

ULURU, NORTHERN TERRITORY, AUSTRALIA

Conference Report

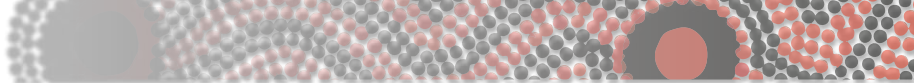




Above: Muster 2014 conference participants

The photos used in this report were gathered from Shutterstock™ and photos submitted by participants of Muster 2014. Photos used from participants are done so with their express consent.

Muster 2014 was held on the traditional lands of the Anangu people. The Muster 2014 Organizing Conference Committee wish to acknowledge the Anangu people, who are the Traditional Owners of the lands on which we met. The Organizing Committee would also like to pay their respects to their Elders, past and present, and the Elders from other communities who may have been present during the conference.



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Report From the Chair



Professor Michael Barber, Vice Chancellor Flinders University and Professor Sarah Strasser, Chair, Muster 2014 Organising Committee

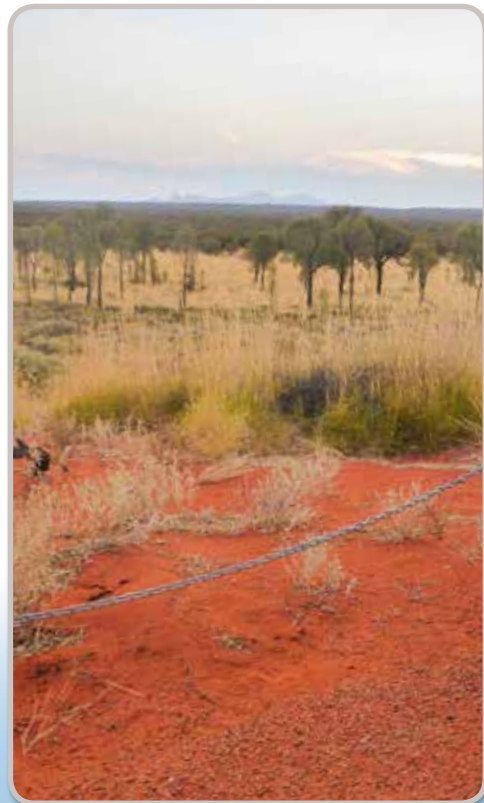
Thank you to everyone who was involved and participated in Muster 2014—all of you made it such a great conference. Thank you for the last minute contributions to the report—they finally sealed it!

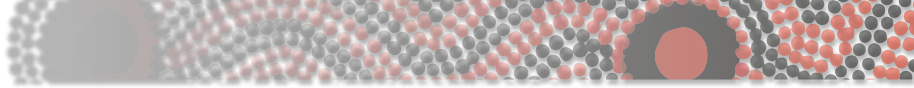
We have taken the time to produce a Muster 2014 Report to ensure that we have captured the key components that made the conference so remarkable. I hope the report will act as a useful reminder and resource for ongoing community-engaged medical education.

To that end, I thought my own contribution to the report would be to give you my Top Ten Tips for organizing an international community-engaged conference.

A handwritten signature in black ink that reads "Sarah E. Strasser".

Professor Sarah Strasser
Chair, Muster 2014 Organising Committee





Sarah Strasser's Top Ten Tips For Organizing a Conference

1. Begin with the end in mind.

You've heard this before—begin with the end in mind. But how will you know if you've gotten there? What will be the long-term outcome?

- Your vision, themes, and opportunities to partner with others will lead to some of the key decisions about your conference, including the number of days, pre/post-conferences, outreach tours, and other add-ons.
- Who is your audience? This will influence sponsorship.
- Do you plan to make a profit? This will influence accreditation requirements.
- How many people do you want to attend? This will influence the venue, logistics, finances, and more. For best and worst case scenarios, base these estimates on other recent or related conferences. Identify other conferences planned for the same period in the year—ensure that your conference dates don't clash with events that will draw a similar audience. Where it makes sense, take the opportunity to create linkages to other conferences to maximize interest (either by linked promotion, joint registration, or sequence a conference 'journey' especially appealing for international visitors).

2. Start planning early.

Start planning at least 18 months to two years ahead. Create a regular timetable for conference calls for the organizing committee. Initially monthly, increasing in frequency as you get closer to the date. Don't leave all the decisions to the end!

3. Keep the local context in mind.

Visit the location early. Take advantage of local attractions. Take local advice, in particular about cultural beliefs, celebrations and ceremony. Be sure that there are local members on all of the committees (whether they are internal or external to your own organization). This will help ensure that your decisions make sense in the local context. Identify local communities/organizations who fit with your vision/themes who might be interested in participating or need an invitation to attend. Be as flexible as possible to facilitate their participation. Ask them about the level of engagement they'd like with the conference, or in what ways they'd like to participate.



4. Be accountable.

Undertake financial planning and be principled in the process. This will give you a guiding mantra, and will help you make strategic decisions. Consider revenue generation as well as bursaries and other forms of support in order to secure the audience you want. Review your budget monthly and keep it up to date. Appoint someone responsible for all legally binding contracts. Don't just assume that if people have read them, they're taking on any responsibility for them! Make sure the contracts don't just meet the other party's requirements... they should be rigorously reviewed to ensure they meet your requirements, too. When you do this, be sure to plan for worst case scenarios and "what ifs."

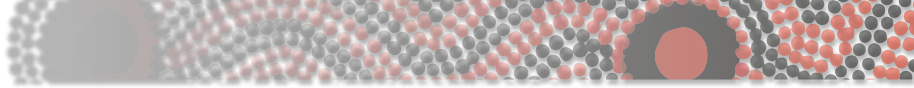
5. Create the environment through communication and marketing.

Establish a calendar of events at least one year in advance. Step through the sequence of events to ensure it is in a timely order. Organizers must be fully aware of the deadlines that impact registrants, and incorporate them into the deadlines for the administrative aspects. For example:

If you have given prior notice for the up-coming conference a year to 18 months in advance, open the abstracts six months ahead of the conference for two months. Remember that submissions only ever seem to be done just prior to any deadline. Extending the deadline will have a flow-on effect to the rest of the conference. Allow a month to review abstracts, and treat this as a hard deadline. Scale up or down the number of reviewers rather than changing the date. Set a date following closure of abstract submissions for when submitters will be informed about whether or not their abstract was accepted. Allow two weeks for confirmation of abstract acceptance. If you require acceptance to be accompanied by registration, consider the date for closing the early bird registration. Don't shut it too early, but remember to be financially accountable! Although this may seem premature, all of this has to be decided and prepared well enough in advance to publish the program if you wish to use it for sponsorship and/or to motivate people to register.

6. Empower the students.

"Student involvement" doesn't just mean that students will be in attendance. Students must be part of all aspects of the conference, including committees and working groups. Seek permission for the students to be excused from regular academic programs well in advance of the conference. Ideally, the conference will not clash with exam periods, which vary in different parts of the world. Provide financial support (for things like travel, meals, and accommodation) as well as reduced registration fees. Set time aside in the program for the students (both for their own program and attending sessions) in addition to asking them to take on specific responsibilities in the conference beyond acting as ambassadors. Making students easily recognizable as helpers (such as wearing stand out t-shirts) is just a small part of how students can actively take part and improve the conference for everyone. Their contribution is often inspirational and should not be undervalued in terms of building the future.



7. Accreditation counts.

Seek accreditation for the conference based on your audience groups. Know the details of the varied accreditation requirements well in advance, and build them into your process from the beginning—from the planning committees to the program and evaluation process. Remember that international requirements vary, and accreditation is best not addressed in hindsight—most accrediting bodies will not provide credit retroactively. Using correct logos in any publications and in particular the terminology for certificates is something that should not be left until the last minute. Obtaining the accreditation stamp of approval for the conference may take a long time, however it can raise the profile of the conference and can sometimes help international delegates acquire visas to participate.

8. Keep up with the times.

Paperless conferences are becoming the norm. Plan to have a “green” conference in as many ways as possible. That said, adequate signage and a few printed copies of the program makes everyone’s life a bit easier. Take the time to step through the logistics of the conference program to ensure that people or signs are at key points for information. Give participants forewarning when possible of any sessions that will have limitation on numbers (based on the room size or nature of the session).

- Another expected norm is the labelling of food choices. Dietary requirements should be considered and ordered in advance, and clearly labelled and placed separate to the standard fare during the conference.
- Being technologically connected is the norm. Making a conference technologically easy for the end user is particularly important for those who need to stay connected to their ordinary day job (these are people who are often key decision makers). In addition, this allows the conference organizers to provide program updates, newsletters, and social media posts. Not everyone brings their own equipment, so have an internet café as well as conference-wide WiFi with sufficient capacity for all registrants to use at the same time (even more important if evaluation is web-enabled). Ensure the access codes are readily known, and consider having an app to help you provide a smooth process (separate administration availability and access may reduce costs). It is critical to provide a Speaker Preparation Room that provides access to computers and the internet—this will help presenters make last-minute revisions or allow them to practice their presentations in advance. Make sure presenters know in advance when this room will open, and give them timelines for uploading presentations. Having technical expertise readily available for all presentations will make or break a conference and is not an expense to be spared.



9. Consider “what if...”

Throughout the entire planning process, always think about worst-case scenarios. Think through as many of these as you can so that you are prepared for any disaster, because undoubtedly, something will ‘go wrong.’ Common challenges include issues around logistics—including accommodations, meals, and illness. When it comes to worst-case, consider keynote speakers and general delegates separately. Your plans may help people decide whether to come or not and what to bring if they do, so include as much information as you can in the program—such as access and availability of medical facilities, alternative routes for travel, alternative accommodation, and likely weather experience.

10. Learn to delegate

Allocate responsibilities (each, any, or all 1-9 of the above items) to reliable people (it helps if they owe you a favour)! Have them report on a regular basis to the organizing committee which has oversight for the whole conference. Make sure there is sufficient administrative support allocated (both in terms of time and people). Some aspects may need reporting at every meeting, others may not need that frequency. However, the organizing committee, just like the rest of the conference, needs to be run to a tight and precise timetable so that peoples’ time is valued and everyone is well prepared. And, most importantly, so that you can plan ahead.



From left to right: Monica Barolits-McCabe, Dr. Pascale Dettwiller, Eliza Gill, and Lila Loveard.

Message from the Flinders University School of Medicine



It is with great pleasure that I reflect on Muster 2014, the fourth in a series of international conferences presented by Flinders University and the Northern Ontario School of Medicine on community-engaged medical education.

Since we began these conferences, it has become apparent that other international groups, most notably, the Training for Health Equity Network (THENet) and the Consortium for Longitudinal Integrated Clerkships (CLIC), share many of our values and aspirations. We believe that there is more to be gained by collaborating at these conferences than by attempting to pursue independence. We welcome this shared intent, and for our shared conference in October 2014, included our Australian partner in THENet, James Cook University, and the Federation of Rural Australian Medical Educators (FRAME) as additional aligned and valued hosts. Each of us had a unique and important perspective to bring, and together we raised the possibility that we may be successful in influencing the direction and impact of health professional education globally. Working together is, after all, at the heart of community-engaged medical education—communities and universities in committed conversation resulting in effective action.

It is ironic in some ways that this meeting took place at the base of Uluru, the world's largest monolith or single stone, as isolation is anathema to collaboration and engagement. However, the recent history of this World Heritage listed site is all about community engagement, with ownership of the site officially returning to the Pitjantjatjara people in 1985, with joint management by the Anangu and National Parks and Wildlife under a 99-year lease arrangement.

The rock now has two official names—Uluru and Ayers Rock. The former is the community name, the latter the institutional one. I suggest the former has much more profound local meaning. If we can suggest that 'medical education' is actually an institutional name to an activity we undertake, what may be the more profound community equivalent? Could it be 'building a better health system,' or 'keeping our community healthy, sustainable, and safe'? Both of these clearly require more than doctors to achieve. Even if we suggest the community term may be as focused as 'creating doctors,' I suggest that the community would still add 'creating doctors who are equipped and willing to care for me and those around me.' All of these suggestions are, of course, guesses—unless we have a commitment as medical schools to ask and listen. I believe that the time together in the ageless quiet of the Australian desert gave us an opportunity to reflect on the questions we could ask, the listening we may choose to embrace, and the commitment to excellence that such asking and listening will demand.

So, last October, we were so pleased to welcome the world to this beautiful part of our world, a region that Flinders is privileged to be engaged with as part of our commitment to transformative medical education. The creativity and learning shared in Uluru left us all thinking about how we can be part of making this a better world for us all.



Professor Paul Worley
Dean, School of Medicine
Flinders University

Message from the Co-Chair of the Scientific Committee



Unique Conference Opportunities for French-Speaking Delegates

I take this opportunity to personally acknowledge Flinders University and the Northern Ontario School of Medicine for providing me with the wonderful opportunity of organising this part of the event with some remarkable people. I have been able to debate Muster's hot topics with my colleagues in French, and able to connect with like-minded academic colleagues and clinicians from Northern Ontario who have shown interest in setting up rural and remote clinical elective service-learning placements offered by the two universities to graduates interested in rural and remote practice for under-served communities. It would be expected that this project—when finalised—will have both an academic and a research component.

As co-chair of the scientific committee for Muster 2014 at Uluru, the privilege and honour fell upon me to welcome the francophone delegates in French, my native tongue. These delegates came from Canada and from Europe and spontaneously gravitated towards each other forming new and exciting group discussions. This 'reflective incubator' included academics, clinicians, professional delegates, and a student from NOSM; it generated discussions around scientific language and the need for the Muster 2014 to acknowledge and recognise French-speaking delegates as active contributors to the event in the spirit of social accountability.

The discussion evolved to create an action plan to write a short article exploring the impact of the

English-language dominating international scientific publications. One of the identified effects was to preclude access to English-language publications from non-English speaking scientists, as well as limiting the English-speaking scientists to access the non-English language publications. It was discussed that Muster 2016 should trial a parallel session in French with English translation; this could attract more non-English speaking delegates to attend and to present their work, and expand the catchment area of the conference. This has already been implemented in international scientific conferences taking place in Latin America with English and Hispanic sessions.

I returned from Muster 2014 rejuvenated by experiencing the passion of all the delegates and their commitment to 'make a difference' in the communities they serve. I was also moved by their commitment to educate a generation of new medical graduates who will become agents of change and will be advocates for patient-directed care. Back at my desk in the geographic isolation of Katherine in Northern Territory of Australia, I revelled in the knowledge that I was sharing my passion for transformative education with many other delegates whom I would never have met if not for Muster 2014.



Dr. Pascale Dettwiller
Associate Professor and Director
Co-Chair 2014 Muster Scientific
Committee
Rural Clinical School Katherine
Flinders Northern Territory Australia

Muster 2014 Hosts



The **Flinders University School of Medicine** has an international reputation for integration and innovation in patient care, education, and research. As a member of the Global Health Education Network and a founding member of the Training for Health Equity Network, the School is also committed to being accountable to the community it serves, both locally and internationally. The School's main campus is situated in Adelaide, South Australia and extends to sites across rural South Australia and the Northern Territory (NT). In 2011, Flinders made a significant step towards improving health outcomes for people in the Northern Territory, in particular towards the "Close the Gap" initiative to improve Indigenous Health by establishing the first full medical program in the Northern Territory. The NT Medical Program (NTMP) has a social accountability mandate to train NT residents, with a particular focus on Indigenous students. The first students will graduate from this program at the end of 2014. The NTMP is based in Darwin and extends to key remote sites for training and research in Katherine, Alice Springs, and Nhulunbuy as part of Flinders in the NT. The NTMP is supported by the NT Remote Clinical School, the Centre for Remote Health, and the Poche Centre for Indigenous Health (Alice Springs).



The **Northern Ontario School of Medicine (NOSM)** is the first medical school to open in Canada in over 30 years. Since its official opening in 2005, the School has developed and delivered a distinctive model of distributed, community engaged, and socially accountable medical education and research. NOSM serves as the Faculty of Medicine of Lakehead University in Thunder Bay and Laurentian University in Sudbury, with teaching and research sites across the wider NOSM campus, Northern Ontario. NOSM is a made-in-the-North solution that is attracting attention from around the world for its innovative model. NOSM has become a world leader in community-engaged medical education and research, while staying true to its social accountability mandate of contributing to improving the health of the people and communities of Northern Ontario.



Muster 2014 Partners



The **Consortium for Longitudinal Integrated Curricula (CLIC)** is a group of faculty from medical schools around the world who have or are considering developing, implementing, and studying the longitudinal integrated clerkship model to address core clinical training for undergraduate medical education. Longitudinal integrated clerkships have the following common core elements: medical students participate in the comprehensive care of patients over time; medical students have continuing learning relationships with these patients' clinicians; and, medical students meet, through these experiences, the majority of the year's core clinical competencies across multiple disciplines simultaneously.



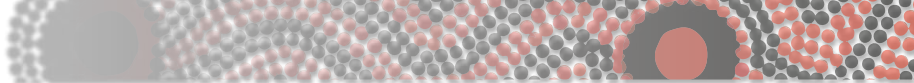
The **Federation of Rural Australian Medical Educators (FRAME)** is the peak body representing the Rural Clinical Schools (RCS) and Regional Medical Schools (RMS) funded (in whole or in part) through the Australian Government Department of Health and Ageing's Rural Clinical Training and Support Program (RCTS). FRAME was established in 2003 to advance the causes common to medical student training in rural and remote Australia.



The medical and dental programs at **James Cook University (JCU)**, North Queensland, have a distinctive regional mission with a focus on the needs of rural, remote, and underserved communities, tropical medicine, and the health of Aboriginal peoples and Torres Strait Islanders. The School aims to lead positive change in health and medical care for communities of tropical Australia and beyond through socially accountable health education, discoveries, partnerships, and advocacy that make a difference. Underpinning our work is a shared commitment to social justice, a passion for innovation, and a commitment to excellence.



The **Training for Health Equity Network (THENet)** is a collaborative of need and outcome-driven medical schools in neglected, rural, remote, and under-served urban regions of Africa, Asia, Australia, Europe, and North and Latin America with a core mission to increase the number, quality, retention, and performance of health professionals in under-served communities. THENet's socially accountable schools are community engaged and embedded into the health system. They orient their education, research, and service activities towards priority health concerns of the communities in the region they have a mandate to serve. THENet school programs address the continuum of education—from recruitment strategies and bridge-programs for high school graduates—to post-graduate and in-service training with the ultimate goal of improving priority health outcomes and services and increasing retention of health workers.



Why Muster?

In October 2014, the topic worth traversing the globe was community engagement: a powerful vehicle for bringing about environmental and behavioural changes that will improve the health of communities and their members.

Strong evidence suggests that community engagement encourages three essential developments in health-care delivery. First, community-engagement improves the supply of skilled workers who are responsive to the needs of the community. Second, it stimulates team functioning, to improve access to care in rural and remote communities. Finally, community engagement encourages health research relevant to the needs of the population. With scores of rural and remote communities across the globe that are all in need of enhanced health services, community engagement is much deserving of attention—a topic of global importance and the potential for staggering local impact.

In the tranquility of the Australian desert, Muster 2014 was the metaphorical eye of the storm: the place where like-minded people could continue to advance a much needed area of scholarship that has the potential to globally transform issues relating to health equity.

Muster—a term primarily used in Australia to round up livestock—called forth those committed to community engagement around the world to gather. The purpose was to equip the catalysts of changes—advocates of community engagement around the world—with new ideas and the renewed passion to continue to make local progress on a global movement for health equity.

One of the best parts about Muster 2014 was the opportunity to be with others who struggle to understand and put into practice the principles and practices of social accountability and community engagement. It was so nice to find this community of like-minded practitioners and to engage with them in deepening the understanding and commitment to this work."

Anonymous, via Muster 2014 feedback

"I have attended several of the CLIC conferences, including the 2014 edition in Uluru. I have been attempting to initiate integrated community clerkships (ICCs) in Saskatchewan and the information gained is always helpful. Perhaps the most rewarding part of the meetings is the networking and establishment of a "support system." When you are alone in your little corner of the planet when it comes to ICCs it is reassuring and extremely helpful to have contacts to whom you can consult when needed."

**Dr. Tom Smith-Windsor, Associate Dean, Rural and Northern Medical Programs
University of Saskatchewan, Canada**

"The approachability of all the leaders was incredible. It was amazing meet people who have pioneered research on LICs and written papers on these topics. Not only that, but they were so lovely and helpful. There's no hypocrisy here—no hierarchy. It was great!"

Flinders University and the Northern Ontario School of Medicine



"I feel much more confident about continuing the LIC program at our school after attending Muster 2014. I've got some awesome ideas for next year, and ideas about how to inspire the clinicians to try again!"

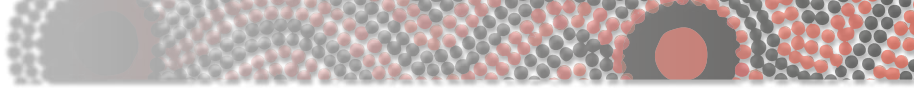
Anonymous, via Muster 2014 feedback

Traditional Owners

Muster 2014 participants were fortunate to meet amidst the breathtaking beauty of the central Australian landscape. In the shadow of the famous landmarks Uluru and Kata Tjuta, international delegates were able to experience going "out bush" in rural Australia, and take in the challenges that a remote community like Uluru might struggle with when it comes to providing health services.

The mythicism of the seemingly untouched Australian desert provided a striking and serene location for delegates to contemplate the path forward for their respective context in relation to community-engaged medical education and research. In order to understand the significance of the land, it was important to pay respects to the traditional land owners, the Anangu people—past and present—who invited international guests onto their land, with whom the conference organizers are committed to work in order to care for our shared future.





The Anangu People

The Central Australian landscape, of which Uluru and Kata Tjuta are an important part, is believed to have been created at the beginning of time. Anangu traditional owners have lived in and looked after Uluru and its surrounding landscape for tens of thousands of years. The Anangu Aboriginal people are responsible for the protection and appropriate management of these ancestral lands. The knowledge necessary to fulfil these responsibilities has been passed down from generation to generation. Anangu mainly speak Pitjantjatjara (pronounced as pigeon-jarrah) and Yankunytjatjara (pronounced as young-kun-jarrah) but can speak up to six different Aboriginal languages. Anangu life revolves around the Tjukurpa (pronounced 'chook-orr-pa'), the ancestral period during which the world was formed. Tjukurpa also tells of the relationships between people, plants, animals, and the physical features of the land. It is the past, present, and future—all at the same time.

Socially Accountable Venue

Not only is Uluru a sacred site for Indigenous Australians, but the Voyages Ayers Rock Resort is owned by the Indigenous Land Corporation (ILC) and has a strong commitment to social responsibility, community engagement, education, and workplace training. All profits from their business activities go toward supporting the ILC's Indigenous programs across Australia.

"The location of this conference was a big part of the appeal. To compare our own work to the under-served populations with experience in Australia was a major draw."

Anonymous via Muster 2014 feedback

"It was absolutely amazing to get so many people in a remote location for this incredible conference."

Denese Playford, Associate Professor in Undergraduate Medical Education, University of Western Australia



Contributions from Partners Make All the Difference

In medical education, sponsorship is often hard to come by. Feedback from past conferences has requested more community and student involvement in community-engaged medical education conferences. Of course, it goes without saying that these things don't pay for themselves. Without financial support from many across the globe, conferences such as Muster 2014 wouldn't be possible. The sponsorship received from this conference meant that costs were able to be subsidized, and more students were able to attend the conference.

The Muster 2014 Organizing Committee was grateful for the contribution of the below organizations, who saw their contribution to Muster 2014 as an important investment in the future of health-care and medical education for rural areas.

Contributors



Muster 2014 Organising Committee

Professor Sarah Strasser
Chair

Professor Paul Worley
Flinders University

Professor Roger Strasser
Northern Ontario School of Medicine (NOSM)

Mrs Monica Barolits-McCabe
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CLIC

Associate Professor TC Tai
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Associate Professor Neelam Khaper
NOSM

Dr Jacques Abourbih
NOSM

Assistant Professor Tim Dubé
NOSM

The Muster 2014 Branding

The Muster 2014 branding was specifically designed to visually represent the unique qualities of the conference, including a commitment to community engagement. It was designed by Ms. Colleen Hayes, a proud Indigenous woman and Aboriginal Cultural Advisor at Flinders University.

Titled “Healthy Pathways for Healthy Bodies,” the graphic depicts people travelling from many places to Uluru to share stories about health and healing. The four circles in the corners of the painting represent the places and countries from which participants were travelling. The centre of the painting—a circle—represents central Australia, the meeting place of Muster 2014. These shared stories can make bigger and better changes to how we approach health and healing in our homes, communities, and workplaces.

About the Artists

Colleen Hayes comes from Black Tank-Apmwerre Outstation and is of Arrernte-Kaytetye descent. She is employed at Flinders University as the Indigenous Health Lecturer, where her main duties are presenting cultural orientation, consultation, preparation, and delivery. This involves exploring, implementing, and learning different operational tools that provide an efficient and supportive cultural program. Hayes’ vision is to maintain a learning, sharing, and caring cultural program that encourages all people to gain the best of their abilities in practice. Hayes is best described as positive, friendly, and supportive. Her main aim is to encourage and support young people to take steps in the pathways where she has travelled and, even further, as community members, individuals, and professionals.

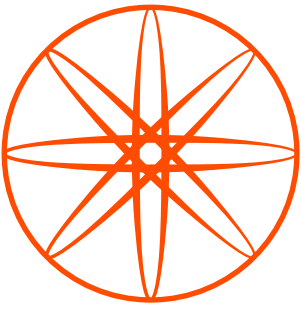


Left: Colleen Hayes



Right: Dr. Paul Worley, Monica Barolits-McCabe, and Dr. Roger Strasser





In addition, an orange wheel was used to represent an iconic element of community-engaged medical education: a model developed by Paul Worley that describes the four relationships (4Rs) that act as a framework to analyze community-based medical education. These relationships are between: (1) clinicians and patients; (2) health service and university research; (3) government and community; and (4) personal principles and professional expectations. Equally important, Worley discusses the importance of integrity when dealing with these relationships.



The wheel was used as part of the branding of Muster 2014 to visually depict the importance of relationships and integrity in medical education. The Organizing Committee felt that this guiding principle of community-engaged medical education should serve as a reminder to guide discussions throughout the conference.

Design adapted from 4R Integrity Model by Professor Paul Worley. Used with permission. Worley, P. (2002). "Integrity: The Key to Quality in Community-Based Medical Education? (Part Two)." *Education for Health* 15(2): 129-138.



Above: Muster 2014 conference participants

Muster 2014 Scientific Program at a Glance

Muster 2014 Uluru - Scientific Program at a Glance

Start Times	Pre-Conference Sunday 26 October 2014	Pre-Conference / Day 1 Monday 27 October 2014	Day 2 Tuesday 28 October 2014	Day 3 Wednesday 29 October 2014	Day 4 Thursday 30 October 2014
8.30am	THEnet Invitational Meeting	THEnet Invitational Meeting	Meeting with Tuesday Co-Chairs	Posters 2	Visit to Purple Truck/Time with Ngangkaris
9.15am					
9.30am					
9.45am					
10.00am	THEnet	THEnet	Plenary: Housekeeping and Updates Ngangkari Presentation (Plenary)	Keynote Speakers: Rachel Ellaway and Lambert Schuwirth	Keynote Speakers: Fortunato Cristobal and Stephen Billett
11.00am (15 mins)					
11.15am (90 mins)					
12.45pm (45 mins)					
1.30pm (90 mins)	THEnet	THEnet	Parallel Session A	Parallel Session C	Parallel Session F
3.00pm (30 mins)	Registration at Sails in the Desert	Registration at Sails in the Desert	Time with Ngangkaris	Workshop Indigenous Training Academy	Time with Ngangkaris
3.30pm	Registration at Sails in the Desert	Registration at Sails in the Desert	Time with Ngangkaris	Time with Ngangkaris	Time with Ngangkaris
4.30pm	Registration at Sails in the Desert	Registration at Sails in the Desert	Time with Ngangkaris	Time with Ngangkaris	Time with Ngangkaris
5.00pm	Registration at Sails in the Desert	Registration at Sails in the Desert	Time with Ngangkaris	Time with Ngangkaris	Time with Ngangkaris
5.30pm	Registration at Sails in the Desert	Registration at Sails in the Desert	Time with Ngangkaris	Time with Ngangkaris	Time with Ngangkaris
7.30pm	Registration at Sails in the Desert	Registration at Sails in the Desert	Time with Ngangkaris	Time with Ngangkaris	Time with Ngangkaris

Table for Parallel Sessions (90 mins)

A	Tuesday	11.15am - 12.45pm
B	Tuesday	1.30pm - 3.00pm
C	Wednesday	11.15am - 12.45pm
D	Wednesday	1.30pm - 3.00pm
E	Wednesday	3.30pm - 5.00pm
F	Thursday	11.15am - 12.45pm
G	Thursday	1.30pm - 3.00pm

Colour Key

THEnet	Plenary Sessions
Administration	Parallel Sessions
Cultural Sessions	Posters



Opening Dinner

Muster 2014 opened with a metaphorical splash in the dry and beautiful desert of central Australia. Participants travelled to Uluru, known as Ayer's Rock, and watched as the hot sun set over the iconic landmark. Together, participants celebrated the beginning of the conference as they witnessed the change in the colour and texture of the light cast on the rock by the setting desert sun.

"The venue was awesome. It was amazing to see overseas people and local Australians travel to Uluru. The conference was also very well organized!"

Anonymous feedback

"One of my favourite parts of this conference was the imaginative settings for the opening and closing dinner."

Anonymous, via Muster 2014 feedback



josephine boland

@jboland_galway Oct 27
Yulara, Northern Territory

[#muster2014](#) fantastic start to the Muster conference Community Engagement and Medical Ed at Ayers Rock at sunset



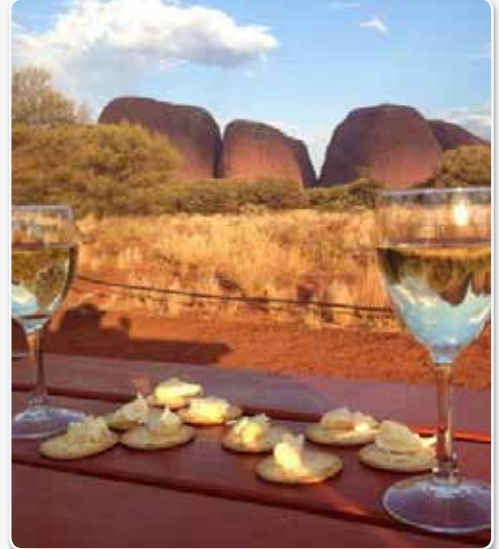


Michele Daly

@Michele_Daly Oct 26

Yulara, Northern Territory

[#muster2014](#) What a great location for a conf :) [#uluru](#) [#olgas](#) [#eatyourheartout](#)



Left: Muster 2014 student participants

Right: Drs. Kathy and Marv Brooks



Opening Ceremonies

Inma

Many people go their whole lives without seeing an Inma—a traditional ceremony of the Indigenous Anangu peoples of Central Australia. The participants of Muster 2014 can consider themselves among a select few after experiencing an Inma performance during the opening ceremonies of Muster 2014. Beneath the stars and amidst candlelight, a group of Anangu women performed a type of corroboree—a sacred display of traditional song and dance, with very rich and ancient meaning. Performing the Inma is one of the ways that Indigenous Australians interact with the dreamtime—their creation—through dance, music, and costume. Special adornments are used, and the dancers' bodies are painted in ochre in unique and meaningful ways.

"This dance is about a wilcha, a shelter. Each night, a grandmother hides a grandfather every night in the back of the wilcha. One morning, while his grandmother had gone out bush, their grandson went out to the wilcha to dry his sheets. He set the wilcha on fire, not knowing that his grandfather lay asleep in there."

Translator for the Anangu women who performed the Inma

"The best part of the conference was the engagement with the indigenous community, which was made possible by the culturally safe environment that was fostered by participants and conference organizers."

Anonymous, via Muster 2014 feedback

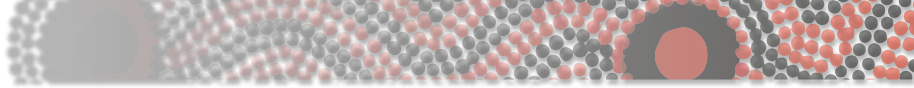


Julie Ozawagosh

Elder Julie Ozawagosh of Atikmeshing First Nation near Sudbury, Ontario and Elder of the Northern Ontario School of Medicine (NOSM), extended greetings on behalf of her people in Canada, and thanked the Anangu people for their ancient dance. After providing her welcome, Julie sang a prayer song, which was accompanied by Inma women using Australian Indigenous traditional rhythmic stick instruments.

"I feel a deep connection to the Anangu people here tonight. Our people are the keepers of ceremonies, of language, of the way we live, of the waters that we have. I would like to say a prayer in the form of a song, because song connects us with everything in creation. Creation is what we acknowledge every day—when we rise and when we go to rest. Creation is there for us."

Elder Julie Ozawagosh, Atikmeshing First Nation



Michael Barber

Professor Michael Barber, Vice-Chancellor of Flinders University, officially welcomed participants on behalf of Flinders University. Among other guidance, Professor Barber offered advice about the need for change in health professional education and practice. He beseeched Muster 2014 delegates to challenge their beliefs to ensure that the international health workforce can meet the urgent medical crises that are occurring around the globe.

"There has never been a time in human history that the professions that you represent have been more important. Yet, I also believe that your disciplines and professions have to change perhaps more than you are ready for. We are but one world, but it's important that we interact across that world. Take on board very seriously the questions asked of you this week, and bring home deliberations that challenge the way we serve our communities, and the way we produce your students. It's time that we question almost everything we do."

Professor Michael Barber, Vice-Chancellor of Flinders University



Roger Strasser

Dr. Roger Strasser, Dean of the Northern Ontario School of Medicine, welcomed participants from far and wide to this fourth conference in the NOSM/Flinders series. Giving a history of the conferences, he set the context for the education in the days to follow.

"Like NOSM, Flinders University School of Medicine has a remarkable track record of community engagement and pioneering longitudinal integrated clerkships. There is a natural affinity for our two schools of medicine, and, recognizing this in 2008, we came together and began this series of medical education conferences. As we continue this series in this truly spectacular location, I invite you to continue to lead forms of innovation in health professional education."

Dr. Roger Strasser, NOSM Dean



The Ngangkari

Tuesday, October 28, 2014

Before the provision of modern medical services, the health of the people of central Australia was quite literally in the hands of the Ngangkari, traditional Indigenous healers. Using a variety of strategies that they have developed and refined for centuries, the Ngangkari treat various diseases and illnesses in Indigenous peoples of Australia.

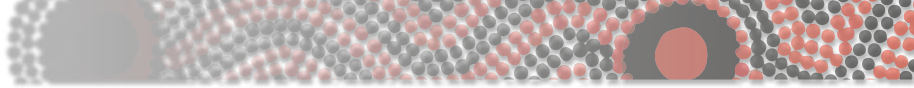
At Muster 2014, four Ngangkari traditional healers—two men and two women—spoke in their traditional language (made accessible with the support of a translator) of the gifts that they inherited from family and community members throughout their lives. According to the Ngangkari, disease and illness result because of disruptions in the person's spirit. They believe that their role is to bring the spirit back and place it properly within the body. In order to accomplish this, the Ngangkari lay their hands on an ailing person, and use their energy and power to balance the spirit and remove the illness.



The Ngangkari spoke about their role in the current delivery of health care in central Australia. At times, Ngangkari travel day and night to their peoples' homes to provide one-on-one care, or participate in group treatments where many Ngangkari come together to treat someone by combining all of their individual strengths and specialties. Perhaps most significantly for conference attendees, Ngangkari augment modern medical care by providing treatments to Indigenous peoples in hospitals and clinics to support modern medical care.

"Some major health problems don't get fixed quickly, and even though someone's got all the right treatments, they're still not quite getting better," says Ilawanti Ken, Ngangkari healer. "That's when the Ngangkari treatments really help. We'll come in and give that person a treatment, and what that will do is help all the medicine and needles that they're getting and make them work better. Our treatments help to harmonize our bodies and make today's medicine work better."

The Ngangkari are responsible for training the next generation of Ngangkari healers in their communities—a topic very relevant to the medical educators in the audience. "We all have students, and generally speaking, they're our granddaughters, grandsons, nephews and nieces," said Toby Baker, Ngangkari healer. "During the night time when everyone is asleep, we take them on dream-like journeys where we are all flying. We look down and decide amongst ourselves who is in need of treatment. We keep our closed eyes on our people,



and descend to give that person a treatment while they're asleep. They perhaps do not even know that they were sick, but wake up feeling great. That's because we sorted them before they knew they were going to get sick. Then, we'll go with our apprentices to visit them the next day and the students will give them a treatment."

"The Ngangkari presentation was the best part of the conference. They did an excellent job of highlighting the ways in which community and modern medicine can work together. I particularly liked that they presented in their native language."

Anonymous, via Muster 2014 evaluations

"It was a unique experience and a privilege to have had a first-hand exposition by the Ngangkari traditional healers on the history and scope of their age-old healing practices. Their practices of relieving pain and making people feel better physically and psychologically pre-date modern medicine by thousands of years. These wise men and women astutely accept that their role is to complement modern medicine, especially where the medical paradigm has its accepted limitations."

Professor Mark Wilson, Academic Leader, Community Based Health Education, University of Wollongong

"I'd like to pay my respect to the Ngangkaris. It's not just here, but rather, everywhere in the world that we are building on the knowledge of communities of practice that have existed for millennia, before we invented the relatively modern term of 'doctor' or 'nurse' or 'allied-health professional.' Their contribution to the conference and to our work in health has been invaluable."

Dr. Paul Worley, Dean of Medicine, Flinders University



Above: Ngangkari traditional healers share with Muster 2014 conference participants.



Collaborative Leadership

Julie Ozawagosh, Monica Barolits-McCabe, Fortunato Cristobal
Tuesday, October 28, 2014

Success in a community-engaged model of education and research requires many people, from a wide variety of backgrounds, locations, and interests, to work together toward a similar goal. Three international leaders spoke about the importance of collaboration. They then held a question-and-answer discussion with participants to delve further into the topic.

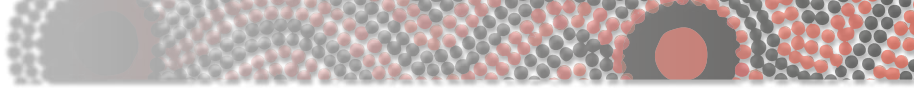
Canadian **Elder Julie Ozawagosh** of Atikmeshing First Nation near Sudbury, Ontario and Aboriginal Elder at NOSM shared her experiences as a community leader. Specifically, she spoke of her perspectives on collaboration within the community, as they engage with organizations such as the Northern Ontario School of Medicine. Thanks to her relationships and experiences in the community setting, Ozawagosh was able to share insight regarding the importance of honour, respect, role clarity, responsibility, and a network of support when working towards a vision

"As a community person, I am not an academic. For me, one of the important pieces of collaborative leadership is feeling that you have a voice. To be able to speak your mind, to agree to disagree, that's important. And, we have to remember that, as humans, we make mistakes."

Elder Julie Ozawagosh



Above: Monica Barolits-McCabe, Dr. Fortunato Cristobal, and Elder Julie Ozawagosh.



Monica Barolits-McCabe, Manager of Flinders School of Medicine, Northern Territory, spoke of her experiences first as an accountant, her subsequent work with community control, and finally, her current position with the Flinders Northern Territory program. As an Indigenous Australian woman herself, Barolits-McCabe discussed her perspectives regarding collaboration with grassroots community members. Among many things, she spoke of the importance of networking, gaining trust, and developing supportive networks in pursuit of your goals.

"For me, making change is about risk. In my life, I have been able to move and go places because I felt confident and encouraged by the people around me. It's about believing in yourself and the support structures you have around you. If you want to do something, just do it. Once you take that leap, it's very liberating."

Monica Barolits-McCabe

Dr. Fortunato Cristobal, Dean of the Atteneo de Zamboanga University School of Medicine, spoke to delegates regarding his experience in founding a new, innovative school of medicine in the doctorless peninsula of Zamboanga in the Philippines with only \$500 startup funding. His drive to create a system that would help the people of his region was so powerful that overwhelming obstacles became inconsequential. One of the important pieces of his success was never taking 'no' for an answer. In addition, he highlighted the importance of charisma, understanding expectations, encouraging a 'live and let live' approach with competitors, and mutually beneficial relationships with all groups—community members, government, students, and health agencies.

"Taking research and education from the larger centres and bringing it to the community doesn't work. We have drugs produced for malaria and tuberculosis, but these problems are still not solved at the community level. You need to challenge the paradigm that the community is just another outpatient department. Communities have their own issues, and their own problems. I always tell my students: always look at things from the point of view of the community."

Dr. Fortunato Cristobal, Dean, Atteneo de Zamboanga University Medical School



Exploring the Intersections between Medical Schools and Communities

Rachel Ellaway

Wednesday, October 29, 2014

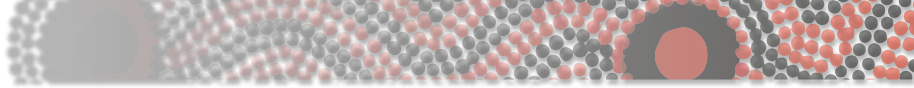
Dr. Rachel Ellaway, Assistant Dean for Curriculum and Planning and Associate Professor at the Northern Ontario School of Medicine delved into theory at Muster 2014, and presented her insights on community engagement, as gleaned from the Community Engaged Medical Education: Systematic Thematic Reviews (CEMESTR) project. CEMESTR is a rigorous, structured thematic review of the published works of literature on medical education and its relationship with community, led by Ellaway and some of her NOSM colleagues. Registered with the Best Evidence Medical Education (BEME) group, the goal of the CEMESTR project was to answer this question: how do different relationships between medical education programs and communities impact educational outcomes?



CEMESTR drew on three prototypes of community relationships in medical education: community-based medical education (location-based education that takes place in the community), community-oriented medical education (education that discusses community as a topic), and community-engaged medical education (wherein the school enters into a partnership or relationship with a community to pursue its programs).

The CEMESTR project reviewers undertook two types of reviews: outcomes reviews and realist reviews. The first used standard outcomes criteria to assess the level or kind of educational impact of a strategy or intervention. The realist arm of the review appraised the different contexts and the different mechanisms that lead to different outcomes in medical school-community relationships. The 38 CEMESTR reviewers completed 489 realist reviews and 271 outcomes reviews of the available published articles, which identified some important findings.

"A major problem was that the research literature we looked at was extremely atheoretical and uncritical," said Ellaway. "It was very surprising given that power and dynamics of community and culture are primary theoretical constructs. The basic, implied theory was that 'community is good,' and it didn't go much further than that. In addition, many papers were aspirational, and became statements of ideology: 'this is the way the world should be' rather than 'this is an appropriate strategy.'"




Another concern was that community was defined in many different ways in the literature. Community was sometimes identified as a single unit of engagement or a location, but it was also defined as an idea, an aspiration, an ideological position, and occasionally as a victim.

According to Ellaway, there were significant differences regarding which groups were engaged when speaking about community, including clinical leads, chiefs of staff, practitioners, community leaders, patients, members of the community, and students placed in the community.

Ellaway summed up by identifying four recommendations to advance scholarship in community-engaged medical education: (1) development of shared models of community relationships; (2) stronger and more explicit theoretical bases for research and evaluation; (3) refocusing the generation and use of evidence; and (4) development of a more sophisticated understanding of 'community'.



 **josephine boland**
@jboland_galway Oct 28
Yulara, Northern Territory

Community attention deficit disorder: common enough syndrome within medical education? Ellaway [#muster2014](#)

"Despite the volume of data presented from the CEMESTR systematic review, we are inspired to look at becoming true community partners for sustainable and system-level change, and not simply users of a community space to fulfil our medical school curricula. The paucity of literature on LIC and community engagement indicates the need for much more research in this area."

**Professor Mark Wilson, Academic Leader, Community Based Health Education,
University of Wollongong**



Programmatic Assessment for Learning

Lambert Schuwirth

October 29, 2015

As those involved with health professional education around the world, many Muster 2014 participants are interested in ensuring that the graduates of health professional programs will be successful. Dr. Lambert Schuwirth, Professor of Medical Education at the Flinders University School of Medicine's Health Professional Education Unit, challenged participants to think differently about assessment in medical education. He asked this question of participants: "If incompetence were an illness and we were diagnosing it as a doctor, what would our assessment look like?"

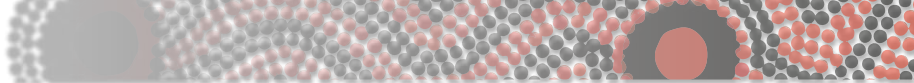
Schuwirth spoke with participants about the current system of testing in medical education: the professor or school designs a test that all students must take. Those who pass are deemed competent, and those who fail are deemed incompetent.

However, as with any test, Schuwirth reminded participants that there are always false positives and false negatives. Schuwirth believes that, unfortunately, this leads to many false classifications in current models of testing.

According to Schuwirth, there are five important elements to each assessment method: reliability, validity, educational impact, costs, and acceptance. Each school is on a "quest for the best test," with educators focusing primarily on the curriculum, and then, often, writing a test at the end of the semester as an afterthought. On the other hand, students are primarily focused on the test, which leads to an important educational disconnect.

In order to address this issue, Schuwirth offered a number of significant suggestions: (1) do not assess students using a single instrument—the idea of a "perfect test" or "perfect tool" is not helpful; (2) combine strengths and weaknesses in order to piece together a puzzle that identifies competence; (3) decouple assessment methods from decision methods; (4) assess student competence based on combinations of a variety of meaningful information regarding student performance; and, (5) decouple the decision moment of success from the assessment moment.





“Traditional testing programs are based on an intrinsic connection between decision moments and assessment moments,” says Schuwirth. “But, in the end, competence is defined as an arbitrary number of plusses and minuses. No one has ever been able to give me a good answer for why they have a pass-fail rate of 60%, and not 59.73%. I would argue that you don’t make decisions about students’ careers based on arbitrary decisions—it must be a well-founded judgement.”

Rather, Schuwirth proposed a revised model of programmatic assessment, where educators collect information continuously and allow for the information to get richer, and richer, and richer. This would involve a dossier, an archive, a portfolio, and a record. Then, the proportionality of the decisions is upheld by ensuring that no high-stakes decisions are made based on small data. Instead, the typical cycle of student assessment would involve collecting information from a variety of sources, analyzing the information, formulating concrete steps for improvement, having meetings to discuss steps towards those improvements, and finally, collecting further information to track progress—a system not unlike delivering ongoing patient care.

“Dr. Schuwirth’s presentation was one of the best parts of the conference. I found Dr. Schuwirth’s presentation to be incredibly thought provoking regarding issues with assessment and curriculum design.”

Anonymous, via Muster 2014 feedback

Health for More: Health Disparity and Health Education Training—An On-Going Tension?

Dr. Fortunato Cristobal

Thursday, October 30, 2014

One of the primary goals of Muster 2014 was to find strategies to bridge theory and practice—essentially, how to transform medical education into health gains. In order to address this, Dr. Fortunato Cristobal (“Dr. Khyrss”), founding Dean of the Ateneo de Zamboanga University School of Medicine (ADZU-SOM) in Zamboanga City in the Philippines, gave a rousing and inspirational presentation about the development of ADZU-SOM.

According to Cristobal, the development of ADZU-SOM was born out of “desperation and disappointment, out of the failed promises of conventional medical education” for many regional areas of the Philippines. Cristobal comes from the most underserved area of the Philippines, which has a population of 3.8 million people. He reported that in 2003, 14 of the country’s 40 poorest municipalities were from his region. The top two poorest provinces in the country are found in this area, as well as the highest incidences of hunger. Zamboanga is also the leader in infant mortality rate (at 75%), and 80% of the communities are without physicians. It was out of these conditions that, in 1994, Dr. Khyrss spearheaded the creation of a new medical school, designed specifically to meet the dire needs of the community.





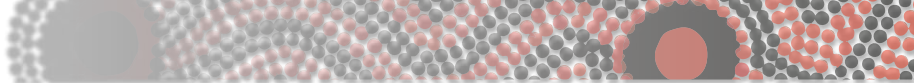
Above: Muster 2014 conference participants give a standing ovation (right) to Dr. Fortunato Cristobal (left).

"In the Philippines, the biomedical model—that illness is in the human body itself—has been adapted and imprinted on us, ignoring the social model that addresses societal issues like food, politics, economics, culture, water, resources, and climate," says Dr. Khryss. "Unfortunately, the biomedical model has failed to serve us well. A private medical school and university hospital can brag about being able to do brain surgery, and yet, about five kilometres away, the Department of Infectious Disease is unable to control cholera. So, quietly and dangerously in isolation, we started to do something different. Not for the sake of being different, but for a purpose."

Cristobal started this new medical school with only \$500 start-up funding. With this, he has created a medical program that trains agents of change to become the next generation of doctors in underserved areas. The students at ADZU-SOM are taught the biomedical model of care within the context of social, cultural, political and economic issues. In order to augment their classroom learning, students at ADZU-SOM spend the large majority of their four-year program within a single community. The community becomes the laboratory for the students to learn about the socioeconomic, cultural, and political issues that affect the development and promotion of health in an individual.

As part of their training, the students must solve one particular social problem that impacts the health of the community. During their placements, students have built arborloos (ecological toilets to solve sanitation issues), developed alternative sources of income (through diverse uses of the coconut), created a centre for expectant mothers out of pop bottles, created a safe system for children to travel via boats to school, implemented floating ambulances, and initiated many other projects that have significantly impacted the health of the communities where the students learn.

"We want to transform these communities," said Ellery Ivan E. Apolinario, fourth-year ADZU-SOM student in a video shown by Cristobal. "When we leave the community, we hope that it is not only the community that has changed, but also us. Eventually, the community becomes part of us. Wherever we go, we have that understanding. We are involved in community."



As a result of ADZU-SOM's community presence, the infant mortality rate has dropped significantly in the region, as well as rates of pneumonia, which was once the leading cause of morbidity in Zamboanga. Seventy percent of the 305 graduates from ADZU-SOM are practising in Cristobal's region, and 50% are practising in previously doctorless areas.

"Sometimes, I think we should travel the road less travelled," says Dr. Cristobal. "A university that has failed to be innovative and relevant has lost its mandate to exist. As a developing country starting to find solutions to health workforce and health outcome inequities, we, the volunteers in Zamboanga, have shown a way forward to assert that the historical disadvantage does not have to be an ongoing destiny."

The audience was moved by Dr. Khryss' presentation about this truly socially accountable model of medical training in an underserved population of the Southern Philippines—so inspired, that many participants wiped tears from their eyes as they gave Cristobal their thunderous applause and a unanimous standing ovation.

"Thursday was an incredible day of The Muster. The word 'inspirational' is appropriate for Dr. Khryss' presentation on the development of the Zamboanga School of Medicine, but seems inadequate to describe the emotions stirred up by his presentation. How could local community engagement, a \$500 investment and the commitment of a few key medical educators have led to such enormous improvements in health outcomes?"

**Professor Mark Wilson, Academic Leader,
Community Based Health Education, University of Wollongong**

"Dr. Cristobal's presentation was the conference highlight for me. An enormously impressive story told by one who is deserving of Nobel consideration."

Anonymous, via Muster 2014 feedback



Cindy Flores

@cindyfloresmd Oct 30

Yulara, Northern Territory

This is how it's done, a community engaged medical school. Kudos Dr Cristobal! Pinoy pride. [#muster2014](#)

"The passion in Dr. Khryss' session was palpable. We had a tear-jerker moment when many people heard for the first time about what amazing achievements can be made with few resources, but huge hearts and a lot of energy."

Anonymous, via Muster 2014 feedback



Developing Professional Competence through the Integration of Experiences in Practice and Educational Settings

Dr. Stephen Billett

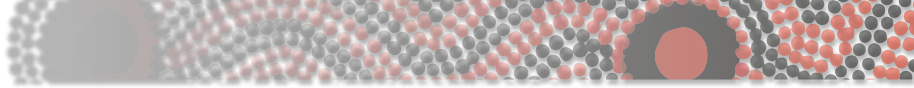
Thursday, October 30, 2014

Learning isn't a special process that is restricted for educational programs: it's something that starts when we're born, and continues our whole life. During his keynote presentation, Dr. Stephen Billett, Professor of Education and Professional Studies at Griffith University in Brisbane, Australia discussed the processes, principles, and theories of adult education, and shared some insight into how to maximize those educational experiences.

Billett highlighted that each student is seeking 'expertise,' but that there is no such thing as a medical expert. Rather, Billett feels that expertise is shaped by the circumstances of practice. One can perform better or worse based on their circumstances and the knowledge they have about their surroundings. Billett spoke about the importance of providing students with 'affordances'—invitations to engage and learn through activity. However, it is up to the individual to choose to engage in these activities. Even when students are given similar experiences, their knowledge of the contexts vary, as does their willingness to engage in the educational invitations offered to them.

Billett presented three main types of knowledge. First, there is domain-specific, conceptual knowledge (known also as declarative knowledge), which is the knowledge acquired when students write things down, or listen. It is a type of factual knowledge that can be developed into 'deep conceptual knowledge' which provides rich links and associations between different pieces of fact and information. Next, there is domain-specific, procedural knowledge, which is how we know how to complete tasks. This type of knowledge can be developed into specific, scattered processes into associations that can develop into strategic processes, which are very important in patient care. Lastly, there is dispositional knowledge, which is formed by the values that you uphold.





According to Billett, these three types of knowledge are richly interactive, and are formed through different experiences. These experiences, though they look uniform from one student to the next at first blush, vary widely based on a student's previous experiences, the knowledge they have in the moment, and their level of engagement with the experiences afforded to them. In order to maximize student placement experiences, Billett emphasized the importance of early and staged engagement with students during their practicum in order to boost their confidence in new locations. Billett also urged participants to encourage their transition into their placements, which then allows them to have a richer educational experience in community settings.

"Both the education and practice settings for medical education make particular contributions to a student's learning," says Billett. "We need to utilize those settings to help students realize their full potential. We need to take a closer look at how learners are prepared for and engaged in their educational experiences—before, during, and after practicum."



Javier Benítez

@jvrntz Oct 29

Yulara, Northern Territory

RT @djillk1: Platform for any curriculum is a set of beliefs, values and theories

"I have been surrounded by many passionate people who live and breathe medical education. My head is full of all kinds of new, applicable ideas that I'll bring home with me."

**Dr. Greville Wood, Clinical Director, General Academic Rural Practice,
University of Otago, West Coast District Health Board, New Zealand**

"Don't let a tutorial get in the way of good education!"

Yasmin Khanbhai



The WHO's Global Toolkit for Evaluating Health Workforce Education

Dr. Erica Wheeler

Thursday, October 30, 2014

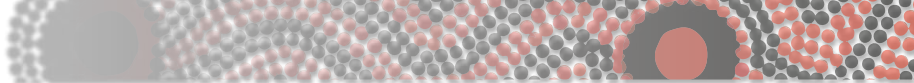
Ensuring that there is a sufficient number of health professionals is a challenge many regions share. Although it might seem like a regional issue, the question has much national and international significance. At Muster 2014, Dr. Erica Wheeler, Technical Officer for the Department of Health Systems Policies and Workforce at the World Health Organization (WHO) spoke about the development of a global toolkit for increasing health coverage around the world, designed to transform the health workforce in support universal health coverage.

According to the WHO, universal health coverage ensures that all people, regardless of where they live, are able to use needed health services—including prevention, promotion, treatment, rehab, and palliation—of sufficient quality to be effective. In addition, universal health care means that using these services does not expose patients to financial hardship. The WHO's "Global Toolkit for Evaluating Health Workforce Education" was designed to transform global health services and education in support of universal health coverage, and assist policy makers and educators alike in assessing the current state of their health services or education, and identifying areas for future development.

"Why are we changing health education and service?" asked Dr. Erica Wheeler. "It's not for the comfort of service providers, but rather, so that we can meet population health needs and expectations. With this tool, we not only need to strengthen countries' health systems and improve population health outcomes, but we need to think about issues of social justice, about social determinants of health, about tackling the inequitable distribution of power. So, when it came to this model, we needed to make sure that assessment and evaluation were at the heart of it, in order to support this necessary move toward universal health coverage."

Taking a systems approach, the goal of the tool is to assess the progress of national and regional initiatives as they relate to social accountability, adaptability, social determinants of health, and transformation of the health-care system. The online tool, likely to be launched in 2015, will allow educators, administrators, service providers, non-governmental services, policy makers, and governmental officials to assess how well their





country, school, or organization is doing in providing relevant, quality, sustainable health care that is available in the appropriate quantity. In order to assess the baseline levels of an organization or service, the individual completing the tool uses a traffic-light system to mark questions as green, yellow, or red to identify where things currently stand in specific contexts. At the end, the tool identifies areas for future progress for the respondent. Perhaps most relevant to the audience at Muster 2014 is the tool's focus on education, including curriculum, community, faculty development, life-long learning, national standards, student selection, career, and retention.

"This is just one initiative, and there's much work still to be done," said Dr. Wheeler. "But, I hope that one day, as a result of this tool, I will be able to come back to you and tell you what the status of the health workforce is around the world, and how we can all work together to continue to improve it."

Since Muster 2014, the World Health Organization has launched their Global Toolkit for Evaluating Health Workforce Education. To access this document, visit bit.ly/WHOglobaltoolkit.

"The best aspect of the conference was the opportunity to work with colleagues from around the world. I always find that so exciting and energizing... It's so wonderful to see everything that is happening in all corners of the world, and how our little piece of the work fits in to the big picture."

Anonymous, via Muster 2014 feedback

Student Plenary

Thursday, October 30, 2014

Many of the discussions held at Muster 2014 were focused on strategies for improving community-engaged medical education. Who better than to give their input than the recipients of that education—the students at community-engaged medical schools?

To this end, the students in attendance at Muster 2014 were asked to share their ideas about what they had learned at Muster, and give feedback to their instructors about what was important from their perspective. Students shared their highlights for the conference—notably, their interaction with the Ngangkari and the integration of traditional healing and western medicine. They also noted that they had developed a much deeper understanding of the importance of social accountability. Students expressed their newfound sentiment that social accountability isn't just a tagline—it's a concept that had inspired a new passion within them as a result of their participation at Muster 2014.

Students discussed their impressions from streams of the program—social accountability, community engagement, longitudinal learning, and Aboriginal health. They gave their teachers in the audience recommendations about longitudinal learning programs (such as supporting students in developing systems of support for coping with stress, and investing in information technology), evaluation (moving away from



high-stakes exams in favour of competency-based learning), and community engagement (encouraging clinical exposure in communities as early as possible in health professional education to help them become socially and culturally aware).

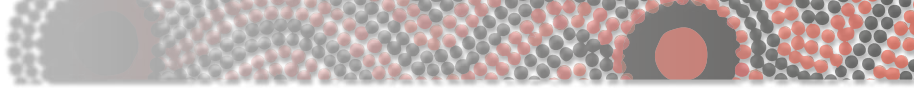
"I've heard that the word success can be derived from succession," said Sunny Krishna, medical student a Flinders University. "I'd like to thank all of you—our teachers and mentors—for your efforts, your time, your dedication, and the many pages of your life that you have dedicated to developing us not only as doctors, and as people who are able to make a difference in people's lives—whether they live in rural or remote communities, or otherwise. You are all really positive role models for us and we are grateful for your all that you do for us."

"Muster 2014 has been a wonderful collaboration of like-minded individuals, forward-looking and prepared to work together for global communities by providing the best possible community-engaged medical education possible. As medical educators, we need to develop strong and lasting symbiotic relationships with the communities in which the medical schools we represent are located."

**Mark Wilson, Associate Professor and Academic Leader, Community Based Health Education
University of Wollongong**



Above: NOSM medical student, Heather Anne Smith (left), with Flinders University medical students (right) during Student Plenary.



Breakout Sessions

15 Workshops

90-minute workshops, half-day workshops or full-day workshops

Through interactive and engaging conversations, workshops were available at Muster 2014 in varying lengths, ranging from 90 minutes to full days. The workshops were designed to stimulate questions and reflection via delivery of core content, followed by small-group discussions. In order to identify key learning outcomes, workshops assisted conference delegates in self-assessing what they may know about the content topics, what they didn't know, and what they could learn by attending the topics.

108 Short Presentations

15-minute oral presentations

The oral presentations highlighted scholarly work in medical and health professional education, service, and research related to the conference themes. Oral presentations were 15 minutes in duration, which allowed for ten minutes of content presentation followed by five minutes of interactive questioning and comments.

25 PeArLs

30-minute PeArLs (Personally Arranged Learning Sessions)

Personally Arranged Learning Sessions (PeArLs) allowed the presenter to deliver their narrative critical dilemma(s) in a way that allowed the audience to actively participate in problem solving. The presenters conveyed their problems and challenges in two to three minutes, providing the context and highlighting up to a maximum of three questions for small-group discussion. Following, participants discussed the situation and provided diverse perspectives and authentic problem solving to the questions at hand. Through a collaborative process generating ideas and solutions, small groups discussed the issues and presented practical solutions back to the presenter(s). The presenters' responsibility was to listen and clarify, and not to direct or guide discussions. Truly conversational, this allowed the presenter(s) to also learn from the diverse groups in their audience.



4 Symposia

90-minute sessions for three 30-minute symposia

Symposia allowed for flexibility in delivery format. Considered “presenter’s choice” in terms of how they wished to manage their session and present their content, symposia were designed to provide the audience with a broad range of topics and modes of delivery to promote learning from multiple presenters. Some sessions were didactic in nature, while others included group discussions and audience participation. Each 90-minute session included three 30-minute symposia, and allowed for discussion in a wide variety of fields of study.

About Symposia “Patients as Teachers or Patients as Text? Augmenting the active involvement of patients in medical education,” presented by Dr. Marion Briggs:

“The idea of patients as text is very interesting and may be particularly important in LICs, where it would seem to have greater impact because of the length of time over which students could have contact with patients. I have not previously considered the difference between directing, shaping, and supporting student learning, nor have I considered the interprofessional approach to clinical education. This is really worth thinking about. The role plays were an excellent way to demonstrate the difference—it was so easy to see how these two strategies differed, and how powerful the patient-as-text and preceptor-as-supporter (not director) of medical students could be. Very interesting thinking, thank you!”

Muster Participant

1.5 Hours of Dean’s Unplugged

It’s rare to find a Dean “unplugged” from his or her desk, but during Dean’s Unplugged, that was exactly the idea. All Deans were invited to congregate poolside at the conference and make themselves available for one-on-one discussion with Muster 2014 delegates. Whether it was about curriculum, academic administration, research faculty, or learner affairs, this was the time for participants to maximize their access to the expertise of senior academics attending Muster 2014 and have their questions answered.

1.5 Hours of Muster Unplugged

Designed to foster collaboration, Muster Unplugged provided participants with the opportunity to share early ideas in education, training, research, evaluation, or clinical service that were not yet well enough developed for formal presentations. The idea was to provide opportunity for international collaboration into early ideas with like-minded people who might be able to provide input or brainstorm ways that the project could be advanced. Muster Unplugged was an “expect the unexpected” type of session, where participants were prepared for anything!

Workshops with the Indigenous Training Academy

One of the reasons why Ayers Rock Resort was selected for the Muster 2014 conference was because of it is owned by Voyages Indigenous Tourism Australia, a wholly-owned subsidiary of the Indigenous Land Corporation (ILC). Known across Australia, the ILC's purpose is to assist Indigenous people in acquiring and managing land to achieve economic, environmental, social, and cultural benefits. Like the participants of Muster 2014, the ILC has a strong commitment to social responsibility, community engagement, education, and workplace training. All profits from their business activities go toward supporting the ILC's Indigenous programs across Australia.

One of the many education programs run by the ILC is the National Indigenous Training Academy (NITA), based in Yulara, the region where Muster 2014 was held. NITA provides enterprise-based accredited training programs for Indigenous youth, offering paid vocational training to Indigenous peoples to support their professional growth and development within the Australian tourism and hospitality industry. The National Indigenous Training Academy has regular intakes of Indigenous trainees, and, by early 2014, had graduated 74 learners who had received Certificate II or III qualifications—professional designations of importance in the Australian tourism industry. Graduates are offered employment at Ayers Rock Resort or other industry partners.

The Workshop with the Indigenous Training Academy provided participants the opportunity to tour the training facilities—which included education rooms, computer labs, libraries, and housing—and speak with program manager and the trainees currently working their way through the ILC's training. Through these, participants gained a deeper understanding of successful socially accountable training in sectors other than medical education and research. Participants learned about the strategies NITA used to develop sustainable Indigenous employment programs in remote regions—strategies that can be developed in their own contexts around the world in health training.



Above: Muster 2014 conference participants with students and staff of the National Indigenous Training Academy.

Closing Ceremonies



After five busy days of intense learning and collaboration, Muster 2014 concluded with grace at the Sounds of Silence Farewell dinner, an evening of dining underneath the sparkling outback sky. Overlooking Uluru-Kata Tjuta National Park, the ceremony brought participants together to mingle amidst the silence of the beautiful Australian outback. Participants were greeted with the sounds of the famous didgeridoo, before led to their tables for a candlelit dinner beneath the stars. After an award-winning meal, participants discovered more about life down under by learning about the night sky in the southern hemisphere—a novelty for visiting North American and European delegates. Delegates were treated to a presentation from a “star talker,” who, with a laser pointer, located a variety of constellations (such as the famous Southern Cross, various zodiac signs, the Milky Way, and other galaxies) visible due to the clear atmosphere in Red Centre. Participants concluded the conference in awe about the “stellar” few days that preceded.



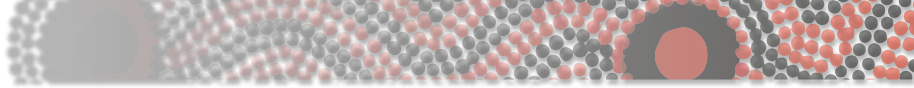
Kelly Meier

@meierkelly1 Oct 30

Yulara, Northern Territory

What better way for [#muster2014](#) to draw to a close than dinner under the stars on the lands of the Anangu people





Lessons Learned

"At Muster 2014, I learned that, in order for health programs and projects to succeed, there needs to be a close relationship between biomedical and social models of health care. This is learning that will continue to be important for us and our work at the Poche Centre for Indigenous Health."

Graham White, Project Officer, Sydney Medical School, Poche Centre for Indigenous Health, Australia

"At Muster 204, I learned so many lasting lessons. I gained an interest in Realist Theory. I learned intriguing concepts regarding innovations in medical education in the Philippines. I heard about the mobilities paradigm. I developed a greater understanding of developmental evaluation. I also heard much about the shared and differing challenges with rural placements in other countries. Among all this, I developed a greater appreciation of varying definitions of rural. "

Maurianne Reade, Assistant Professor, Family Medicine, Northern Ontario School of Medicine

Looking Forward

Every two years, NOSM and Flinders alternate in hosting community-engaged medical education conferences. At Muster 2014, participants were asked to recommend topics for the next conference in the series, which will be held in Sault Ste. Marie, Northern Ontario, Canada in June 2016. The below are a list of recommendations provided by participants for the next ICEMEN conference.

ICEMEN Recommendations

Topics

- What communities want from their medical schools.
- Something on the ethics of working in communities.
- IT use in education.
- How to transform the recalcitrant institution currently undermining attempts at community engagement.
- Teaching about Aboriginal Health Disparities in Canada.
- Assessment / Professional Identity Development.
- CE research strategies; update from Dr. Chris and what that program is up to; service learning at a CE Strategy.



ICEMEN Recommendations, continued

Topics

- Community perspectives on community-engaged medical education.
- Communities in how medical care enhanced lives from the grassroots.
- Similar.
- Continue “the LIC student has failed, now what?”
- Community focus.
- Supporting scholarship at a distance.
- Learning about social movements, more about educational design, more about cutting-edge education and the learning sciences, more discourse.
- Assessment in Community Engaged Medical Education.
- Layered learning in clinical situations (how-to).

Local community visits for 2016 Northern Ontario, Canada:

- At Rendez-Vous I visited local community groups and health professionals – this was brilliant.
- Sioux Lookout again.
- AHAC in Sudbury.
- Indigenous Community.
- Perhaps have community people volunteer in areas of welcoming and guides.
- It would be helpful to see some of the teaching communities: clinics, hospitals, information on demographics, etc.
- To meet with local leaders and discuss their experience of the teaching would be great.
- Fly-in rural clinics, Nunavut.
- Just keep them brief so as to have the important learning but not take too much time when we can be together.



Scientific Program **In Full**

The following pages provide the Scientific Program in full, up-to-date as of the date of printing prior to the conference. PowerPoint presentations from workshop presentations are available online at slideshare.net/Muster2014/presentations.



Above: Muster 2014 conference presenters and participants engage in learning sessions, poster presentations, and keynote addresses.



Day 2 Tuesday 28 October 2014

● Plenary Sessions
 ● Social Accountability
 ● Community Engagement
 ● Longitudinal Learning
 ● Aboriginal Health
 R Rural

9.15am	Meeting with Tuesday Co-Chairs (Room 3)									
9.45am	Housekeeping and Updates - Chair: Sarah Strasser (Rooms 1 & 2)									
10.00am	Ngangkari Presentation (Plenary) - Chair: Michael Kidd (Rooms 1 & 2)									
11.00am	Morning Tea									
	Parallel A	Short Presentation Room 1	Short Presentation Room 2	Short Presentation Room 3	PeArLs Room 4	PeArLs Room 5	Workshop Room 6	Workshop Room 7		
	Co-Chairs	Penny Moody-Corbett / Greg Raymond	Denese Playford / Doug Boreham	David Campbell (Monash) / Basia Siedlecki	Roger Strasser	Sarah Strasser	Cathy Cervin / Greville Wood	Björg Pálsdóttir / Joel Anderson		
11.15am	Time with Ngangkari at the Marquee	12 Community health assessment project curriculum in rural LIC; a program evaluation (Kathleen Brooks) R	96 Cultivating community engagement, expanding cultural competency and defining curriculum: The NOSM Aboriginal and Francophone experience (Lee Rysdale)	119 Aboriginal health and cultural safety training, how do we know if health professional students and staff have connected the dots? A research and tool validation process (Courtney Ryder)	70 The juice bar and more! Building a holistic student experience for successful collaboration, integration and development in a rural community (Adrian Griscti) R	110 From leadership to followership: Supporting clinical academics to become culturally safe (Lucie Walters)	182 Developing a program logic for socially-accountable health initiatives (Simone Ross)	19 Approaches to distributed, socially accountable, and community-engaged medical education research (Rachel Ellaway)		
11.30am		157 Experiences in the implementation of longitudinal medical student placements in urban general practice – lessons learned and recommendations (Mary-Louise Dick)	187 Conceptual design and evaluation of a new rural medical curriculum attracting and retaining health professionals in poor and rural areas in Germany (Markus Hermann) R	26 Community cultural mentoring program (Leanne Pena)						
11.45am		82 Learning to fly: The experience of piloting the LIFT program in Alice Springs (Debbie Fearon) R	183 Positive impacts on rural and regional workforce from the first seven cohorts of James Cook University medical graduates (Tarun sen Gupta) R	72 The clinical and operational benefits of point-of-care testing for Aboriginal people from remote communities in Australia's Northern Territory (Mark Shephard) R	64 Medical students as agents for social change in a rural area? (Lizzie Shires)	138 Closing the gap – are we teaching students enough about good clinical governance? (Kathy Brochie)				
12.00pm		153 Student centred learning for quality teaching in anatomy (Buddhika Weerasundera) R	129 A model for enhancing community engagement of undergraduate health professional students on rural placement (Nicky Hudson) R	48 Increasing global capacity to improve diabetes care for Indigenous peoples through point-of-care testing (Lara Motta) R						
12.15pm		155 Peer and student support group (PaSS): Supporting rural learners and teachers (Jill Konkin) R	122 Upstream student/patient dyads: addressing social determinants of health (Nancy Dickey)	190 Building the Aboriginal health workforce in East Gippsland (Jane Greacen) R	39 Why are some general practices more successful than others at engaging students to be future employees? (Leesa Walker)	2 Preliminary validation of a problem gambling assessment tool for Aboriginal people... implications for GP and allied health practice (Sue Bertossa)				
12.30pm		154 Implementing a successful reflective practice program at six different distributed ICC sites – an exercise in diversity and adaptation (Maggie Watt) R	151 Hospital policy, the learner and quality of care: A student-centered learning tool (Emmanuel Abara)	171 Be a change maker: interagency collaboration between governmental department, university, training operator and community health services in the Katherine region (Judith Mackay) R						
12.45pm		Lunch								

Time with Ngangkari at the Marquee

Day 2 Tuesday 28 October 2014 (continued)

● Plenary Sessions
● Social Accountability
● Community Engagement

● Longitudinal Learning
● Aboriginal Health
● Rural

Parallel B	Short Presentation Room 1	Short Presentation Room 2	Short Presentation Room 3	PeArLs Room 4	Deans Unplugged Poolside	Workshop Room 6	Workshop Room 7
Co-Chairs	Ann Poncet / Adrian Gristci	Helen Wozniak / John Dabous	Cheryl Davis / Kathy Brothie	Sarah Strasser	Paul Worley	Denise Raftis / Lionel Green-Thompson	Courtney Ryder / Tina Armstrong
1.30pm	56 Learning and teaching after dark—innovative techniques inspired by the Tasmanian devil (Bruce Peyser)	73 Medical students being IMMERSED into a "virtual clinical setting" (Kellie Britt)	147 Remote clinical school - where are they now? (Sarah Chalmers)	79 How to make social accountability accountable (Carole Reeve)		118 Moving from community involvement to active participation, engagement, and ownership: Developing influential local groups for transformational health professional education (Danielle Barbeau-Rodrigue)	28 Exploring the journey to cultural safety (Samia Goudie)
1.45pm	184 Longitudinal tracking of graduates: 'tips and tricks' from the JCU School of Medicine and Dentistry (Torres Wolley)	71 Longitudinal integrated clerkships—a model for facilitating medical student resilience (Janet Richards)	136 Blueprinting a new medical school—the challenge offered by the Nelson Mandela Metropolitan University, South Africa (Ian Couper)				
2.00pm	116 Progressive clinical skills—teaching clinical reasoning skills in the Northern Territory (Emma Kennedy)	145 Creating effective change agents: Leadership training for students within the context of community engagement (Susan Rogers)	127 The impact of a distributed education model on specialty practice location intent (Doug Myhre)	77 Effectiveness of inter-professional learning in clinical simulation scenarios using standardised patients (Lucie Walters)			
2.15pm	121 Reflection on the value of longitudinal generalist experience for undergraduate medical education (Nikki Hudson)	46 Rural longitudinal integrated placements—How do they work? A social learning systems perspective (Michele Daly)	22 Global health and health equity: Developing a global medical curriculum (Basia Siedlecki)		Deans Unplugged and Student Posters (Poolside and Atrium)		
2.30pm	8 The public and private good benefits in addressing the chronic disease pandemic among Indigenous peoples (David Campbell, Flinders)	165 Medicine, assessment and the community: A space for the arts? (Margaret Simmons)	61 Exposure to Public Health—a pathway to social accountability (Carole Reeve)	78 Impact of sub-quota selection on rural career (Joanna Rutzen)			
2.45pm	105 Example of an effective feedback loop in socially accountable medical education: NOSM's engagement of Aboriginal communities (Kim Daynard)	111 Calling all comments: Using short phone calls as grading conferences in a LIC (Danielle Dickey)	50 Moving towards a health professions school in the North West province of South Africa: possible models for a collaborative approach (Ian Couper)				
3.00pm	Afternoon Tea						
3.30pm	Plenary: Collaborative Leadership Conversation - Chair: Michael Kidd; Speakers: Agnes Soucat, Donna Ah Chee, Pat Miller (Rooms 1 & 2)						
4.30pm	Posters 1 (Room 3) - Chair: Fortunato Cristobal	Meeting with Wednesday Co-Chairs (Rooms 1 & 2)					
8.30am	Posters 2 (Room 3) - Chair: Ian Couper						

Day 3 Wednesday 29 October 2014

● Plenary Sessions
● Social Accountability
● Community Engagement

● Longitudinal Learning
● Aboriginal Health
R Rural

9.45am	Housekeeping and Updates - Co-Chairs: Pascale Dettwiller/ Paul Worley (Rooms 1 & 2)
9.50am	Keynote Speaker: Rachel Ellaway - Exploring the intersections of medical schools and communities (Rooms 1 & 2)
10.20am	Keynote Speaker: Lambert Schuwirth - Programmatic assessment for learning (Rooms 1 & 2)
11.00am	Morning Tea

Parallel C							
Co-Chairs							
	Short Presentation Room 1	Short Presentation Room 2	Short Presentation Room 3	PeArLs Room 4	Symposia Room 6	Master Class Room 7	Workshop Room 8
11.15am	Lisa Graves / Mark Wilson 33 Learning trajectories in longitudinal rural medical school placements (Cathy Owen) R	Jennene Greenhill / Jeff Bachiu 83 Community engagement case presentation (Jill Bestic) R	Leesa Walker / AJ Neusy 27 How do contextual issues influence socially accountable medical schools? (Robyn Preston)	Jill Konkin 44 Developing a simulation-based education program in a distributed environment: breaking new ground and avoiding the potholes (Siobhan Farrell) R	Sarah Larkins / John Watkins 186 Toward a Theory of compassionate, evidence-informed, interprofessional, person-centred practice (Marion Briggs)	Deb Fearon / David Musson MASTER CLASS I Assessment problems and their possible solutions; critical analyses (Lambert Schuwirth)	Emma Kennedy / Timothy Billington 160 Social accountability and community engagement in the local urban context (Sarah Mahoney)
11.30am	108 What do medical students in an integrated longitudinal clinical placement actually see and do? (Kathryn Weston) R	177 Lessons learned in the development of self-directed online learning for community-engaged faculty development (Kim Falcigno) R	31 Longitudinal integrated clerkships – what is their long-term career impact? 10-year impact of The Rural Clinical School of Western Australia (Denese Playford) R				
11.45am	206 From scratch – a new medical school in Portugal (Pedro Marvaio)	23 Social networking in the student, professional and wider community in longitudinal integrated placements – Is it associated with better preparedness for practice opportunities? (Michele Daly) R	134 Taking social accountability forward – a proposed framework (Lionel Green-Thompson)	142 Embedding community engaged learning within medical education: Levers, barriers and strategies for sustainability? (Josephine Boland)	133 Assessing Patient-Centered Care in an Objective Structured Clinical Examination (Luann Wilkinson)		
12.00pm	58 Feedback on the fly – an innovative approach to student assessment using a smart phone application (Bruce Peyser)	80 Designing 'community' into a distributed community-engaged curriculum (Tim Dubé) R	20 Planning and developing a global community-engaged learning experience for undergraduate medical students (Basta Siedlecki)				
12.15pm	24 Effectively addressing challenges presented by multi-cultural medical learners (Kimberly Kohn)	89 How do you get from here to there – LIC expansion to new sites (Robert Boulay) R	191 How well can a rural longitudinal integrated clerkship prepare a medical student for internship? (Jane Barker) R	176 Is community engagement fundraising/ fundraising or fundraising/ fundraising community engagement? (Gail Brescia) R	99 Views from the field: Exploring the perceptions of students on the reality of interprofessional learning and practice in rural and urban settings (David Thompson)		
12.30pm	88 Tracking value formation of medical student exposed to the ADZU-SOM iterative sandwich curriculum. A cohort study (Fortunato Cristobal)	66 A multi-perspective evaluation of a new rural campus in England (Richard Hays) R	170 The Frozen North meets the Tropical North: six years down the track in the Centre of Australia (Pascale Dettwiller) R				

Time with Ngangkari / W/S Indigenous Training Academy

Day 3 Wednesday 29 October 2014 (continued)

● Plenary Sessions
● Social Accountability
● Community Engagement

● Longitudinal Learning
● Aboriginal Health
R Rural

Parallel D		Short Presentation Room 1	Short Presentation Room 2	Short Presentation Room 3	PeArLs Room 4	Workshop/PeArLs Room 6	Master Class Room 7	Muster Unplugged Room 8
Co-Chairs		Sarah Chalmers / Markus Hermann	Amanda Barnard / John Steeves	Lizzie Shires / Owen Prowse	Pascale Dettwiler	Jane Greason	Penny Moody-Corbett / John Wakeman	Kellie Britt / David MacLean
1.30pm	Time with Ngangkari / W/S Indigenous Training Academy	1 Factors related to medical students' engagement in LICs: A longitudinal study (Doug Myhre)	69 Building distributed community-based research capacity by leveraging a health systems data platform across Northern Ontario Canada (Joe Elbl)	92 Let's start at the very beginning - Med Quest: A pipeline program to medical school and practice (James Hourke)	54 Conversion of traditional block rotation education (TBR) in an academic medical centre to longitudinal integrated clerkship (Longitudinal Integrated Flinders Training LIFT) (Bill Heddie)	168 (Workshop) "On your own at the sharp end": A workshop to address the challenges of providing the institutional/ educational leadership in an isolated/ remote location (Sarah Strasser)	MASTER CLASS II Using realist methods to explore the relationships between medical schools and communities: expanded (Rachel Ellaway)	41 Mobile devices in the clinical setting: information overload and ethical dilemmas? (Helen Wozniak)
1.45pm		25 Using distance technology to facilitate a student balint group (Jay Erikson)	126 Malignant hyperthermia in a local community: How a rural clinical school creates links for research (Zelda Doyle)	141 Northern Ontario School of Medicine undergraduate learners' perspectives on rural practice and medical discipline (Owen Prowse)	60 Mountain moving (Bruce Peyser)			200 Interprofessional education in the NTMP (Greg Raymond)
2.00pm		114 Case-based learning: Participant opinions of its value in medical education. (Timothy Billington)	5 Interviewing third-year medical students in situ: Employing guided walks during a longitudinal integrated clerkship in rural and northern communities (Tim Dubé)	158 The development and implementation of an international student and graduate outcome cohort with medical schools aspiring to social accountability (Sarah Larkins)				163 Transformational change in a big, old, traditional medical school: the "how" of becoming socially accountable (Jill Konklin)
2.15pm		144 Case-based learning through peer review (Nancy Dickey)	164 Community based research in practice: Shared reflections on process, outcomes and impact (Josephine Boland)	172 NOSM health sciences summer camps... a successful community-engaged collaborative model (Danielle Barbeau-Rodrigue)				196 We need to have a chat about that! Bringing social equity to the student conversation (Michael Douglas)
2.30pm		87 Developing personal attributes of professionalism during clinical rotations: Views of final year bachelor of clinical medical practice students (Nontsikilelo Mapukata-Sondzaba)	179 Improvisational scenarios to enhance communication and patient-centred education (Maurianne Reade)	10 Pre-med summer institute - promoting & preparing Aboriginal students to apply to medical school in Canada (Michael Jong)	102 Teaching and learning the skills of telepractice/ telemedicine: Challenges and opportunities (Sue Berry)	189 (PeArLs) Scaling up: From social accountability in medical schools to addressing health inequity and universal health coverage at a national or international level - what will it take? (Sarah Strasser)		90 How we established community engagement projects (Robert Boulay)
2.45pm		159 Do medical students maintain their empathy differently depending on the location of their study in year three? (Sarah Mahoney)	104 A model for rural health education for first year medical students (Ruth Bush)	205 Indigenous health in Scandinavia - Pitfalls and Summits (Oleg Kravtchenko)				13 "Have I jumped the gun?" - assisting students' transition towards clinical reasoning competency in a longitudinal integrated clerkship (Daryl Peeler)
3.00pm	Afternoon Tea							

Day 3 Wednesday 29 October 2014 (continued)

Plenary Sessions
 Social Accountability
 Community Engagement
 Longitudinal Learning
 Aboriginal Health
 Rural

Parallel E	Short Presentation Room 1	Short Presentation Room 2	Workshop Room 3	PeArLs Room 4	Symposia Room 6	Workshop Room 7	Workshop Room 8
Co-Chairs	Doug Whyre / Cathy Owens	Sarah Mahoney / Robert Boulay	Nancy Dickey / Paul Worley	Nicky Hudson	Deb Fearon / Tim Dubé	Kathy Brookes / Jane Barker	Gail Robertson / David Musson
3.30pm	29 Designing student centred and online learning approaches to develop clinical judgement: The student experience (Helen Wozniak)	7 School based service learning for medical students: Design, implementation and reflections (Suzanne McKenzie)	86 Developing tools for the evaluation of community-based education (Ian Couper)	124 Meaningful patient cohorts in a LIC (William Pierrat)	75 Engaging local community members as standardised patients for clinical simulation (Jenenne Greenhill)	156 Curriculum development for community engagement (Josephine Boland)	152 Specific challenges in starting Longitudinal Integrated Clerkship (LIC) in an Academic Medical Centre (AMC) (Bill Heddle & Ann Poncelet)
3.45pm	67 Changing perceptions of final year medical students throughout a fifteen week placement in rural primary care: A study using serial focus groups (Richard Hays)	45 Service-learning: Linking the local and global learning environment (Siobhan Farrell)					
4.00pm	130 Virtual clinics and vertical medical education (Patricia Knight-Billington)	9 Extending the explanatory power of subjective wellbeing in relation to health through the integration of the psychosocial determinants (David Campbell, Flinders)		97 Developing and evaluating Aboriginal cultural self-efficacy in health professional learners (Lee Rysdale)	57 Part 1. Patients as teachers or patients as text? Augmenting the active involvement of patients in medical education (Marion Briggs)		
4.15pm	150 Teaching clinical urology to learners training as "generalists" in a rural setting (Emmanuel Abara)	188 A model of oral health services in remote Aboriginal communities (Kylie Gwynne)		202 How to transform a specialized clinical palliative care unit into a teaching performance (Peter Pype)			
4.30pm	180 A 360 view of simulated learning environments and interprofessional learning at a wilderness medicine event (Maurianne Reade)	132 Learning with community – students' reflections on social accountability after community experiences (Lionel Green-Thompson)			68 Part 2. Community engagement with a patient-centred approach (Sue Berry)		
4.45pm	106 "I followed him all the way" - the continuity-of-care experiences of longitudinal clerkship medical students (Kathryn Weston)	125 Strategies to manage Over-users of medical services (Philip McGuire)					
5.00pm	Meeting with Thursday Co-Chairs (Room 6)						
9.15am	Visit to Purple Truck/Time with Ngangkari						

Day 4 Thursday 30 October 2014

Plenary Sessions
 Social Accountability
 Community Engagement
 Longitudinal Learning
 Aboriginal Health
 Rural

9.45am	Housekeeping and Updates - Co-Chairs: Dave MacLean / Roger Strasser (Rooms 1 & 2)
9.50am	Keynote Speaker: Fortunato Cristobal - Health for More, Health Disparity and Health Education Training: An on-going Tension? (Rooms 1 & 2)
10.20am	Keynote Speaker: Stephen Billett - Developing professional competence through the integration of experiences in practice and educational settings (Rooms 1 & 2)
11.00am	Morning Tea

Parallel F	Short Presentation Room 1	Short Presentation Room 2	Workshop Room 3	PeArLs Room 4	Symposia Room 6	Master Class Room 7	Workshop Room 8
Co-Chairs	Suzanne Mackenzie / Peter Pype	Pascale Dettwiller / James Rourke	Danielle Barbeau - Rodrigue / Greg Raymond	Sue Berry	Kimberley Krohn / David Campbell (Flinders)	Ann Poncelet / David Musson	Cheryl Davis / Michael Jong
11.15am	161 Survival as a pathway in transformative learning: Experiences of medical students in a rural clinical school (Sarah Mahoney) R	52 Distributed community-engaged dietetics learning as the road to rural practice: Examining the impact of the Northern Ontario Dietetic Internship Program on recruitment and retention of Registered Dietitians in rural and underserved areas (Denise Rafits) R	21 How to communicate the facts about medical radiation risks to patients, families, peers & the community (Douglas Boreham)	11 The struggling rural LIC learner: Remediation challenges (Kathleen Brooks)	65 A proposed innovative model in interprofessional longitudinal learning focusing on the care of seniors and the potential role for developmental evaluation (DE) (Marion Briggs)	MASTER CLASS III Curriculum and pedagogic practices for work-integrated learning (Stephen Billett)	120 How can Aboriginal health models incorporate western medical and other worldviews for better health outcomes? (Courtney Ryder)
11.30am	162 Student approaches to learning: Comparison of longitudinal integrated and rotation based clerkships (Jill Konklin) R	63 Blood service fellows transfusion rounds: Engaging the transfusion community in patient blood management (Cindy Flores)					
11.45am	81 Evaluation of Longitudinal Integrated Flinders Training (LIFT) 2013 (Gayle Robertson)	112 NOSM postgraduate medical training: Creating sustainable funded programs for a community-engaged distributed education environment (Jennifer Fawcett) R		30 Tracking learning in longitudinal integrated clerkships & community based medical education: The NTMP electronic logbook experience (Helen Wozniak) R	53 How to contextualize the curriculum – to wherever you and your learners happen to be located and covering the full extent of learning in medical education (Sarah Strasser)		
12.00pm	16 Comparison of models of curriculum delivery for the Monash MBBS Y4C Curriculum (Loy Perryman)	17 Can you track the long term outcomes of your Graduates? (John Steeves) R					
12.15pm	95 How do we compare? Longitudinal Integrated Clerkships: A snapshot of an Australian rural clinical school curriculum for final year medical students (Andrew Dean) R	109 A medical workforce for regional, remote and rural Australia: Are we on track to fulfil our mission? (David Garne) R		137 Using multiple methods to measure outcomes of longitudinal integrated clerkships (Debbie Fearon)	166 "Wicked problems and exquisite dilemmas" for non-health professionals who teach health professional students (Robyn Preston)		
12.30pm	117 Comparable learning experiences at NOSM's Longitudinal Integrated Clerkship (Jeff Bachiu) R	148 Learner experiences of a hybrid distributed pediatrics residency program (Rachel Ellaway) R					
Time with Ngankaris / Visit Purple Truck							

Day 4 Thursday 30 October 2014 (continued)

- Plenary Sessions
● Social Accountability
● Community Engagement
● Longitudinal Learning
● Aboriginal Health
R Rural

WHO Toolkit Launch - Chair: Paul Worley																
Parallel G		Short Presentation Room 1		Short Presentation Room 2		Short Presentation Room 3		PeArLs Room 4		Symposia Room 6		Workshop Room 7		Workshop Room 8		
Co-Chairs		Kathryn Weston / Bill Heddle		Joe Eibl / Robyn Preston		Richard Hays		Sarah Strasser		Cathy Cervin / Josephine Boland		Jennifer Fawcett / Jill Bestic		Kathleen Meacham / Andrew Dean		
1.30pm	Time with Ngangkari's / Visit Purple Truck		34 Distributed learning in occupational medicine for family physicians (Joel Anderson) R		47 Challenges in developing a new graduate program in a socially accountable medical school (David MacLean) R		Posters 3		197 We are in this together: Evaluating the experience of a collaboration of medical schools in rural NSW (Michael Douglas) R		59 Weekly longitudinal student centered primary care seminars (Bruce Peyser)		185 Moving beyond the rural elective: Building and stabilizing the rural education team (Cheri Bethune) R		18 The international evidence base for LICs: Where is the MISSILE heading? (Paul Worley)	
1.45pm			173 Remote Health Experience (RHE): An innovative and unique education activity in remote Northern Territory, Australia. (Pascale Dettwiller) R		91 The geographic pipeline to rural family medicine at Memorial University (James Rourke) R				42 What influence does rural prevocational training have on future medical career choices? (Julie Forgan) R		128 UCLA SMDEP a student-centered program designed and modified by a novel evaluation and assessment program (Lawrence Hy Doyle)					
2.00pm			175 Case based learning through interprofessional peer review (Nancy Dickey)		169 Slipping under the radar in a parallel universe — Social accountability and community engagement in a rural clinical school program (David Campbell, Monash) R											
2.15pm			74 THE Collaborative Community Engagement – "Working in Health Teams" Education Project (Kellie Britt) R		203 Interprofessional workplace learning in primary palliative care (Peter Pype)											
2.30pm			62 Medical students as Peer educators in rural schools (Lizzie Shires) R		140 Exploring the link between the admission process and the social accountability mandate of the Northern Ontario School of Medicine (Owen Prowse)				103 Investigating the impact of NOSM on the health of rural and Northern Ontario using health services data (John Dabous) R		51 Using critical incident reflection sessions to promote reflection in undergraduate medical learners: Exploring elements of the hidden curriculum (Siobhan Farrell)					
2.45pm			204 Public Health – an essential part of rural practice? (Greville Wood) R		167 Evaluating the impact of a rural clinical school on rural communities (Sally Hall) R											
3.00pm	Afternoon Tea															
3.30pm	Student Panel (Plenary) (Rooms 1 & 2)															
4.30pm	Wrap Up (Rooms 1 & 2)															
6.00pm	Buses depart from Sails in the Desert Hotel for the Sounds of Silence Dinner and Farewell															

Poster Presentations

● Plenary Sessions
 ● Social Accountability
 ● Community Engagement
 ● Longitudinal Learning
 ● Aboriginal Health
 R Rural

Chair	Poster Presentations 1
Fortunado Cristobal	
198	Faculty development planning: A key strategy for success in the implementation of a longitudinal integrated clerkship Pilot Program at the University of Toronto, Faculty of Medicine (L. Graves)
193	The University of Toronto, longitudinal integrated clerkship students' perspectives (L. Graves)
149	The PACK's first year as a longitudinal program at Texas A&M (K. Coble)
131	Allocation of medical students to a 38 week longitudinal integrated community-based placement (T. Duguid)
43	Expanding the boundaries of clinical skill development in undergraduate medical education: Instruction in Point of Care Ultrasound (POCUS) at the Northern Ontario School of Medicine (S. Farrell)
36	Wilderness & Survival Medicine as an Interprofessional Educational Forum (M. Reade)
15	Comparative clinical ethics education: LIC v TBR (K. Meacham)
178	John Flynn Placement Program – does community engagement shape rural careers? (L. Godier)

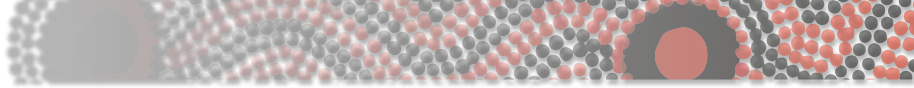
Chair	Poster Presentations 2
Ian Couper	
199	Evolution of the indigenous entry stream in the NTMP (G. Raymond)
123	The LIME Network: indigenous pathways into medicine online resource and videos (O. Mazel)
35	Who writes the stories? Anishnaabeg animators creating patient-centred simulations (M. Reade)
32	Impact of simulated emergencies in wilderness-based setting on learning interprofessional collaboration from the facilitators' and simulated patients' perspective (H. Smith)
107	Use of context scoring in the medical school admission process as a tool in addressing the social accountability mandate of the Northern Ontario School of Medicine (NOSM) (O. Prowse)
101	The power of PaNDA: NOSM student placement locale data provides accountability and quality improvement measures (L. Rysdale)
93	How is rural defined and used in Canada? (J. Bourke)
143	Communication for the patient's needs... the key to competent healthcare (D. Barbeau- Rodrigue)

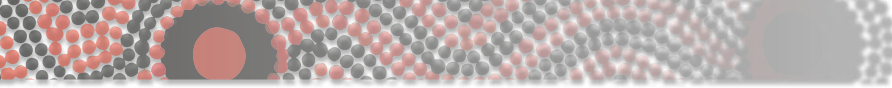
Chair	Poster Presentations 3
Richard Hays	
201	Community engagement: Integration through the Memorial University medical school curriculum (K. Stringer)
146	Effect of interprofessional training at rural small hospital ~ rural community is suitable field for interprofessional education~ (R. Nakaoke)
115	Go to the people: Reflecting on the long-term outcomes of 1990s community-engaged teaching and learning in Indonesia (B. Marjadi)
38	The 2nd evaluation for a pilot study of community participatory medical education ~Possible new spectrum of community oriented medical education?~ (A. Takamura)
100	How do graduates of longitudinal integrated clerkships fare on the Medical Council of Canada Qualifying Exam Part II? (D. Mhyre)
98	Student satisfaction with community versus academic medical center clerkship experiences (S. Tieman)
94	Progressive diabetic ketoacidosis simulation (J. Watkins)
195	The University of Toronto, Longitudinal Integrated Clerkship A process map: Avenues and roadblocks (L. Graves)
194	The University of Toronto, Longitudinal Integrated Clerkship The patient panel: A unique challenge (L. Graves)

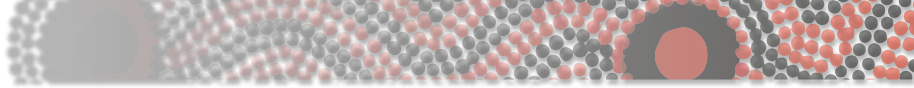
Candid Shots

Muster 2014 was a truly interdisciplinary conference, bringing together people with a wide variety of professional backgrounds, interests, and affiliations. Participants were asked for their professional affiliations in the Muster 2014 evaluations. Those who filled out the survey were able to list more than one affiliation, and indicated the following: 43% were physicians, 11% were health-care professionals, 38% were educational professionals, 34% were researchers, 15% were administrators, and 3% were other (including medical students). In addition, participants reported a wide variety of affiliations with various conference partners. Again, able to choose more than one selection, 25% of delegates were connected with the Consortium for Longitudinal Integrated Curricula (CLIC), 6% were connected with the Federation of Rural Australian Medical Educators (FRAME), 5% were connected with The Network: Towards Unity for Health (TUFH), 8% were connected with Training for Health Equity Network (THEnet), 42% were connected with NOSM or Flinders University, 11% were connected with Wonca, 2% were students, and 6% listed "other," such as James Cook University and The University of Otago.









INTERNATIONAL CONFERENCE: COMMUNITY ENGAGED MEDICAL EDUCATION IN THE NORTH

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ICEMEN2016.CA

ICEMEN 2016

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ICEMEN 2016 is a five-day conference exploring themes of social accountability and community engagement in medical education and research. Within this dynamic program, **ICEMEN will also include:**



Conference On The Move
June 20-21, 2016



Aboriginal Research Gathering
June 23-24, 2016



Northern Health Research Conference
June 24-25, 2016



2014 **The Muster**
Global Community Engaged
Medical Education

