



COMMUNITY-RELATED ISSUES

Commentary on introducing Community-based Teaching of Third Year Medical Students: Outcomes of a Pilot Project One Year Later and Implications for Managing Change).

The Critical Role of Faculty in Supporting and Sustaining Innovation

SARENA D. SEIFER, MD

In spite of the fact that during the year students spend about 120 days on the wards in which to learn and practice clinical skills, and only four days in the community, there was some anxiety expressed that students would be disadvantaged. (Thistlethwaite, 2000)

Over the past decade, an impressive number of expert panels and professional organizations have examined the implications of changing health care delivery systems for the educational mission of academic health centers and health professional schools (Boelen, 1992; General Medical Council, 1993; Pew Health Professions Commission 1995, 1998; Council on Graduate Medical Education, 1999). Their analyses of changes in the financing and delivery of health care and health professions education, and concerns about the size, distribution and quality of the health workforce, have led these panels and organizations to all call for changes in the competencies needed by health professionals in the next century and the content and location of teaching and learning.

The Pew Health Professions Commission was the first to advance a set of competencies needed by all health professionals to be effective in the 21st century (O’Neil, 1991). Today many believe that in addition to being clinically competent, health professionals also need to embrace a personal ethic of social responsibility and service; rigorously practice preventive care; integrate population-based care and service into practice; improve access to care; and provide culturally sensitive care (Boelen, 1992; General Medical Council, 1993; Pew

Executive Director, Community–Campus Partnerships for Health, Research Assistant Professor. Address for correspondence: S.D. Seifer, University of Washington School of Public Health and Community Medicine, UW Box 354809, Seattle, WA 98195–4809, USA. Tel: (206) 616-4305. Fax: (206) 616-9415. E-mail: sarena@u.washington.edu <<http://futurehealth.ucsf.edu/ccph.html>>

Health Professions Commission 1995, 1998; Council on Graduate Medical Education, 1999).

In response, government agencies, private foundations and academic institutions themselves have invested millions of dollars in curricular reform initiatives in the last decade.¹ These initiatives have led to a number of significant curricular innovations, including a greater emphasis on teaching and learning in ambulatory and community-based settings as described by Dr. Thistlethwaite at Leeds University Medical School (2000).

While the full ramifications of these reforms are not yet known, there is a growing evidence base to support the premise that ambulatory and community-based education has contributed to positive changes in the attitudes, knowledge and behaviors of health professionals in training and in practice (Irby, 1995; Seifer, 1997, 1998).

Of concern to Thistlethwaite, and indeed to all those who seek to improve health professions education, is to achieve institutional support and ultimately sustainability of the proven reform. Could improvements in the process undertaken at Leeds have led to greater support for the ambulatory curricular component among hospital-based faculty? What do we know about the change process and the sustainability of change that could be helpful to Leeds and other health professional schools undertaking similar reforms?

Organizational change theory can help us understand how and why health professional schools resist or embrace innovations (Rogers, 1995). The stage theory of organizational change asserts that there are several layers within an organization where change can be influenced. In health professions education, these layers include administrators, faculty, working groups and committees, and students, among others. Understanding the roles and motivations of individuals in each of these layers is important in targeting or influencing change, as is the point at which their influence may be greatest. For example, within health professions education, academic administrators may be more important during the adoption and early implementation of an innovation, while faculty and curriculum committees may be more instrumental when it comes to institutionalizing and sustaining the innovation.

Numerous studies of the adoption of curricular innovations suggest that several factors appear to be critical to faculty support for ambulatory and community-based health professions education (Kaufman, 1985, 1989; Waugh & Punch, 1987; Neufeld *et al.*, 1989; Gruppen *et al.*, 1993; Hitchcock *et al.*, 1993; Swanson & Anderson, 1993a,b; Wilkerson, 1994; Foley *et al.*, 1996).

1. Curriculum changes must be connected to larger strategic issues faced by the institution. Thistlethwaite (2000) explains that “the community-based teaching was inserted into an existing curriculum rather than being incorporated as an integral part of the third year of teaching.” Although this approach is preferable to designing a new course that is not connected at all to the

existing curriculum, there might be more support for the innovation if it is seen as an essential method for addressing deficiencies in graduates' competencies, strengthening the school's community relations, or any of a number of other expressed institutional goals. The fact that the author's institution is embarking on a major curriculum overhaul presents an important opportunity to advance community-based education to the extent its goals and outcomes can be connected to those of the overall curriculum.

2. Faculty must understand the educational philosophy of the new curriculum, and they must perceive a need for the change. Thistlethwaite reports that "the head of each firm was informed about the aims and objectives of the community attachment ... its emphasis ... and the process." Beyond providing information, curriculum reformers need to engage all stakeholders in the change process as integral participants. For example, meetings with the heads of each firm—individually and as a group—prior to the development of the community attachment—would have uncovered concerns that could have been addressed in the curriculum design and evaluation. How familiar are the hospital-based faculty, for example, with trends in health care delivery and financing or with the evidence base for ambulatory and community-based education? Presentations at faculty meetings and in "grand rounds" type forums could inform faculty about experiential learning theory and the documented outcomes of ambulatory and community-based education.
3. Evaluation of the innovation must gather data that responds to stakeholder concerns. For example, Thistlethwaite quotes two hospital-based faculty members who are concerned that community-based education will "dilute" the students' exposure to pathology, and undermine their acquisition of clinical exam skills. If these are concerns shared by other faculty members, they could have been directly addressed by having students maintain logs of the patient problems they observed, and by comparing the clinical exam skills of students who participated in the community attachment with those who did not.
4. Faculty must be provided with ongoing support for making the change. For example, faculty development through workshops, individual consultation and opportunities to test and apply their new knowledge is a critical component of the change process. Providing opportunities for community-based and hospital-based faculty to interact and learn together might help to overcome the suspicions and negative views each has of the other.
5. The institution's corresponding faculty reward system needs to support the intended change. The development of supportive faculty roles and rewards policies, processes and structures is largely lacking in health professional schools. Many institutions that have initiated innovations in health professions education risk having them remain isolated and marginal efforts unless they tackle the complex and political issues of how scholarship is defined and how faculty are recruited, prepared and rewarded. There is a profound disconnection between the demand for change within health professions

education and the usual faculty roles and reward system. This system typically places a premium on generating research grants that pay the institution's overhead (indirect costs), and defines as the gold standard of faculty accomplishment the publication in peer-reviewed journals of findings from biomedical research and randomized controlled clinical trials. Even in institutions that are considered leaders in the innovations described above, faculty often realize that they have made career sacrifices. They discover a disconnection between the institution's publicly stated mission and priorities, and those that are actually rewarded.

Thistlethwaite and her colleagues at Leeds should be commended for taking some important initial steps toward the curriculum changes that will be needed to effectively prepare their graduates for practice in the 21st century. Fortunately, others have forged that path and have published their experiences and "lessons learned." The greatest challenge for all of us lies ahead in attending to the process of fully implementing and institutionalizing these changes.

Notes

1. In the United States alone, these include: Bridges to Healthy Communities, funded by the Centers for Disease Control and Prevention; Community Partnerships for Graduate Medical and Nursing Education, funded by the WK Kellogg Foundation; Community Partnerships in Health Professions Education, funded by the WK Kellogg Foundation; Community-Based Public Health Initiative, funded by the WK Kellogg Foundation; Generalist Physician Initiative, funded by the Robert Wood Johnson Foundation; Partnerships for Quality Education funded by the Robert Wood Johnson Foundation and The Pew Charitable Trusts; Geriatric Interdisciplinary Training Project, funded by the Hartford Foundation; Health of the Public Project, funded by the Robert Wood Johnson Foundation and The Pew Charitable Trusts; Health Professions Schools in Service to the Nation Program, funded by the Corporation for National Service and The Pew Charitable Trusts; Interdisciplinary Generalist Curriculum Project, funded by the Health Resources and Services Administration; Partnerships for Training, funded by the Robert Wood Johnson Foundation; and Undergraduate Medical Education for the 21st Century, funded by the Health Resources and Services Administration.

References

- BOELEN, C. (1992). Medical education reform: the need for global action. *Academic Medicine*, 11, 745–749.
- COUNCIL ON GRADUATE MEDICAL EDUCATION (1999). *Thirteenth report: physician education for a changing health care environment*. US Department of Health and Human Services, Washington, DC.
- FOLEY, R., YONKE, A., SMITH, J., ROE, B. & VANCE, J. (1996). Recruiting and retaining volunteer community preceptors. *Academic Medicine*, 71, 460–463.
- GENERAL MEDICAL COUNCIL (1993). *Tomorrow's doctors*. London: General Medical Council.

- GRUPPEN, L.D., WISDOM, K., ANDERSON, D.S. & WOOLLISCROFT, J.O. (1993). Assessing the consistency and educational benefits of students' clinical experiences during an ambulatory care internal medicine rotation. *Academic Medicine*, 68, 674–680.
- HITCHCOCK, M.A., STRITTER, F.T. & BLAND, C.J. (1993). Faculty development in the health professions: conclusions and recommendations. *Medical Teacher*, 14, 295–309.
- IRBY, D.M. (1995). Teaching and learning in ambulatory care settings: a thematic review of the literature. *Academic Medicine*, 70, 898–931.
- KAUFMAN, A. (Ed.) (1985). *Implementing problem-based medical education: lessons from successful innovations*. New York: Springer-Verlag.
- KAUFMAN, A. *et al.* (1989). The New Mexico experiment: educational innovation and institutional change. *Academic Medicine*, 64, 285–294.
- LAWRENCE, R.S. (1988). The goals for medical education in the ambulatory setting. *Journal of General Internal Medicine*, 3, S5–S25.
- NEUFELD, V.R., WOODWARD, C.A. & MACLEOD, S.M. (1989). The McMaster MD program: a case study of renewal in medical education. *Academic Medicine*, 64, 423–432.
- O'NEIL, E.H. (1991). *Health profession's education for the future: schools in service to the nation*. San Francisco: Pew Health Professions Commission.
- PEW HEALTH PROFESSIONS COMMISSION (1995). *Critical challenges: revitalizing the health professions for the twenty-first century*. San Francisco: UCSF Center for the Health Professions.
- PEW HEALTH PROFESSIONS COMMISSION (1998). *Recreating health professional practice for a new century*. San Francisco: UCSF Center for the Health Professions.
- ROGERS, E.M. (1995). *Diffusion of innovations*, 4th edn. New York: The Free Press.
- SEIFER, S.D. (1997). *The impact of community-based education on health professions students and communities: an examination of the evidence and recommendations for future research*. Report to the Health Resources and Services Administration, US Department of Health and Human Services, Washington, DC.
- SEIFER, S.D. (1998). Recent and emerging trends in undergraduate medical education. Curricular responses to a rapidly changing health care system. *Western Journal of Medicine*, 168, 400–411.
- SWANSON, A.G. & ANDERSON, M.B. (1993a). Educating medical students: assessing change in medical education—the road to implementation. Educational strategies. *Academic Medicine*, 68, S29–S33.
- SWANSON, A.G. & ANDERSON, M.B. (1993b). Educating medical students: assessing change in medical education—the road to implementation. Faculty development. *Academic Medicine*, 68, S17–S21.
- THISTLETHWAITE, J.E. (2000). Introducing community-based teaching of third year medical students: outcomes of a pilot project one year later and implications for managing change. *Education for Health: Change in Learning and Practice*, 13, 53–62.
- WAUGH, R.F. & PUNCH, K.F. (1987). Teacher receptivity to systemwide change in the implementation stage. *Reviews in Educational Research*, 57, 237–254.
- WILKERSON, L. (1994). Faculty development. In: D.C. TOSTESON, S.J. ADELSTEIN & S.T. CARVER (Eds), *New pathways to medical education: learning to learn at Harvard Medical School*. Cambridge, MA: Harvard University Press.