HEALTH PROFESSIONS EDUCATION IN RURAL CONTEXTS: A CASE FROM SOUTH AFRICA

ASME ASM 2018

Susan van Schalkwyk
The RCS study team: SURMEPI (HRSA: T84HA21652)
The CBE study team: FIRRH (SU)
The Distributed Learning study team: SUCCEED (CDC: of GH15-1574)

ACKNOWLEDGEMENTS
Why this focus on rural?


Faculty of Medicine & Health Sciences

- Five undergraduate health professions programmes:
  - Dietetics
  - Medicine
  - Occupational therapy
  - Physiotherapy
  - Speech-language and Hearing therapy
- Clinical involvement at multiple district and community health facilities (urban, peri-urban and rural)
- Includes longitudinal integrated clerkships (LICs)
Established in 2011 according to a set of guiding principles:

- **Recruit** students from rural areas
- **Teach** students in rural areas to encourage future retention
- ‘**Teach where the patients are**’ to ensure relevant exposure to the burden of disease and practical experience
- Enable **continuity** with **patients** for better learning
- Enable **continuity** with the **mentor** for better guidance and supervision
- Enable **continuity** with a specific **community** for better service orientation and contextualization of health problems
Today

• Close to 200 students have been through the RCS (including some students from the allied health programmes)
• ALL medical students and many students in the allied programmes receive some form of distributed training
• 120 rural and other distributed sites across three provinces in South Africa
• Adopting a collaborative approach to care has become key
Our journey
Developing an educational research framework for evaluating rural training of health professionals: A case for innovation

S. VAN SCHALKWYK¹, J. BEZUIDENHOUT¹, V.C. BURCH², M. CLARKE¹, H. CONRADIE¹, B. VAN HEERDEN¹ & M. DE VILLIERS¹

¹Stellenbosch University, South Africa, ²University of Cape Town, South Africa

Relationships, risk and relevance

A FIRST STEP
ORIGINAL RESEARCH

‘Going rural’: driving change through a rural medical education innovation

SC Van Schalkwyk, J Bezuidenhout, HH Conradie, T Fish, NJ Kok, BH Van Heerden, J Blitz
Faculty of Medicine and Health Sciences, Stellenbosch University, Tygerberg, South Africa

ORIGINAL RESEARCH

'I felt colonised': emerging clinical teachers on a new rural teaching platform

J Blitz, J Bezuidenhout, H Conradie, M de Villiers, S van Schalkwyk
Stellenbosch University, Tygerberg, South Africa

Research

‘We have to flap our wings or fall to the ground’: The exper medical students on a longitudinal integrated clinical model

M Voss,1 FCS (SA), MPH; J F Coetzee,2 MMed Fam Med; H Conradie,2 M Prax Med, FCFP (SA); S C van Schalkwyk,1 PhD
1 Division of Community Health, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa
2 Division of Family Medicine, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa
3 Centre for Health Professions Education, Stellenbosch University, Cape Town, South Africa

Research

Academic achievement of final-year medical students on a rural clinical platform: Can we dispel the myths?

S van Schalkwyk,1 PhD; N Kok,1 MPH, H Conradie,2 MB, ChB, FCFP; B van Heerden,1 MB, ChB, MSc, MMed
1 Centre for Health Professions Education, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa
2 Ukumila Centre for Rural Health, Division of Family Medicine and Primary Care, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa

‘GOING RURAL’

The longitudinal study – the RCS under the spotlight
Making sense: building theory


Figure 1. Being and becoming: person, participation and place.
The rural space

- **Context** within which clinical training occurs is critical – does not happen by accident
- Requires building **relationships** with district and regional hospitals and clinics, and local communities – this takes time!
- **Student** – **preceptor ratios** need to be kept small
- Student **hands-on exposure** to patients both within the hospital and at community level is key
- **Structure** is important, **logistics and planning** are crucial – it is still about student learning
Participation in the Community of Practice

• Students need opportunities to participate ‘legitimately’ and be recognised as ‘members of the team’
• An inter-professional approach establishes future practice
• The role of the clinician educator, both as ‘teacher’ and as role-model is key (and they need to be supported)
• The exposure to the ethos, values and culture of the community of practice is an important mechanism in transforming student attitudes
Transformative learning

- Exposure heightens awareness, but **immersion** (over time) can shift attitudes regarding community needs and patient care
- Opportunities for **regular, mentored practice**, foster confidence and enable competence
- The student needs to be able to take **responsibility** for her/his own learning – student agency is key for success
- **Curriculum renewal and innovation** is fundamental to implementation:
  - Opportunities for **immersion** in the community
  - Foregrounding of **graduates attributes** that see the doctor as an agent of change
  - **Integrated models** that are patient-centred
  - **Assessment practices revisited**

Towards a model for good practice

A focus on quality healthcare for all through interdependence between the health system, the educational system (Frenk et al 2010) AND, the communities we serve.

Context counts: the rural training platform (Strasser & Neusy 2010; Reid 2012)
Learning in, with and from the community; promoting active citizenship and social accountability (De Villiers et al 2014)

The student’s learning experience – authentic, transformative (Mezirow 1997)
Expanding the conversation

* the role of CBE/decentralised/distributed training
* national consensus – *participatory action research*

Decentralised training for medical students: a scoping review

Mariëtjie de Villiers, Susan van Schalkwyk, Julia Blitz, Ian Couper, Kalavani Moodley, Zohray Talib and Taryn Young

Consensus Statement on Decentralised Training in the Health Professions
International collaborations

- Impact on patients
- Impact on communities
- Impact on quality of care

Medical Education in Decentralized Settings: How Medical Students Contribute to Health Care in 10 Sub-Saharan African Countries

Zohray Talib, MD, Susan van Schalkwyk, PhD, MPhil, Ian Couper, MBChB, MFamMed, Swaha Pattanaik, MPH, Khadija Turay, PhD, MPH, Atiene S. Sagay, MBChB, Rhona Baingana, MSc, Sarah Baird, PhD, MS, Bernhard Gaede, PhD, MBChB, MMed, Jehu Iputo, PhD, MBChB, Minnie Kibore, MBChB, MPH, Rachel Manongi, MD, PhD, MPhil, Antony Matsika, MBA, MICHA, Mpho Mogodi, MBChB, MPH, Jeremais Ramucesse, PhD, MPH, Heather Ross, MPH, Moses Simuyebu, MBChB, MPH, and Damen Haile-Mariam, MD, PhD, MPH
<table>
<thead>
<tr>
<th>Category</th>
<th>Consequence</th>
<th>Conditions</th>
<th>Caveat</th>
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<td>WORKLOAD</td>
<td>decreased workload</td>
<td>students are involved in everyday work activities</td>
<td>then students need to be more senior</td>
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<td></td>
<td>increased patient satisfaction as a result of, for example, shortened time to be seen in the emergency unit</td>
<td>students are “more hands”</td>
<td>lengthens time of each consultation because students take longer</td>
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<td>enhanced patient care</td>
<td>students are more thorough and holistic</td>
<td>this may be dependent on their skills and the nature of the supervision</td>
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<td>PATIENT</td>
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<td>then teaching should occur by involving the student in everyday work</td>
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<td>SATISFACTION</td>
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<td>this requires university support</td>
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<td>CARE</td>
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<td>TEACHING</td>
<td>job satisfaction and personal growth</td>
<td>teaching is not seen as a “burden”</td>
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<td>COMMUNITY</td>
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Where are we now?
CONNECTING THE DOTS

Stakeholders
Context
Practices
Enabling factors
Framework for Effective Distributed Health Professions Education
Dall’Alba and Barnacle (2007) have argued that knowing and being are conjoined. We have shown that in the rural place, knowing (and being) becomes capable of transforming who we are. It is instructive to note how this experience is not always about academic learning and typically defies quantification or visible identification (Bleakley et al. 2011). It is much more about the intangibles: the sharing of values, being respected and accepted as part of a team, being trusted and confident to assume responsibility for a patient who is both individual and community at the same time.

Ultimately, it implies that we think differently about our teaching, that we have expanded agendas for our student’s clinical learning and that we intentionally consider what this means for ‘transforming and scaling up’ what we do.
Enkosi
Baie dankie
Thank you

Health care must reach the most disadvantaged: the poorest, the least educated and those in rural areas

#healthforall

scvs@sun.ac.za
References


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