will demonstrate supervision of medical student learning and supervision of a junior GP teacher, teaching the medical student.

The presenters are experienced GP teachers working in an innovative not for profit practice that has up to 11 medical students each semester with 5-6 GP registrars in pre-Fellowship positions.

Goals:

- to demonstrate the synergies in learner centred teaching within General Practice including a focus on development of GP teaching skills
- to explore the model of supervision support that is necessary to support learner centred teaching in General Practice
- participants to practice review of learner performance within the structure of team supervision model, to reflect on elements for own use

Paper ID: 161

Shame-Resilience: A Novel Approach to Resilience Training for Longitudinal Integrated Clerkships

Claire Edelman¹, Bruce Peyser² and William Bynum³

¹ Duke University School of Medicine, Primary Care Leadership Track (United States)

² Duke University School of Medicine, Department of Internal Medicine (United States)

³ Duke University School of Medicine, Department of Community and Family Medicine (United States)

Introduction:

Given high rates of depression and burnout in medical education, leaders continue to seek effective ways of promoting learner resilience. Shame is a ubiquitous emotion that may cause significant distress but is not routinely addressed in resilience initiatives in medical education. A recent study in medical residents identified the triggers, nature, and negative outcomes of shame, as well as factors that enabled shame-resilient approaches to learning. This workshop will explore these data, the psychology of shame, and the construct of shame-resilience in the context of longitudinal clerkships. Attendees will consider how they might implement emotionally resilient approaches to learning and teaching to optimize learner wellness within longitudinal clerkships.

3 learning objectives:

Attendees will be able to:

- Identify and differentiate shame and guilt and describe how they can lead to divergent responses to error.
- List specific strategies to constructively engage with shame and/or assist others (e.g. learners, colleagues) in constructively engaging with shame
- Articulate specific ways to build resilience within longitudinal clerkships.

Issues/areas for exploration:

Attendees will explore influences that may contribute to feelings of shame within longitudinal integrated clerkships and will identify strategies for mitigating their potential to cause shame.

Activities:

1. Introduction (10 minutes) – Didactic PowerPoint
2. Shame story (5 minutes) – Student
3. Shame story (5 minutes) – Faculty
4. Small group activity (35 minutes) - Groups will respond to unique prompts and brainstorm shame-resiliency strategies for longitudinal learners.
5. Large group discussion (35 minutes) – Groups will summarize conclusions and then we will open discussion up to the large group.

Paper ID: 162

Unlocking the Longitudinal Integrated Clerkship Academic Curriculum at NOSM

Ed Hirvi¹, Peter Istvan¹, Claudia Rocca¹ and John Dabous¹

¹ Northern Ontario School of Medicine (Canada)

The Comprehensive Community Clerkship (CCC) at the Northern Ontario School of Medicine is an 8 month mandatory longitudinal clerkship developed using philosophy, “clinical curriculum walks through the door”. Due to constraints of using traditionally blocked examinations, the academic curriculum previously followed a strict calendared schedule. The disconnect between clinical experiences and the formal curriculum was consistently apparent as seen from program evaluation. The goal was to make attempts to align the clinical experiences with the academic curriculum.

The first step taken to unlock the curriculum from a strict schedule was the move to progressive testing exams. Progress testing has been widely implemented in medical education, with the philosophy of limiting student stress and surface learning resulting in poor study habits, or ‘cramming’. By implementing progressive testing that consists of content from the entirety of the academic curriculum, the timing of academic events, such as case presentations, is driven by student experience. Students within a CCC community decide the order of academic events, using their own clinical experiences. This allows academic curriculum to be aligned with the philosophy that the curriculum “walks through the door”. Additionally, the use of an online, self-directed, case-based resource was implemented to supplement learning ensuring achievement of all required learning outcomes.

This major change in approach to examinations allowed for a student driven curriculum and has resulted in a more seamless experience for students in their CCC. Progress examination reports provide students with areas of weakness, which in turns provides area of focus in the clinical environment, and further followed-up in the academic sessions. This streamlined approach to curriculum allows student to be more efficient with study time, and focus on areas of need, rather than specific time curriculum requirements. Program evaluation focused on the reaction of students, preceptors and administrators will be used to continue to improve this model.

Paper ID: 163

Virtual Academic Rounds: How to get engagement in a distributed learning scenario

Rick Senior¹

¹ Northern Ontario School of Medicine (Canada)

Virtual Academic Rounds (VARs) are a core educational activity during the Phase 2 Comprehensive Community Clerkship (CCC) at the Northern Ontario School of Medicine: they are 3-hour case based, objective driven sessions in which learners consolidate clinical material. The intention is to provide a shared basis of learning across a very distributed Northern Ontario learning environment VARS facilitators guide students as they identify learning issues, develop strategies to acquire relevant knowledge, support peer learning, and apply findings to their clinical experiences. The effectiveness of VARS has been quite variable. Based on a ten-year experience of facilitating VARS, the presenter will discuss approaches that foster student's learning and assist with community engagement across large distances. Further, unsuccessful techniques that do not enhance learning in a longitudinal distributed program will be reviewed. Summarizing will lay out learning strategies that have worked successfully in a rural location with an experience of over 100 learners

Paper ID: 164

En-Couraging Moral Imagination in LICs

Katharine Meacham¹ and Ira Sloan¹

¹ UNC School of Medicine Asheville Campus (United States)

Mark Johnson's 1993 book, *Moral Imagination: implications of cognitive science for ethics*, has influenced scholars and practitioners across disciplines, including educators and bioethicists. **If *moral imagination* is defined as the ability to envision a wide range of possibilities for understanding and resolving a particular ethical challenge, are there ways that Longitudinal Integrated Clerkships can provide for its growth and nurture?** This PeArLs session will explore how we as educators in LICs could be intentional in our use of this opportunity, if we value this as a goal worth addressing. It will be conducted in a highly interactive way, using the discussion methods of *mutual inquiry* and a *write-pair-share* process. The collective wisdom of the group of experts will be recorded.

Aims/ Objectives:

- To share ideas about how to define, encourage, and observe the development of *moral imagination*
- To explore the opportunities for doing this in LICs
- To consider what barriers might exist to that development and to imagine ways of addressing those challenges

Discussion Questions:

- What is *moral imagination* and is encouraging its development a desirable goal in medical education? If so, why?
- How might education to nurture moral imagination be related to or different from traditional medical ethics education?
- How might it be possible for LICs to become fruitful contexts for the development of moral imagination?
- How important is it that *moral imagination* be named, or can/does/will this happen without explicit attention or intention?
- What aspects of a LIC education may encourage or discourage the development of moral imagination?

Paper ID: 165

Seminar-based Approach for Solidifying Foundational Knowledge in the Duke LIC

Myles Nickolich¹, Katherine Peters¹, Melissa Graham¹ and Eugene Kovalik¹

¹ Duke University School of Medicine (United States)

Background

The Duke LIC Seminar is a case-based weekly program for students in the Duke University School of Medicine LIC program. This seminar guides students through history and physical exam review, differential diagnosis creation, evaluation of complex medical and psychosocial issues relating to patient care, and understanding of patient care throughout a health system.

Aims/Objectives

To provide a strong and practical exposure to medical, psychosocial, economic, and systems-based issues impacting a patient case so as to promote both depth and breadth of skills fundamental to patient care and innovations across health systems.

Discussion

One student presents weekly. The student presenter leads the group through a chief complaint and review of history, exam, labs, and imaging. Students create a differential diagnosis, learn how to perform pertinent physical exam skills, and interpret labs and imaging studies as they create a management plan. When able, a patient is present for interview and exam or patients with pertinent exam, imaging, or lab findings are interviewed on the Duke University Hospital inpatient wards. Students critically review current evidence-based practice in creating assessments and plans and interpret primary literature on related topics. Finally, students evaluate systems-related issues to improve patient care. Mid-year student evaluations have shown that 100% of students identified the seminar as above average or excellent overall and 100% of students indicated that the seminar faculty provided useful and actionable feedback and that student goals and expectations for seminar presentations were clear. A full formal course evaluation will be completed by students and faculty at the completion of the academic year.

Conclusion

The weekly seminar is a catalyst for students to deeply understand foundational tenets of patient care while examining health systems and barriers to high quality health care.

Paper ID: 166

Creating an Advising and Support System in the Duke LIC

Myles Nickolich¹, Eugene Kovalik¹, Melissa Graham¹ and Katherine Peters¹

¹ Duke University School of Medicine (United States)

Intro/background

The Longitudinal Integrated Clerkship (LIC) track at the Duke University School of Medicine is an LIC spanning a wide range of clinical experiences and settings and extending throughout the clinical year for 8 students annually. This program is a hybrid LIC with half of the clinical year as inpatient time and half as longitudinal outpatient time over a 14-month academic year during the second of four years of medical school. Each student develops a diverse patient panel of 15-20 patients. Students are paired with an "LIC Mentor" physician who advises up to four students.

Aims/goals

LIC Mentors serve as academic advisors and support mechanisms to promote student excellence in foundational and aspirational clinical experiences. Each student meets with their LIC Mentor every 2-3 weeks to review clinical requirements completion, tailor clinical experiences to meet student requirements and interests, foster student wellbeing and resiliency, and promote an organized approach to academic and research endeavors.

Discussion

LIC Mentors provide a strong support system for students and allow frequent assessment of clinical requirement completion. Mentors promptly identify students at risk of falling short of clinical requirements and those demonstrating unhealthy behaviors. Mentors assist students in refining patient panels in order to develop depth and breadth in understanding medical, psychosocial, and systems-related issues in patient care. Further study is needed to understand the full scope and impact of the mentor role.

Conclusions

LIC mentors encourage student excellence in areas of interest while still completing academic requirements. Mentors ensure that students have a rich clinical experience and healthy lifestyle during LIC student clinical track experiences. Further formal study is needed to fully understand impact of this role and to fully utilize available resources.

Paper ID: 168

Finding the evidence for longitudinal integrated Clerkships

Jan Illing¹

¹ Newcastle University (United Kingdom)

There is plenty of evidence that Longitudinal Integrated Clerkships (LICs) are effective for medical students.

However, what are the outcome measures that show patient benefit?

In this workshop participants will be invited to share experiences and expertise and propose what the outcome measures should be.

How do LICs enhance the development of student - patient relationships? How do we measure this?

For example, how do we measure compassion and what are the best measures for patient centeredness or patient partnership?

Participants will be invited to discuss selection of the outcomes, how they could be measured and help devise the ideal study, possibly using an experimental design, to show patient benefit from LICs.

LICs will be introduced for the whole 4th year cohort at Newcastle Medical School, UK in 2020.

The workshop will feed into a research study at Newcastle University, with over 350 students, thus having the power to show effectiveness as well as patient benefit.

Paper ID: 170

Using Technologies to Improve Rural Health: Learner, Patient, Practitioner Perspectives

Emmanuel Abara¹

¹ Northern Ontario School of Medicine (Canada)

Introduction and Background: Advances in digital and information technology have provided numerous applications to meet the health care needs of individuals and communities. Hospitals, Health care institutions, Educational facilities and health care professional offices are adopting these tools and platforms with interest over the past 20 years. In this workshop, we shall learn how Telemedicine as a tool of building equity in health care is improving access and saving costs with improvement in quality of patient care. With the ubiquitous smart phones and mobile health technology, we shall explore how some doctors' offices are being transformed in time and space. Engagement of the learner of the digital age, the increasing interaction between the practitioner, the patient and the community will be highlighted to keep all well informed. This session shall be interactive using case studies from individual health care professionals, Health institutions/Hospitals and Educational facilities from around the world. Participants (learners, faculty, patients) shall be encouraged to share their stories so that we can all learn together.

Learning Objectives: At the end of the session, the participants will

1. Learn how appropriately applied technology can improve access, build equity resulting in enhanced health in rural communities;
2. Review the perspectives of the learner, faculty and patient in the adoption of these technologies;
3. Learn about the challenges and opportunities in the use of ever-growing digital and information health technology in rural health

Methods: Interactive > 50%, Power-point, Case studies, Small group discussion, Question and Answer

Paper ID: 171

Interprofessional Teleurology Care in rural Northern Ontario: Lessons from Patients and relatives

Emmanuel Abara¹, Cameron Reid², Ndidi Abara³, Manon Lacroix⁴ and Cholemkeril Thomas⁵

¹ Northern Ontario School of Medicine (Canada)

² Hornepayne General Hospital (Canada)

³ University of Texas Medical Branch, Galveston (United States)

⁴ Kirkland and District Hospital (Canada)

⁵ Anson General Hospital, Iroquois Falls (Canada)

Introduction and Objective: Since we adopted Telemedicine, inter-professional collaborative care has been encouraged. The patient, relatives, primary care provider and the specialist all meet at the point of care by Telemedicine. When possible, learners attend. By January 2015, we attempted to determine how the patients and their relatives perceived this pattern of care.

Materials and Methods: Approval was received from the Ethics Boards of the rural hospitals. Data were collected by paper questionnaire. Informed consent was obtained from participants. Diagnosis, Treatment, Telemedicine encounters and perceptions were recorded. Information regarding computer and internet use among the patients' relatives was also obtained. Quantitative and qualitative data were analysed using the Statistical Analysis Software (SAS) and conceptual matrix respectively.

Results: 124 patients have completed the survey- 74 men and 48 women aged between 31 and 92(average 64) years. Cancer diagnoses and the elderly with multiple co-morbid conditions were predominant. Spouses comprised 90% of all accompanying relatives. There were 8 primary health care providers/care givers. Patients and relatives were satisfied with the care provided with timely access nearer home; cost saving and minimal travel time especially during the winter.

Conclusion: This study suggests that patients and their relatives value Telemedicine assessment because it helps to minimize travel, reduces cost, time off work and provides appropriate care by the "Care" team. Further experience with this pattern of care and its ramifications is required. Visits to Physicians offices for minor assessments may soon become virtual in time and space

Paper ID: 172

Teaching Clinical Reasoning in Rural and Remote Practice

Lawrie McArthur¹

¹ Adelaide Rural Clinical School (Australia)

Increasingly busy rural doctors are involved in teaching under and post graduate students, often without formal teacher training or skills. The student's experiential learning can occur through bedside teaching and patient encounters, providing a catalyst for case presentations and discussions. Clinical diagnostic decision making can be an intuitive process for experienced rural practitioners, and this clinical reasoning can be difficult to teach.

SNAPPS is a simple, quick and easy to use tool that provides rural doctors with a learner-centred approach to this teaching of clinical reasoning.

The SNAPPS acronym for case presentations stands for:- **Summarise**, **Narrow** the differential diagnosis, **Analyse** the differential, **Probe** further, **Plan** management, and **Select** for self-study.

Learning goals

1. Group sharing experience of teaching clinical reasoning in rural practice
2. Learn the SNAPPS approach.
3. Practice the use of the SNAPPS tool.
4. Identify strengths and weaknesses of SNAPPS tool in assessment

This topic and research is suitable and relevant to a wide range of health professionals, and has potential to translate into a variety of allied health, medical, rural, resource poor clinical teaching environments.

Paper ID: 174

Inter-professional education and longitudinal clinical teams - where the rubber hits the road.

Sarah Tieman¹, Laura Karcher², Donyel Byrd³, Douglas E. Carr Doug⁴ and John Watkins¹

¹ IU School of Medicine (United States)

² American Speech-Language Hearing Association (ASHA) (United States)

³ National Association of Social Workers (United States)

⁴ FACS (United States)

Longitudinal integrated clerkships offer unique opportunities for inter-professional education (IPE) students to work together providing patient focused continuity of care in the community setting. This presentation describes a collaboration of speech-language pathology (SLP) students, social work (SW) students and medical clerkship students in a four month IPE project focused on both patient centered outcomes and IPE team work. Interdisciplinary teams of students were assigned to visit a patient with a brain injury monthly and use motivational interviewing to identify patient centered goals of care that the team then worked collaboratively to address in a semester long project. Student teams were accompanied by IPE faculty on their home visits and coached on communication with both the patient and the team. Student and team progress was tracked using rubrics and at the end of the project each team presented a summary of their work to the other IPE teams. Informal feedback has been positive from both students and faculty and scores on communication rubrics show a trend towards improvement over time. This small pilot demonstrates successful implementation of a clinical IPE team that provides students with meaningful experiences in patient care and interdisciplinary teamwork as well bringing added value to the patient.

Paper ID: 176

Improving quality of nursing education in Malawi

Thokozani Bvumbwe¹ and Ntombifikile Mtshali²

¹ Mzuzu University (Malawi)

² University of KwaZulu Natal (South Africa)

Introduction/Background

Nurses and midwives constitute the majority and backbone of health workforce. Responsive nursing and midwifery education is important in meeting the needs of rural communities.

Aims/Objectives

To explore the challenges facing nursing education in Malawi and to describe efforts being put in place to improve nursing education and the process of development of a model to improve nursing education in Malawi.

Method

Qualitative descriptive design was used. A panel discussion was conducted, guided by core concepts from an analysis of research report from a national nursing education conference. Two focus group discussions with nurse educators, practitioners and clinical preceptors filled gaps from data obtained from the panel discussion. A qualitative abductive analysis was used for the development of the model.

Results

Transforming and scaling up of nursing education emerged as main concept of the model. Community based education emerged within two main strategies of curriculum reforms and capacity building. Competent graduate as a theme shows that graduates are ill prepared to respond to healthcare needs for rural service users.

Discussion

Community based education is responsive and relevant to healthcare needs for rural users. It promotes social justice and accountability. Nursing education transformation is needed now more than before.

Conclusion

The National Health Sector Strategic Plan which highlights evidence based needs for equitable access and universal coverage of healthcare services should guide development of nursing education programmes.

Paper ID: 177

"But I don't want to teach via video conference."

Amy Schulz¹, Jacqui Michalski¹, Bernie Hobbs¹, Kiara Hoffmann¹, Amy Thomas Savory¹, Leesa Walker¹ and Meredith Peters¹

¹ Flinders University Rural Health South Australia (Australia)

For over 20 years, Flinders University has conducted successful Longitudinal Integrated Clerkships (LIC) through its Parallel Rural Community Curriculum (PRCC). The program offers third year medical students the opportunity to complete a year of training in a rural community.

The PRCC program delivers academic teaching from numerous locations across rural South Australia using a mixture of local and visiting clinicians via face to face teaching and video conferencing. Some clinicians are more open to using technology to deliver their sessions whilst other clinicians have a strong preference for face to face teaching.

Aims/objectives:

- To explore how other programs are utilising technology to deliver teaching
- Understanding & overcoming the obstacles of using technology for distance education
- To explore alternative teaching options for distance education

Questions:

1. In the audiences experience how effective is teaching via technology?
2. What are the obstacles and how can we overcome them?
3. How can we maximise distance teaching via the use of technology?

Who the presentation will appeal to:

This presentation will appeal to Program Administrators, student support staff, clinicians and students engaged in longitudinal placements.

Paper ID: 178

Making Wellness Everybody's Business

Vanessa Ryan¹, Leesa Walker¹, Jessica Bailey¹ and Jacob Jeffery¹

¹ Flinders University Rural Health South Australia (Australia)

Introduction and Background

In the Beyond Blue National Mental Health Survey of Doctors and Medical Students October 2013, medical students reported high rates of general and specific distress in comparison to the general population. Doctors reported substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professional.

Acknowledging the growing need for formalizing and raising the profile of their support of staff and student groups, Flinders University Rural Health SA (FURHSA) developed a Wellness Committee in 2017 with staff and students representatives. The Wellness Committee is a means of effecting cultural change, reducing burnout and improving personal and professional wellness for students and staff.

The FRHSA Wellness Committee aims to promote a culture that enables our staff and learners to thrive where the importance of self-care is recognised. A positive inclusive culture in which staff and learners feel equally valued, respected and recognised with a wellbeing approach that is integrated between staff, learners and sites.

Aims/Objectives

This PeArL is aimed at increasing capacity around wellness initiatives through sharing the challenges and achievements of setting up and running a wellness committee that meets the needs of staff and learners located in rural and disparate locations. Opportunities to understand wellness initiatives from participants will be invited aimed at building a wellness framework which can be applied and transferred into other learning and teaching environments.

Discussion including questions/issues for exploration

Building organisation, staff and learner wellness is everybody's business. This collective information sharing and workshopping opportunity is focused on sharing thoughts and experiences to help build capacity and networks in the wellness space. The following questions will be explored in this PeArL –

- How do you effectively meet the needs of learners and staff in the one stop wellness committee? How important is role modelling?
- How do you foster inclusive culture in rurally disparate organisation?
- What wellness initiatives work? What should be avoided?
- How do we know if wellness initiatives are being effective?

Paper ID: 179

Medical student responses to a practice-based Aboriginal Cultural Awareness program

Colleen Hayes¹, Kerry Taylor¹ and Lorna Murakami-Gold¹

¹ Poche Centre for Indigenous Health Alice Springs (Australia)

Alice Springs Poche Centre provides cultural orientation and awareness teaching to medical students undertaking placements in Central Australia. Time allowed for this is often minimal. The challenge is to provide knowledge and understanding that has immediate relevance for students in practice.

Cultural orientation is acknowledged as an important element to culturally safe health service delivery. This paper will share details of an innovative and practice-based approach to cultural orientation for medical students in Central Australia.

Cultural orientation and awareness teaching is evaluated using a mix of Likert scale responses for content assessment as well as qualitative responses, anecdotal feedback and peer review of teaching.

Medical students who undertake cultural orientation and awareness at Alice Springs Poche Centre overwhelmingly rate sessions as very practical and relevant. Responses suggest the students rate these sessions as some of the best cultural awareness experienced and ask more time be allocated.

Cultural orientation that is specific to context reinforces the diversity of Indigenous Australia. Innovative techniques used to quickly engage medical students include challenging them to tell their personal story using Indigenous methodologies of story-telling using drawing and symbols.

Cultural orientation and awareness is often considered a 'soft content area' within medical training. However, students who undertake high quality, practical cultural awareness training, recognise the importance of the subject and suggest more time is needed to ensure culturally safe practice.

Paper ID: 181

Realistic breast models: can they be used for rural clinician training and accreditation?

Daisy Veitch¹, Lilian Fellner² and Melissa Bochner³

¹ TU Delft, The Netherlands (Australia)

² Flinders University, South Australia (Australia)

³ University of Adelaide, South Australia (Australia)

Introduction

Clinical breast examination (CBE) is a useful screening and diagnostic tool for the early detection of breast pathologies. CBE is part of the triple test: imaging, CBE then biopsy. Out of these three tests, CBE is the first line, and requires clinician training but not specialist equipment such as mammography. This makes CBE important for rural and remote communities with limited access to resources, as a screening and diagnostic tool.

Realistic breast models have been developed as a teaching tool to increase clinician accuracy and confidence in performing CBE. There are six breast models representing a range of normal variation for softness and texture. They also include various breast pathologies. These models have been developed and tested in an urban context. However, we see an opportunity for the models to be particularly useful in rural and remote Australia, Canada or in third world countries, if an appropriate training program is developed.

Aims

This PeArLs seeks to gauge interest in further development of a CBE curriculum specifically for health professionals working in rural and remote areas.

Discussion

Please come along if you have an interest in developing your skills as a clinician, and/or are interested rural medical teaching.

We are hoping to explore if the breast models could be useful for rural and remote medical education.

Paper ID: 182

What is important to medical students for clinical school choice?

Riitta Partanen¹, Remo Ostini¹ and Diann Eley²

¹ The University of Queensland Rural Clinical School (Australia)

² The University of Queensland, Faculty of Medicine (Australia)

Understanding the factors medical students' consider when deciding where to spend their clinical years is important for Rural Clinical School's (RCS) to address negative and capitalise on positive perceptions.

In 2017, 161 medical students at the University of Queensland; female (n=84, 52%), age 21-43 years (median 24) completed a survey rating the most important factors in clinical school choice.

Rural background (RB) students (n=58, 36%) rated the same four factors in order of importance as the whole sample; Breadth of clinical experience, Teaching reputation, Hands on experience, Student recommendation. All students, for whom RCS was their first choice, rated Hands-on experience most important. There was no relationship between RB and choosing RCS as first preference.

Rating factors for level of impact showed RB students' top four were the same as the whole sample. These were: Commute length, Knowledge to make an informed decision, Living costs, Future career intentions. Those who chose RCS first, accommodation had the highest impact. Rural career interest rated highly for both RB and those who chose RCS first. Qualitative comments described the importance of family and ability to work in students' decisions.

Active promotion of the key characteristics of rural placements that medical students report positively influences their decision to choose a rural placement is important to ensure the RCS program continues to at least meet but preferably exceed its quotas.

Paper ID: 184

Impact d'un programme de résidence bilingue sur l'offre de services en milieu minoritaire

José François¹

¹ University of Manitoba (Canada)

Introduction

Le Manitoba compte une importante population minoritaire francophone (8-12% de la population) répartie dans la partie sud de la province, tant dans les milieux ruraux qu'urbains. Reconnaisant ses obligations envers la francophonie, le Manitoba a mis en place une politique de service en français pour s'assurer que les services de santé sont disponibles en français. Pour atteindre ces objectifs, il faut qu'un nombre suffisant de professionnels de la santé parlent couramment le français.

En 2005, l'Université du Manitoba a mis sur pied le Programme bilingue de résidence en médecine familiale, un programme de formation novateur basé à Winnipeg, au Manitoba, avec des sites de formation dans les communautés francophones en régions rurales du Manitoba.

Buts / Objectifs

Ayant maintenant diplômé 10 cohortes du programme, cette étude évalue le succès du programme dans la préparation des diplômés appelés à servir la population francophone.

Méthodes

Une enquête transversale de tous les diplômés du programme (N = 36) a été réalisée. Les questions du sondage portent principalement sur l'utilisation du français lors de l'entrevue clinique, ainsi que sur l'emplacement et la portée de la pratique des médecins depuis le début de leur pratique médicale jusqu'à aujourd'hui, y compris les changements au fil du temps.

Résultats

La majorité des diplômés offrent des services complets en médecine familiale dans les communautés francophones du Manitoba, et un petit nombre de résidents ont choisi de compléter une formation supplémentaire dans un domaine ciblé. Une proportion importante participant également dans la formation de futurs médecins.

Conclusions

Le programme a eu un impact positif sur le nombre de médecins francophones et sur la prestation de services en français dans les communautés minoritaires francophones rurales et urbaines du Manitoba.

Paper ID: 185

Clinical Reasoning - Should this be taught explicitly?

Pradeep Vijayanand¹, Leesa Walker¹ and Michelle McIntosh¹

¹ Flinders University Rural Health South Australia (Australia)

The Parallel Rural Community Curriculum (PRCC) is a longitudinal integrated clerkship (LIC) in which 3rd year Flinders University Doctor of Medicine students are placed in rural General Practices and regional hospitals for the full academic year. This is a curriculum of authentic learning opportunities with direct supervision of experienced clinicians. Students learn by actively engaging in patients care in complex health care systems and by becoming integrated into the health professional team. When working alongside experienced clinicians in busy work environments the process of clinical reasoning can be quite mysterious to students. There is literature on a variety of frameworks to teach clinical reasoning skills like hypothetico-deductive reasoning, pattern recognition, making thinking visible, “Blackbox” of reasoning, principles of knowledge, Cognition and Metacognition among others. This PeArL will explore if we should be more explicit in how we teach clinical reasoning.

1. How do students learn about the clinical reasoning process currently?
2. Should we be teaching frameworks / Models of clinical reasoning to help students understand and reflect better?
3. What frameworks can clinicians use to teach clinical reasoning in busy clinical practice environments?

Paper ID: 186

Maximising Continuity in Longitudinal Integrated Clerkships

Michelle McIntosh¹, Peter Michelmore¹, Pradeep Vijayanand¹ and Leesa Walker¹

¹ Flinders University Rural Health South Australia (Australia)

The PRCC (Parallel Rural Community Curriculum) is a year-long longitudinal integrated clerkship (LIC) in which students are placed in a rural community for the third year of a four-year Doctor of Medicine (MD) at Flinders University. Continuity is a fundamental organising principle of LICs. Following patients through the health care continuum is central to the rich learning that occurs in the PRCC. While the PRCC provides strong continuity of supervision, peers and support, the opportunities for continuity in patient care are becoming more difficult. Changes in local health services including a centralisation of care and less of the care being delivered by local clinicians are having an increasing impact. There is also variability in how students maximise the available opportunities due to scheduling, variable motivation, and sometimes the perceived “low yield” of this type of learning. This PeArLs will explore if there are similar issues in other programs and strategies that can be used to strengthen the participation of students in the continuity of patient care in LICs.

Questions

- What impacts students' ability to follow patients and be involved in their care through the health care continuum in LICs?
- How do we motivate students to make the most of the opportunities that exist to follow patients and be involved in their care?
- What are some strategies that can be used to strengthen the involvement of students in the continuity of patient care?

Paper ID: 187

The integration of Cultural Safety Training and Communications Skills Teaching in Medical Education

Mark Dalglish¹ and Candice McKenzie¹

¹ Deakin University School of Medicine (Australia)

Communication skills are now regarded as integral to medical education for training future doctors. Increasingly, particularly in nations with traumatic histories of colonial occupation, cultural awareness and safety training is seen as important in ensuring that future health care professionals are sensitive to these histories, and efforts can be made to close health inequality gaps, and address both historical and ongoing injustice.

This poster seeks to explore aligning cultural safety training with communication skills as they are taught in medical schools in Australia, and then propose strategies for integrating this teaching into the medical education curriculum, before then offering this as insight so that it might be expanded both to other nations with post-colonial histories, and also expanded to other areas of cultural safety, for example, in relation to sexuality or gender diverse communities, class conflict and socioeconomic disparity, and immigrant and refugee communities.

Communication skills are often taught as relating to process issues; about the way questions are asked, how much time is given to listening rather than asking more questions, body language, professional behavior, and the use of para-verbal or non-verbal cues. At the same time, it is recognised that some content issues need to be more readily utilised, for example, by asking patients about their ideas, concerns and expectations. By integrating broader cultural awareness and safety with communication skills teaching, the third aspect of communication, sometimes called perception or attitude, can be hopefully developed in medical students to facilitate a more effective approach to all patients.

Paper ID: 188

Continuity and time builds trust between University and Aboriginal community

Keren Wu¹, Kathryn Sylvia², Doug Turner², Kaylene McLoughlin³ and Daniel Richardson⁴

¹ Flinders University Rural Health Society (Australia)

² Flinders University Rural Health South Australia (Australia)

³ Point Pearce Aboriginal Community (Australia)

⁴ Point Pearce Aboriginal School (Australia)

Aboriginal leaders consistently recommend genuine community partnerships require time, effort and consistency. University projects are problematic as students graduate and move on, threatening continuity. Aboriginal health and community engagement is a key priority for rural health students and expensive short-sighted activities can be tokenistic, failing to provide meaningful outcomes.

The rural health student club Flinders University Rural Health Society (FURHS), sought to address this problem and considered strategies to build a strong genuine partnership with the rural South Australian Aboriginal Community of Point Pearce.

Between 2015-2018 FURHS have worked with local school leadership and Aboriginal elders, to implement five intergenerational community directed activities.

Two University staff members provide an ongoing consistent contact for community, enabling students to progress toward consultation, planning and implementation of activities. Turnover of FURHS members, school leadership and contacts within the community can cause communication breakdown. Care is also taken to ensure community members in attendance are not outnumbered by FURHS members. Attendance by Aboriginal FURHS students provides highly regarded role model opportunities, promoting University entry pathways.

There are clear indications our relationship is getting stronger. Long term commitments and stable key contacts are essential for meaningful University-Aboriginal community relationships. Gone are uncertainties and now visits are like a friendly reunion. Activities are intergenerational with the whole community engaging with our students. Flinders University is now a career goal for some of the Point Pearce students and this is attributed to the connections made and information that has been shared over the past four years.

Paper ID: 189

Location, location, location: influence of post-graduate training locations on later workplace

Kath Weston¹, David Garne¹ and John Bushnell²

¹ University of Wollongong (Australia)

² University of Wollongong (New Zealand)

Graduate outcomes are a key measure of how well medical schools meet their aims. The mission of the University of Wollongong's Graduate Medicine program is to address workforce mal-distribution in Australia. A large proportion of students enter the course from rural and regional background, and all students spend a 12-month LIC placement in one of a non-capital city urban, regional or rural location. After 5 years of post-graduation training, we undertook a telephone-based survey of graduates to identify their current workplace location and the training locations of the preceding years.

Despite a low response rate, we found a strong association between location of training and location of workplace after 5 years. Most graduates who trained primarily in capital cities had remained there after 5 years. Similarly, students who trained primarily in non-capital city urban locations stayed there. Graduates who, after 5 years, were working in regional or rural locations had spent most of their training in those locations. Limited training was undertaken in the first 5 years in the RA3 (outer-regional) locations; however those who had spent most of their training in those locations were also more likely to be working there after 5 years. Many graduates reported that the 12-month LIC placement experience had played a role in their current work location. Additional data using electronic survey method are being collected.

These results support the development of rural and regional training initiatives in helping to keep junior doctors working in those locations.

Paper ID: 190

Capturing Climate Change: building the Arts into medical education

Kath Weston¹ and Louella McCarthy¹

¹ University of Wollongong (Australia)

Osler counselled his medical students over 100 years ago that it was more important for them to know about the *patient* with the disease rather than about the *disease* affecting the patient. Yet in this science-saturated culture in which we live, the patient may be at risk of getting lost in the fog of science and technology. How can we put the humanity back into the medicine? The longitudinal integrated clerkship (LIC) model of medical education supports Osler's advice, providing opportunities for continuity of: care, curriculum, supervision, idealism, peers, and systems.

At the University of Wollongong (UOW), a focus on the medical humanities has seen a new development called Art in Bodies early in the course and plans for modules in the senior phase teaching about narrative and creative works in medicine. The LIC community-based phase represents another opportunity to extend the students' medical humanities experiences through their reflection on the global issue of climate change.

As part of Global Climate Change Week and, within the public health curriculum, students are invited to contribute a photograph and narrative about an aspect of their community placement that causes them to think about climate change and its impact. This presentation describes how students are moved to engage in this activity and their responses.

This activity typifies the approach of medical humanities in dealing with the intersection of human experience, medical practice, and scientific technology, and centres on the meaning of medicine in relation to the individual within the society and community.

Paper ID: 191

Making change in the LIC: developing medical students as community-based clinician researchers

Kath Weston¹, Warren Rich¹, Pippa Burns¹, Judy Mullan¹, Shahid Akhund¹ and Peter McLennan¹

¹ University of Wollongong (Australia)

The concept of a clinician-scientist conjures up an image of a doctor seeing patients in the morning, then spending the afternoon in the laboratory, or something similar. Yet, the idea of translational research does not have to remain behind the laboratory door. Generalist practitioners in any setting can be researchers. Seeking to identify and understand issues of relevance in a community setting is a critical form of research. Moreover a research-aware practitioner can promote early translation of research findings into clinical practice or can engage with other researchers to investigate an issue revealed through observation. A doctor can practice science-based medicine without having to actively work as a scientist in a science laboratory, and real-world issues can inspire relevant research.

It is well recognised that early exposure to research is one way to develop a culture of research-aware and research-active clinicians. At the University of Wollongong all students on a 12-month LIC placement are supported by academic staff to undertake a community-relevant research project. Analysis of the projects undertaken to date (n=519) showed that all student projects incorporated one or more research methods, such as sampling, epidemiology, statistical analysis, research ethics, and other methods of enquiry such as qualitative research and health care evaluation. Appreciating the importance of ethical conduct of research can also help develop good practice.

Researching in the community setting represents a practical way to engage medical students can help to develop their potential to become 'clinician researchers', investigating and making change relevant to their communities.

Paper ID: 192

Global Health in Surgery-A Platform for 'Learner-Faculty Growth': The West African Experience

Emmanuel Abara¹, Ndidi Abara² and Samuel Osaghae³

¹ Northern Ontario School of Medicine (Canada)

² University of Texas Medical Branch, Galveston (United States)

³ University Teaching Hospital, Benin (Nigeria)

Introduction and Objectives: Since 2012, a group of surgical health professionals have undertaken an outreach to marginalized populations in West Africa aimed at 'building capacity while providing services'. By 2014, residents have been encouraged to attend to gain experience and develop professionalism. We report the Burkina Faso experience of 2017.

Methods: For seven days, health professionals from 8 countries functioned as a team. We worked at the Ouahigouya District Hospital. The program included: Out-patient assessments and Surgeries-pediatric, oncology, general surgery, otolaryngology, orthopedics, gynecology, and urology. Transfer of skills and tricks of the trade among peers; Faculty Case-based Learning and an interactive workshop for peers and learners; Learner-Learner exchange of ideas from their institutions - all provided stimuli for professional growth The host provided accommodation, meals and local transportation. Participants cared for their travel arrangements.

Results: There were 7 'diaspora' and 10 local surgeons, 2 anesthetists and several nurse anesthetists, OR nurses and support staff. Three residents (from the Cameroons and Texas, USA) were present. There were 200 cases in all. Short -term outcomes were satisfactory. Long-term results will be necessary to validate the efforts. The educational content of the outreach was described by most as transformative as the professionals shared knowledge and skill while patients received excellent collaborative care.

Conclusion: Short-term surgical outreach like this can be questioned as ineffective and unsustainable. However, the building of interdisciplinary, collaborative partnerships that are respectful and culturally sensitive is an asset. Our learners become winners and partners in global health for all.

Paper ID: 193

Using the retrospectroscope: Student satisfaction with their geographic LIC placement

Mark Wilson¹, David Garne¹, Louise Wright¹, Belinda Smith¹ and Ian Wilson¹

¹ University of Wollongong (Australia)

Aims: To determine the satisfaction of senior medical students with the geographical location of their year-long LIC in regional and rural Australia, and the reasons for this.

Methods: Structured interviews are offered to the entire cohort as a voluntary monitoring and evaluation exercise at the end of each LIC. In 2017, the students were asked to preference again for the LIC placement with the benefit of having just completed the year there, to rank their hub preferences, and to explain these.

Results: With the benefit of hindsight, 53 of 72 students would choose the same LIC placement location again. For six of the rural hubs, there was a notable increase in proportion of first preferences given for the hub placements if the students were able to preference for a repeat LIC. There was a trend for students who had been placed in the five most popular hubs, with 100% or greater subscription pre-LIC, for a small to medium proportion of students to change their first preference post- LIC. The main themes arising from qualitative analysis were educational, social and geographic.

Discussion: This shows that the majority of senior medical students placed in a distributed LIC in New South Wales have a high level of satisfaction with their LIC allocation. This gives program staff the confidence to inform future cohorts of students that they will have a rewarding educational experience no matter where they are placed. It forms part of a larger longitudinal study investigating trends for student satisfaction with their LIC experiences.

Paper ID: 194

Long teaching days- how long is too long and how do you avoid them?

Amy Thomas Savory¹, Amy Schulz¹ and Kiara Hoffmann¹

¹ Flinders University Rural Health South Australia (Australia)

Introduction/Background:

Flinders University Rural Health SA offers a post graduate medical program where students in their 3rd year participate in a twelve month longitudinal integrated clerkship within a rural community known as the PRCC (Parallel Rural Community Curriculum).

One of the locations for the program is the Riverland, which is located approximately 3 hours from our capital city. Many of the clinicians that teach into the program are visiting and funded from other sources to provide patient care when in the region. These clinicians generously offer their time after hours to provide formal teaching to our students however this can result in very long days for the students. Attempts have been made to try and encourage clinicians to utilise other technologies such as video conferencing to provide teaching on alternate days but the clinicians have a strong preference for face to face teaching.

Aims/Objectives:

To explore novel ways of delivering the curriculum in a rurally based distributed medical program

Questions:

- How do other programs combat long teaching days when the primary source of specialist teaching occurs after hours?
- In the audiences experience how effective is teaching in the evening? How long a day is too long?
- How have other rural programs structured their teaching times to improve this?
- Are there additional skills needed for teacher and students when teaching is deliver via other technologies rather than face to face teaching? How do engage busy clinicians to upskill?

Paper ID: 195

Learner-Faculty Feedback and Reflective Practice in a Rural Urology Clinic

Emmanuel Abara¹

¹ Northern Ontario School of Medicine (Canada)

Introduction and Background: Learners from several health institutions, spend sometime in our rural urology clinic to gain experience. Over the years, we have adopted various methods of feedback to enrich our teaching and clinical practice. We report one such method that seem to resonate with the learners.

Materials and Methods: Our learners are residents and medical students from NOSM and other Medical and Nursing Schools who elect to spend some blocks of time to gain some urological knowledge. On arrival, the learner meets the Faculty and Unit staff and discusses the learning contract or plan, setting some simple achievable goals. The learner works alongside with faculty. There is End of Day Debriefing. Learner selects 2 or 3 topics/cases for in-depth review and literature search. Learner reflects on the day's activities, workplace and professionalism, produces a report after critical analysis and literature review. This is submitted electronically to faculty who reviews the work and responds with a feedback, sometimes resulting in multiple loops of feedback

Results: Learners were very receptive with close to 90% compliance rate. Knowledge gained led to change in practice, attitude and skill acquisition. Reflective practice, critical analysis, development of professionalism and publication of case reports were good harvests from this feedback process.

Discussion and Conclusion: Learner -Faculty Feedback is a healthy strategy for professional health care education. Benefits to learner and faculty result in growth and sustainable workplace relations. Respectful, honest, genuine feedback generates confidence and trust. Negative feedback taken seriously can result in lasting benefit

Training and continuing professional development of Rural Generalist Anaesthetists.

Peter Gilchrist¹ and Lucie Walters²

¹ Flinders University (Australia)

² Flinders University Rural Health South Australia (Australia)

Rural Generalist Anaesthetists (RGAs) perform pivotal work within rural communities across Australia. In many communities there would be no elective surgical services, significantly reduced maternity services, and arguably no pre-tertiary hospital critical care without RGAs.

Australian RG Anaesthetists are a disparate group of practitioners. Affiliations to several colleges, variable credentialing practices, inequitable hospital resourcing, situational peculiarities, and the tyranny of distance are significant challenges, which have led to differences in the scope of RGA practice around the country.

Scant data exists about the work undertaken by RGAs. No single credentialing body is responsible for data collection - and inconsistent, incomplete data exists within health authorities.

The Joint Consultative Committee of Anaesthesia (JCCA) has played a key role in development of the initial training curriculum and credentialing of RGAs over the past 25 years. The JCCA is a tripartite committee with equal representation from ANZCA, ACRRM and the RACGP. Recently, questions have been raised as to the ongoing role of the JCCA and its relevance in contemporary medical education. Additionally, there have been recent changes mandating core continuing professional development courses for RGAs and aligning these to the requirements of the Australian and New Zealand College of Anaesthetists (ANZCA).

In 2017 ANZCA unilaterally decided to develop a diploma of anaesthesia for RGAs. This decision has been largely welcomed by RGAs but the details of the proposal have provided cause for concern.

This presentation will contextualise the medico political position of RGAs in the delivery of medical care to rural Australians. It will also discuss some of the major issues with current training and raise questions regarding the future direction of RGA training and ongoing credentialing.

What are the training and continuing professional development requirements for rural anaesthetics in other countries?

What is the link between training and continuing professional development requirements and quality and safety in these contexts?

What might best practice training and continuing professional development look like in rural Anaesthetics?

Paper ID: 197

How does context affect change management for RCEME program development?

Praphun Somporn¹, Lucie Walters² and Julie Ash³

¹ Collaborative Project to Increase Production of Rural Doctor/ Ministry of Public Health (Thailand)

² Flinders University Rural Health South Australia (Australia)

³ Prideaux Centre for Research in Health Professions Education, Flinders University, Adelaide (Australia)

Thailand has sought to remedy the shortage and poor distribution of its rural medical workforce. The Ministry of Public Health has collaborated with the Ministry of Education over two decades to train rural background medical students through its CPIRD (Collaborative Project to Increase Production of Rural Doctor) program. In order to improve rural doctor production and distribution, after graduation CPIRD alumni must work in a rural town for three years. However, the challenges of rural retention rates persist. To maximise students' interest in rural careers, better prepare students for their future rural general practice roles, as well as improve rural retention rates, Thai Rural Community Engaged Medical Education (RCEME) placements are being developed, however in a resource-limited context there are change management challenges associated with this. A stakeholder analysis has revealed concern about regional lack of medical educators and clinicians experienced in developing and delivering such RCEME programs.

The aim of this session is to seek insight from participants about the implications of RCEME in the context of developing countries.

Discussion questions:

What can Thai RCEME stakeholders learn from the international evidence and experience of applying RCEME to context?

What strategies do support RCEME capacity building locally?

What strategies can CPIRD put in place to build RCEME program evaluation and research capacity?

How can CPIRD support rural clinical educator career pathways and progression to sustain the quality of RCEME?

Paper ID: 198

Faculty Perceptions of Block Clerkship vs. Longitudinal Integrated Clerkship Models

Mark Beard¹ and Shane Schellpfeffer¹

¹ University of South Dakota Sanford School of Medicine (United States)

PURPOSE:

In July of 2013, the University of South Dakota Sanford School of Medicine converted its curriculum model from block clerkships to a longitudinal integrated clerkship (LIC) across all clinical campuses. There was initial hesitation about switching the curriculum for many faculty members.

Previous research has found that faculty who teach in an LIC report more satisfying professional lives,¹ as well as satisfaction with the experience of teaching clinical students.^{1,2} Additionally, mentoring of and getting to know students increases for faculty members in an LIC.² Changes to teaching methods and practices was also reported.^{2,3}

METHODS:

In the spring of 2015 and again in December of 2017, all faculty were surveyed about their experience in the two different models. Surveys included campus and specialty information and 1-5 numeric ratings comparing block clerkships to the LIC on six aspects of experience. After each rating, faculty were also able to provide narrative information. Statistical analysis included descriptive statistics, ANOVA, and Chi Square examination of differences between campuses and disciplines. Narrative data were examined thematically and conclusions were drawn.

RESULTS:

The baseline data results found that primary care faculty were quite positive regarding the LIC while faculty in pediatrics, psychiatry and surgery tended to be more skeptical. This presentation will include the results from the follow up survey conducted in December of 2017 and make comparisons between the original research and faculty perceptions after completing three additional iterations of the LIC.

CONCLUSIONS:

In the baseline survey, we found that changing from block clerkships to LIC is a long process and some faculty in some disciplines embrace the LIC more rapidly than others. We anecdotally expect to find that more faculty are engaged and accepting of the LIC after three additional iterations.

Paper ID: 199

An Analysis of Grade Inflation, Grade Point Average and Step 2 Clinical Knowledge Scores in Two Curricular Models: LIC vs. Block Clerkships

Lori Hansen¹, Shane Schellpfeffer¹, Mark Beard¹, Janet Lindemann¹, Matthew Simmons¹ and Tim Ridgway¹

¹ University of South Dakota Sanford School of Medicine (United States)

55% of Internal Medicine Clerkship Directors report grade inflation exists, and 78% feel it is a serious problem. At the Sanford School of Medicine, all students since 2014 have trained in the Longitudinal Integrated Clerkship (LIC) model. Previously, the grading rubric included only discipline specific grades in the block clerkship (BC) model at two campuses and only competency grades at one campus (LIC). Now the grading rubric at all campuses includes both competencies and discipline specific grades. National Board of Medical Examiners Shelf exams comprised 19% of LIC grades in Yankton and now accounts for 32% of overall grade point average. Bowen in American Journal of Surgery reports inflation of grades leads to decreased correlation with shelf scores.

The purpose of this study is to determine:

- If the model of medical education, the LIC model vs the traditional BC, affects grading.
- The effect of shelf board exams comprising a larger percentage of the overall grade in the primary clinical year.
- The effect of curricular change on Step 2 Clinical Knowledge (CK) scores.

The office of Student Affairs will report average GPA and Step 2 CK scores for students on all three clinical campuses for three years prior to curricular change; and three years after the curricular change. Two transitional years were excluded from the analysis.

Preliminary results:

1. There was very little change in GPA for the primary clinical year for the BC students after curricular change.
2. The average of LIC student's GPA increased with the change of the grading rubric.
3. Step 2 CK scores increased on all campuses after curriculum change.

Paper ID: 201

Assessing Medical Student Competencies in a Longitudinal Integrated Clerkship Curriculum

Shane Schellpfeffer¹, Mark N. Beard, M.D.¹ and Lori Hansen, MD¹

¹ The University of South Dakota Sanford School of Medicine (United States)

During the past five years, the University of South Dakota Sanford School of Medicine has undergone numerous curricular changes. One of these changes was a conversion from traditional block clerkships to a longitudinal integrated clerkship.

Because of this curriculum change, the development of new methods of assessment was required. An increasing emphasis was placed on the importance of formative assessment and feedback in order to provide students with timely and standardized feedback.

A system of centralized grading during the clinical year was developed. Competency-driven grading, where competencies are integrated into the disciplines, was a part of this new model. Numerous data sources are used to calculate competency grades. The original study sought to determine: Are the competency grades really measuring a different set of skills than the discipline grades?

Methods

The original analysis used data from three cohorts of students (N=154). An additional two cohorts of students, with approximately 120 more subjects, will be added to this analysis. The follow up study will exactly replicate the original study. For the original study, descriptive statistics and Pearson correlations were calculated, and a factor analysis was conducted, using a Varimax (orthogonal) rotation.

Results

The baseline data results from the initial study found that competencies showed more variation in means and standard deviations than did the disciplines. All of the disciplines were highly correlated to each other. Correlations between only the competencies were less strong than among only the disciplines, and the correlations between disciplines and competencies were relatively constant.

Conclusions

We found that the four components of the factor analysis measured a student's: exam-taking ability, interpersonal skills, professionalism, and inter-professional collaborative skills. These results suggest that medical student competencies do measure unique constructs. We anecdotally expect to find, with additional data, that competencies continue to measure unique constructs.

Paper ID: 203

A Multidisciplinary Paediatric Respiratory Education Update in Mount Gambier Hospital, presenting new Clinical Practice Guidelines (CPG) on Early Administration of Humidified High Flow Oxygen (HHFO): a life-saving treatment for infants with Bronchiolitis

Gillian Watterson¹ and Ruth Lawson ED¹

¹ Mount Gambier Hospital (Australia)

Historically in rural paediatric units across Australia, there has been a low threshold to transfer infants with early bronchiolitis (a common viral infection in winter, potentially causing significant respiratory distress) to Tertiary Paediatric Centres.

However a recent international study, the **Paediatric Acute Respiratory Intervention Study (PARIS)** has demonstrated that prompt use of HHFO via nasal cannulae in Emergency Departments (ED) of Rural Hospitals, has reduced the need for escalation of care by half. HHFO, increases Peak End Expiratory Pressure and reduces atelectasis.

Medstar Retrieval Service in South Australia have no facility to provide HHFO during transport of infants with bronchiolitis, only CPAP which has the potential for causing barotrauma with air ambulance transport and so encourage rural Paediatricians where possible to care for the infants locally which is also less disruptive for the family.

A multi and inter disciplinary Paediatric Respiratory Education update has recently been provided in preparation for the winter period, by a joint team of Emergency Department Nurses and Staff Specialist Paediatricians in Mount Gambier Hospital (MGDHS). The aim of the update was to:

Inform those frontline clinical staff at MGDHS regarding the importance of early administration of HHFO to infants with bronchiolitis, including the practical set up of the HHFO circuit.

Following the Educational Update, a local Clinical Practice Guideline (CPG) has been established and an audit post winter will be carried out, hopefully demonstrating a reduction in the need for retrievals for infants with bronchiolitis.

Paper ID: 204

A Place at the Table for All: Building a Community of Practice in an LIC

Susan Rogers¹

¹ Duke School of Medicine (United States)

Often implicit in its creation, the structural, geographic and sometimes cultural components of an LIC are far flung. Learners, faculty and administrators easily risk being siloed by virtue of different sites, divergent, wearing clinic schedules and competing priorities. At risk then is the successful implementation of the LIC itself. A shared vision of the LIC mission, the teamwork necessary to implement that mission, supported by an ethos of self-care, are critical elements to the LIC's success, without compromising the well-being of its participants.

How then, to build a *community* of practice within an LIC? That is the aim of this PeArLs, with the following objectives:

1. Learn best practices to strengthen a sense of togetherness within an LIC.
2. Engage in critical thinking about strategies to support LIC learners and faculty.
3. Follow up with participants regarding any implementation of discussed best practices and strategies.

The discussion among the PeArLs participants would include the following questions and issues for exploration:

1. What are some of the outcomes in attempts to build community within your LIC? Share your stories.
2. How have you shared the vision of your LIC's mission?
3. How have you engaged in teambuilding in your LIC?
4. How you have cultivated an environment of self-care for all participants in your LIC?
5. What roles do learners play in building community within your LIC?
6. What have been some of the greatest challenges in building community within your LIC?

Paper ID: 205

Retaining Doctors in Remote Areas

Lara Wieland¹

¹ GMT (JCU) – Generalist Medical Training (Australia)

Over 20 years of experience as a doctor in remote and rural Australia and later as a remote medical educator has led the author to explore what the factors are that keep doctors in the most remote areas. She has explored these issues in remote Canada through a Churchill fellowship and shares her findings along with her Australian experiences.

The author contends that retention of doctors in remote areas should be of specific interest because health disparities are generally greater the more remote the location and yet retention of doctors is poorer the more remote the location - precisely where they are most needed.

As a doctor who loves remote work, the author's hypothesis is that there are doctors who will work remotely if the right factors are addressed.

The findings of the Churchill fellowship interviews in rural and remote Canada will be published in October in a Churchill report.

An unpublished literature review by the author was done on retention of rural and remote health professionals - a summary of the findings as well as the clear gaps around remote retention will also be discussed.

Paper ID: 206

L'offre active des services de sante en francais : pourquoi et comment la mettre en pratique

Diane Quintas¹

¹ Réseau du mieux-être francophone du Nord de l'Ontario (Canada)

Le Réseau du mieux-être francophone du Nord de l'Ontario (Réseau) a lancé la nouvelle formation interactive en ligne sur l'offre active des services de santé en français.

Les modules ont été inspirés des priorités établies par le Commissariat aux services en français de l'Ontario, ainsi que par le Cadre de référence pour la formation à l'offre active des services de santé en français et la Boîte à outils pour l'offre active du Consortium national de formation en santé (CNFS) et divers autres partenaires provinciaux et nationaux.

Cette formation vise à sensibiliser les gens qui travaillent et étudient dans le domaine de santé à la valeur de l'offre active de services de santé en français. La formation est gratuite et est offerte en français et en anglais. La réussite de la formation permet d'acquérir des crédits d'apprentissage continu par l'entremise de certains collèges et ordres professionnelles. La formation est composée d'une série de six modules :

1. Excellence de service centré sur le patient
2. Équité et sécurité
3. Compétences culturelles
4. Recrutement et rétention des ressources humaines bilingues
5. Environnement de travail et culture organisationnelle
6. Engagement communautaire

Cette initiative est financée par Santé Canada, dans le cadre de la Feuille de route pour les langues officielles de 2013-2018 : éducation, immigration, communautés ainsi que par le Réseau local d'intégration des services de santé (RLISS) Centre-Toronto.

Pour en apprendre davantage sur la formation interactive en ligne sur l'offre active des services de santé en français, veuillez consulter www.formationoffreactive.ca ou www.activeoffertraining.ca.