

**MUSTER Conference:
Summary of Community Engagement theme
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Community Engagement is the process by which Universities build ongoing, permanent relationships with community organisations and individuals so as to realise a collective vision, for the benefit of a community. The Muster commenced with a dinner provided by the Barossa Rotary Club, which raised over \$1000 for the club's community service activities. Max Kamien set the scene and introduced us to the pioneers of community-engaged medical education in rural Australia, providing us with a sense of collectiveness. There was a palpable energy as old friends reacquainted and introduced new colleagues to this community. We were privileged to be welcomed to country by Angelina Harradine, a traditional healer, with her apprentice actively contributing to the ceremony. Arjun Karki reminded us that a collection of people is a crowd, while a community is the total network of relationships between these people. These important activities, early in the conference, affirmed the connection that community has with people, with action and with place.

The major themes explored during the conference included:

- Who is the community which your University/Educational Institution serves?
- How is the process of community engagement measured?
- What are the tangible outcomes which result from this engagement?

This theme explored the connectedness between students and community members; and also between medical education programs and the broader communities in which they are situated. Individuals within the general community were acknowledged for their important roles as representative leaders, key community champions and private people who formed personal relationships with students. There was special recognition of: the community of students who learn from us, clinical preceptors, health professionals more generally, and health care systems which interface with Universities through clinical placements.

Dr Steve Reid's presentation defined "community" in ever increasing concentric circles. The general community was recognized as: the patients we administer to, the people with health needs, the people at risk of illness who would benefit from preventative medicine, to all people within a geographically defined region. He used this conceptual model to consider the breadth

of roles for clinicians to connect, as professionals, with their communities. Students too potentially gained from the lived experience of social determinants of health (McCarthy).

The majority of presenters at the Muster presented case studies of their community engagement with all the levels of community. Individual relationships between students and private individuals developed organically or where facilitated through formal community contact programs (Brown) or through articulation with Local Council led young professional groups. Several students reflected on their experience of integrating with community (Dube, McKenzie, Ross) Outcomes of student community engagement were less well articulated. The skeptic might ask “What are we doing community engagement for?” There was some evidence presented that confirmed the widely held view that a student with community connections would be less isolated, more resilient to the stressors of study and happier (Brooks, D’Amore, Hansen, Myhre). There was clearly some optimism that this would in turn transpire to increase the likelihood of students being retained as local clinicians (Stagg, Young). Further work needs to be done to understand the complex nature of this association.

The formation of strong positive connections with clinical supervision through continuity of supervision resulted in students becoming novice members of a professional community of practice which again was assumed to increase opportunities for recruitment and retention geographically and within generalist medicine; although the data to evaluate this is in its infancy (Hough, Hudson, Perkins, Stagg). Several case studies demonstrated on a small scale that development of broader professional relationships with more senior colleagues from the same profession and interprofessional peers resulted in opportunities for career progression for students and recruitment and retention of health workforce in areas of need (Craig, Stagg, Walker). The responsibility of Universities to select and support students to ensure they contribute constructively was recognized (Brooks).

Individuals from the general public engaged as patients (Day), and participants in research. There were also innovative examples of students, university leadership and general public working together on meaningful activities such as: a book describing the history of the first doctors in Taralgon region of Victoria (Dettrick); locally generated research projects; locally recognized health promotion activities. Key members of the public were also empowered to take lead roles in the university activities including leading community liaison with community contacts across South Australia (Brown), selecting students for entry into medical school

through a rural subquota pathway (Stagg); and providing point-of-care blood testing services to their remote indigenous communities (Shepherd). The challenges of developing meaningful community engagement with indigenous peoples and their communities as whole entities was acknowledged, with issues shared and solutions celebrated (Burton, Day, Chalmers, Lowe, Senecal). As Wes Jackson articulated so clearly, it was well recognized that the process of community engagement requires sustained effort, respect, sensitivity, and the receptiveness to incorporate feedback and new ideas iteratively.

The stories told at the Muster and the sense of community which emanated from the entangled relationships of the participants energized the collective. It was however recognized that the role of this conference was to do more than nurture and sustain us as individuals. It is vital that the process and outcomes of community-engagement are more than articulated. They must be defined and conceptualized in theoretical frameworks which will allow us to translate our experiences into knowledge that can impact on the broad health professional education context, and indeed create the health workforce each international community requires for the future.

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