Creating successful suburban based longitudinal integrated clerkships: parallel experiences from Canada and Australia

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Introduction

- 2 suburban based longitudinal integrated clerkships (LICs) – one in Australia, the other in Canada.
- Based on year-long rural LICs initially
- Rapid changes after inception
- Similar patterns of evolution
- Response to local resources and challenges

What CLIC says about LIC…

- LIC model based on
  - continuity of place, preceptor, and patient
  - integration of clinical experience across disciplines
- "Students participate in the provision of comprehensive care of patients over time; students participate in continuing learning relationships with these patients' clinicians, and students meet the majority of the year's core clinical competencies across multiple disciplines simultaneously through these experiences."

Reference: Walters et al 2012. Outcomes of longitudinal integrated clinical placements for students, clinicians and society. Medical Education 2012: 46: 1028–1041

Rural LICs

- Rural Physician Associate Program in Minnesota since 1971
- Parallel Rural Community Curriculum (PRCC) in rural South Australia since 1997 (Flinders University)
- Many others over past decade

PRCC

- Aim to increase the number of clinicians practising in rural areas.
- Immersion experience in rural general practice.
- Integrated across disciplines.
- Patient focussed.
- Academic results comparable to peers in rotation based programs.

Suburban LICs

- Chilliwack in Canada 2004 (University of British Columbia) and Noarlunga in Australia (Onkaparinga Clinical Education Program-Flinders University) 2009

- Initially based on PRCC model

- Aims:
  - increase clinical training opportunities in non-traditional settings
  - increase the chances of learners returning to practice in those relatively underserved areas.

- Emphasis on student-patient continuity.
- Substantial ongoing student attachment to a general practice and a local hospital with integrated curriculum.

Early Challenges

Longitudinal Patient contact

- Difficult for students to follow patients through their medical journey in any sort of time efficient manner.

- Fragmentation and delay in non-emergent care is inherent in suburban health care delivery in both Canada and Australia.

Inconsistent contact with specialists

- Unpredictable, episodic contact between specialists and students limited specialist preceptor-student continuity.

- Difficult for specialty preceptors to meaningfully evaluate and assess the students.

Overwhelmed GP Preceptors

- GP preceptors overwhelmed with having students for extended periods all year long.
- Difficult to reconcile effective teaching with time demands of practice.
- Both programs had preceptors and practices withdraw from the program after the first year.

Other issues

- Preceptor concerns regarding curriculum and course objectives
- Unpredictable student presence
- Collision of undergraduate and post-graduate training
- Lack of direct observation
- Student insecurity
- Financial considerations

New suburban LIC models

Problem solving

- Relational, respectful approach.
- Recognition of some systematic incompatibilities of the curriculum with the health care system in which it was based.
- Pragmatism and realism informed program revision.
- Importance of ongoing relationship of the program with all stakeholders.

Changes to schedules

- Change structure to:
  - re-instate opportunities for student-teacher relationship for specialists
  - decrease teaching load for GPs
  - Remove unpredictability of student presence

- Opportunities for longitudinal patient contact maintained

The new schedules

- Chilliwack instituted specialty mini-blocks and maintained weekly GP attachment

- OCEP changed to a ‘hybrid’ program
  - 20 wks LIC, 20 wks specialty rotations, 40 wks continuity of peer group and clinical educator.

Other issues

- Preceptors:
  - LIC specific faculty development
  - Teaching tools for preceptors
- Students:
  - re-assured by the academic success of previous students
  - Pre-emptive roadmapping by site director: “all students get discouraged in February / June.”
- Financial considerations:
  - Programs require substantial administrative support
  - Remuneration for clinical teaching is problematic (can’t compete with clinical remuneration). Attitudinal and structural change rather than just dollars?

Where are we now?

- Student popularity and academic success.
- ‘getting the best of both worlds’
- UBC ICC:
  - 20 students a year at six different sites, three underserved.
- OCEP:
  - 24 students for a full year each year. Operates in an area of need.

Outcomes

- UBC outcome data:
  - students do as well academically as rotational peers
  - equal success in being accepted into chosen residency
  - students placed in full range of specialities, but more as family physicians.
- OCEP outcomes:
  - academic results at least as good as those of the whole student cohort.
  - several students have returned to work locally

What are we?

- Hybrid programs
- Maintain year-long continuity of preceptor, peer group and place.
- Longitudinal continuity with patients.
- Emphasis on general practice attachment and integrated learning.

Conclusion

- These suburban LICs were based on LIC organizing principles but evolved in response to the dynamics of suburban health care delivery – in Australia and in Canada.
- Continuity and Integration have been maintained but in a manner that looks different from their rural templates
- LIC organizing principles can inform a diverse array of clerkship models.

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