

GCEME Muster Synopsis

Medical Education for the Future

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Conferences deal with the past, the present and the future. The past in terms of the work presented, the present in terms of the discourse and discovery through the meeting, and the future in terms of the ideas and plans that come out of the meeting. The Global Community Engaged Medical Education Muster 2010 certainly had all of these elements and more. And yet despite several days of presentations and discussions the tone was noticeably not self-congratulatory. Rather there was an underlying unease amongst the many positive messages as to where we go next, how we get there and why it is important that journey happens at all.

The tone for the meeting was set by the introductory address from Professor Max Kamien, a lifetime campaigner for community-engaged medical education. In recounting the progress made over the last few decades he also reminded us that, although we might be on the ascendant just now, there are reactionary forces just waiting in the wings to undo the progress that has been made. Complacency is therefore a major threat to the future of community-engaged medical education. The challenge was clearly to up our game and to strengthen our work and our message. Put succinctly, he stated sharply that the true challenge to innovative programs we have created is to make sure that they result in placing graduate physicians in the locations where they are most needed and for these physicians to truly serve the needs of the populations they serve.

One theme was the growing difference between community and specialist care that was well illustrated by Dr Malcolm Cox of the U.S. Veterans Administration. We are perhaps at a crossroads or a point of speciation where health professional education begins to bifurcate into increasingly technical forms through tertiary centres and into increasingly humanistic forms through community-engaged schools. That is not to say that urban schools cannot be community-engaged or indeed that a relatively rurally-located institution such as the Mayo Clinic will not continue its path of super specialization. It would seem to be the politics and philosophy of an institution that determines which path it takes. Other sessions identified that perhaps the biggest challenge to innovation in medical education is actually in urban settings where speciality medicine is so entrenched and this is reinforced by the Medical boards that control them.

There were also many challenges to the nature of the research we do, both in terms of the subjects and the methods. Qualitative and narrative forms were mixed fairly equally with more quantitative measures but many presentations were light on the theoretical grounding for what we do. Another challenge was who can talk about these issues, whose voices are legitimate contributors: clinicians, AHPs, academics, manager/administrators, patients, or indigenous peoples? A number of people were puzzled why we stood for the Deputy Governor but not for the elder or the astonishing didgeridoo playing – cultural difference was tangible even within the meeting.

That 2010 was the centenary of the Flexner report was noted by a number of presenters along with a consideration of why do we do what we do. The issue of sustainable reform came up a number of times. Indeed, although presented in a more or less academic fashion the political nature of both the meeting and the work being presented there was a major undercurrent. Politics in terms of what we should be doing and what should change. Dr Arjun Karki reminded us of the challenges not just of remote and rural but also political in terms of civil conflict and social gradients between the needs of the ultra poor in Nepal and the number of wealthy medical schools without a model of community engagement in his country. Bjorg Plasdottir from THEnet challenged herself and the audience to question themselves as to why we are doing what we are doing and is it really for the best reasons and the best outcomes. She posited that much of what is being proposed in innovative programs in health professions education might well be construed as a social movement, a notion that may well cause discomfort in some if not many educational

institutions who see themselves as apolitical in this regard. There may also be challenges, identified by some, with mixing faith-based social agendas with those of CEME. Ideologies rapidly become battlegrounds and Professor Alison Lee raised the challenges neoliberal agendas bring that frame so much of what we say and do. There are also challenges arising from vested interests within the CEME community as well as beyond it. This particular concern was echoed in many conversations throughout the meeting.

There was also a clear and distinct voice coming through Muster as to the humanist aspirations of the presenters and delegates. Whether the opinions are driven by secular or faith-based personal beliefs and however loud these voices are at a meeting like Muster they are virtually unheard at meetings like AAMC or AMEE. We are not particularly visible yet but the message is strong. Clearly there is a large emotional commitment and belief in CEME as well as much firsthand experience but we are light on the strong evidence to back up our beliefs and experience. If we want to persuade, even change, health professional education as a whole (and that's a big 'if') then we need to up our game and establish a sound evidence base for CEME, social accountability and the other keystone concepts we use. In approaching a more robust evidence-base we not only need to question the models of research and the language used by the mainstream large-centre institutions, we need to make sure our own are well-grounded, well-defined, defensible and, better still, persuasive and accessible. In fact, better research may well require new and better-aligned research paradigms. Any such change will require researchers to have courage and coherence to develop and perseverance to disseminate. Moreover, we need to be willing to report our failures and what we have learned from these experiences.

There was also concern expressed about ways in which the progress of such organizations as CLIC and THENet that are committed to change can be sustained in the face of the inevitable push-back from traditional organizations who find change difficult if not undesirable. Dr. Barbara Ogur from Harvard indicated the challenges of sustaining a longitudinal clerkship model in one of the world's largest medical schools. Other conversations considered that many communities are neither rural nor particularly self-sustaining, which in turn indicates quite different approaches to social accountability and community engagement.

The presentations and discussions at the GCEME Muster were passionate and robust but sometimes a little thin on a strong academic grounding for the beliefs and experiences presented. However, we were perhaps both more comfortable with acknowledging that the future of CEME is uncertain and recognizing our responsibilities to face up to the challenges of the realpolitik we live and work in. The future will not be easy but it will be determined by how we organize and approach it. The direction and the commitment shown at the Muster for taking on this challenge was perhaps the greatest reason for hope for a better future.