Rural and Remote Health
MEDLINE listed
Impact factor .979
FRAME
ARHEN
Wonca
RURAL HEALTH
ISSN 1445-6354
The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy

ORIGINAL RESEARCH

Why community members want to participate in the selection of students into medical school

P Stagg, DR Rosenthal

Flinders University Rural Clinical School, Renmark, South Australia, Australia

Submitted: *10 October 2011;* ***Revised:*** *26 March 2012;* ***Published:*** *20 August 2012*

Stagg P, Rosenthal DR

Why community members want to participate in the selection of students into medical school
Rural and Remote Health **12: 1954. (Online) 2012**

Available: http://www.rrh.org.au

ABSTRACT

Introduction: Medical schools around the world have established affirmative selection policies to support applicants from the populations they serve. Increasingly they are involving community members in selecting students into medical school. At Flinders University, South Australia, community involvement in the selection of students into the medical school can be by participation in the mainstream Graduate Entry Medical Program (GEMP) selection process at the city campus in Adelaide, or through membership of the rural based Community Liaison Committee (CLC). The aim of this research was to understand what motivates community members to participate in the selection of medical students, how they feel about their participation, and their perceptions of who are the beneficiaries of their involvement.

Methods: Eight community members were purposefully selected from the pool listed to participate in the mainstream GEMP selection process, and each of the four community members of the CLC were invited to participate in this research. Interviews with each participant were audiotaped to assist in gaining an accurate transcription. The interview consisted of seven open-ended questions. Using a qualitative methodology two rounds of coding of the data were undertaken independently by each of the authors. The first round determined descriptors of motivators and feelings held by the participants as a result of their participation in the selection process. From these descriptors a second round of coding was undertaken to draw inferences, and these inferences resulted in a thematic analysis.

Results: Five themes described why the community members are motivated to be involved in the selection of medical students: opportunity for professional growth; for personal growth; responsibility to represent the broader community; protecting the student and public interest and self-interest in shaping the future workforce. Participating community members experienced feelings

associated with energising; emotive feelings; feelings associated with self-worth, positivity and feelings of obligation. By bringing their own views and values to the selection process they believed that the students selected will meet the needs of their respective communities. They believe that the university gains both financially and politically by their involvement. Members of the rural based CLC considered this role a service to their community, to which they have a strong sense of accountability.

Conclusion: Given the opportunity, community members are willing participants in selecting students into medicine. Community members bring different skills and perspectives to the selection process from which they can influence the future medical workforce.

Key words: community, community participation, medical school admissions, medical student.

Introduction

In line with the principles of health for all[1], medical schools are increasingly moving towards a social accountabilty agenda[2-4]. Within this context many medical schools around the world have established affirmative admissions and selections policies to encourage and support applicants originating from the populations they serve[2,5-8]. In parallel with affirmative admissions and selection policies, medical schools are increasingly involving community members in selecting students into medical school. This is particularly evident in schools which have a rural or remote focus in Australia.

In line with its own social accountability agenda[9], community involvement in the selection of students into the Flinders University Medical School occurs in two different ways. One is by participation in the the mainstream Graduate Entry Medical Program (GEMP) selection interviews at Flinders University, Adelaide, and the second is through membership of the rural based Community Liaison Committee (CLC).

In 1998, Flinders University created a pathway for rural origin students to enter medicine through the establishment of a quota of four places for rural origin applicants. The CLC was established to specifically increase rural community participation in the selection of rural origin students into medical school. This is important because selection committees with local community members can reduce inadvertent discrimination by urban based admissions committees[10,11]. This view is supported by the Australian Medical Association which, in its 2006 submission to the Department of Education, Science and Training Medical Education Study[12], stated:

> *Diversity is important. It is appropriate that there is some variation among the selection criteria and methods employed across medical schools and independence for the individual medical schools to determine their own selection processes… It allows for selection from a wider pool of applicants and within appropriate benchmarks can be used to achieve social objectives such as greater representation from rural students. Variation of selection processes, just like variation of medical school curricula content and delivery, ensures that there is adequate diversity in our medical school graduate cohorts to meet the future health care needs of our society.*

The CLC have ownership of the selection process. They have developed their own selection criteria, application marking tool, program of activities for the selection weekend, standardized interview questions, marking tool for ranking the interviewees, and an evaluation process. This process has been ratified by the Flinders University Admissions Committee[11,13-19]. This year (2011), the CLC will select the twelfth cohort of rural origin students (48 students) into the rural admissions quota.

The purpose of this research was to understand what motivates community members to participate in the selection of students into medicine, and also how they feel about their participation. The research also sought to identify who the community members thought benefitted from their involvement.

Method

Community members in Adelaide are invited to join a three person panel to select students applying for entry into the GEMP. Each panel consists of a community member, a clinician and an academic staff member. Community members are recruited by word of mouth and any community member selected to participate in the process can nominate other community members who they consider to be suitable. All members of the selection panel undertake training to ensure that interviews are standardised.

The CLC has eight members. The composition is four community members (3 male, 1 female) , one local rural male clinician, one female academic staff member, one medical student and one female administrative member of the Parallel Rural Community Curriculum (PRCC) team. Three of the four community members have been on the CLC since its inception[20].

Eight community members (4 male and 4 female), were purposefully selected from the pool used in the mainstream GEMP selection process. In order to increase the validity of the data a ratio of 2:1 community members were interviewed in ths group compared with the CLC because of the size of the this pool of community members. These community members were selected to match as closely as possible the four CLC members in terms of number of years involvement in the selection process. Interviews were undertaken with each of the 12 community members. The interviews were audiotaped to assist in gaining accuracy in the transcription of responses.

The questionnaire template had the following questions:

- Why did you get involved?
- How long have you been involved?
- What do you think are the benefits to: (a) you, (b) the students, (c) the University, and (d) the community in general, of community members being involved in selecting students into medicine?
- What opportunities are there for you to engage the students once they have been selected into the medical program?
- What opportunities are there for you to get feedback about the students you have interviewed?
- Do you feel you input into the selection process is valued by the university?
- Is there anything else you want to tell me about your involvement in selecting students into the medical program at Flinders University?

Using a qualitative methodology, two rounds of coding of the data were undertaken independently by each of the authors. The first round sought to determine descriptors of motivators and feelings held by the participants as a result of their participation in the selection process. From these descriptors a second round of coding was undertaken to draw inferences from them. These inferences resulted in the thematic analysis presented.

Ethics approval

The research was approved by the Flinders University Social and Behavioral Research Ethics Committee (#4623).

Results

Motivators

Motivation is a driving force that initiates and directs behaviour[21]. It is a kind of internal energy which drives a person to do something in order to achieve something. Five themes were drawn from the data that describe what motivates community members to be involved in the selection of medical students.

Opportunity for professional growth: Community members described the experience as providing an opportunity to develop new professional networks, to acquire new knowledge and new skills to apply to own work and as providing an opportunity for their own professional development. They also describe having a professional interest in the methodology of different selection processes. Having positive, stimulating

involvement initially, community members are motivated through reciprocity to continue their involvement.

> *I guess the enjoyment of assisting in what I consider a great cause because I think the selection of doctors in Australia is something important so just the sheer enjoyment in contributing to that, and being impressed by the structure of the interview process itself and learning the system and adopting elements myself that's a very tangible benefit that I can take into the workplace.* (HF)

Responsibility to represent the broader community: The responsibility of being a community representative and the contribution that selecting the 'right' medical students makes to community was described as a motivator for involvement. Specific to the CLC, a motivating factor for participation was to contribute to the successful PRCC education model for the benefit of their rural community.

I think we, the community members, take the role seriously. We are representing the community and it's a big responsibility representing thousands of people. I'm sure if more people knew they would find it reassuring to know that they are represented with good cross communication with other panel members. (AH)

Opportunity for personal growth: The act of self-reflection after interacting with the student candidates was described as personally fulfilling and adding to individual personal development. Community members described the responsibility of selecting medical students and the positive feeling of being an enabler as personally rewarding. The increased understanding of the role and commitment of being a doctor was seen as imbuing them with 'superior' knowledge:

> *I find it a completely satisfying activity, I feel that I've been of some use and I do tend to be a little philanthropic in some ways so I feel very satisfied that I've been of some assistance. I'm always fascinated by what the students say by their own experiences I find that life expanding.* (HF)

Protecting the student and public interest: Protecting both the student and public interest was a motivator for their participation. This includes ensuring a balanced selection panel for the students benefit and representing their own community's interests. The opportunity to 'humanise' and 'ground' the selection process was an important driver. The community members sought to ensure that selection into medical school was a democratic process. The CLC describe having ownership of the process and being the voice of the rural community as a strong motivator.

> *And I thought if you are going to focus on looking for just one kind of person, say you're choosing all of the extroverts, you know the ex captain of the cricket team type of person then you might really be missing out on all of those other personality types that I think you need in the whole of the medical field. You just need a balance, so I think that having the community members brings a wider opinion, a different perspective.* (AA)

Self-interest in shaping the future workforce: Community members had a strong awareness that they had the opportunity to bring their own personal values of what a doctor should be like the process. This was described as a positive motivator. They describe the need to ensure that there is diversity in the future workforce and that they can contribute to this outcome. There was a strong recognition of self ageing and its needs together with an awareness of their own experience of doctors as being relevant to the process.

> *I guess I am interested in selecting the appropriate people and seeing them through and as a patient I'm interested in seeing a good practitioner when I am unwell, or when I need to see a practitioner. I think it's important to have a good blend of knowledge, academic knowledge but also emotional intelligence and I think it's those two things coming together that I'm interested to see.* (AS)

Internally held feelings

In order to understand why community members want to engage the authors needed to know how the community *felt* about their involvement with us in selecting students into medicine. The feelings described by community members due to engagement in the selection process are shown (Table 1).

Table 1: Feelings described by community members due to engagement in the selection process

Themes	Words community members used to describe their feelings
Feelings associated with energising	Invigorating, stimulating, mentally stimulating, refreshing, exciting, challenging
Emotional	Spiritually stimulating, enjoyment, uplifting
Feelings associated with self-worth	Valued, Positive affirmation of self
Positivity	Satisfying, rewarding
Feelings of obligation	Sense of responsibility, Part of a community of practice, Privilege, Being an enabler, Ownership of the process, Ensuring equivalence, Empathy for students

Benefits

Benefits of community involvement in selecting students into medicine: Individual members give their time freely to the process of selecting students into medicine because they believe there are real and tangible benefits to their communities. Community members also believe that the university and the student applicants benefit from their involvement (Table 2).

Discussion

Community members participate freely in the selction of medical students into medical school because they believe they have much to offer the process. There is a strong sense that their involvement will protect both the student and public interest. By bringing their own views and values to the selection process they believe the students they select will meet the needs of their respective communities.

Community members bring to the selection process their experience of the doctor–patient relationship. They acknowledge a level of self-interest in shaping the future workforce. Many have a strong feeling of their own aging and their future requirements from doctors. Drawing on their own past experiences with doctors, they want to select students they feel they could relate to as a patient.

There is a strong sense of reciprocity identified by community members. In giving their time and expertise to the process they receive back many positives. This includes the acquisition of new knowledge and skills to apply to own work place and their professional development and a sense of personal growth. In representing the broader community there is a strong sense of responsibility and privilege. This is accompanied by feelings of increased self worth, positivity, energising and in some cases strong emotions.

Community members do believe that there are multiple benefits to others in their involvement in the selection process. There is a belief that the university gains both financially and politically by their involvement. As the university does not pay any community members for their services there is a financial benefit to the university. Similarly it is felt that there is kudos to be gained by the university from promulgating an image of community engagement and 'ticking' the community engagement requirements of funding bodies.

Community members believe that through their involvement the students will be reassured by the multiple and diverse perspectives of assessment panel. They believe that students find it easier to relate to the 'non-academic' who brings a sense of normality and balance to the process and, hopefully, puts the applicant at ease.

Table 2: Community-member-identified benefits to others by their involvement in selecting students in to medical school

Beneficiary	Benefit	Input of community members
Community	Supports health and wellbeing of the community	Increased chance of selecting students that reflect community values which lead to improved patient outcomes Reflecting back personal values Ensuring diversity of future workforce
	Balance of power	Brings objectivity to the process Affirms the process Reduces the notion of prejudice (elitism) Brings an inclusive approach
	Multiplicity of viewpoints	Powerful collective of experienced and diverse professionals Tangible ownership of the process Value adding
	Local accountability (CLC)	Brings the rural perspective, Service to the community
Perceived university benefits	Positive publicity	Manages and responds to negative media Community members adds to university integrity and credibility Community members provide positive marketing
	Financial	Cost benefit Resource savings
	Enriching the process	Adds value to the selection process The value of the "non-academic" Balance Objectivity Local knowledge
	Political gain	Increased legitimacy Students become ambassadors for the university when students are situated in the community Community become ambassadors for the university
	Community engagement	Connectivity with the broader community Enhanced educational role within the community Developing and improving social capital Forming links with the community
Perceived student benefits	Multiplicity of viewpoints	Variety of the panel Reassurance that multiple perspectives of assessment are in play Relating to the "non-academic" Normalisation of the panel, Humanises the process Puts the students at ease Developing links with the community for future education placements

CLC, Community Liaison Committee.

The CLC have selected 48 rural origin students to study medicine in the rural Riverland region of South Australia. The CLC have a strong sense of accountability to their community and they consider this role as a service to their community. In representing their communities they hope that there is an increased chance of selecting students that reflect community values which will ultimately lead to better health outcomes for the community.

Conclusions

Community members have high expectations of medical schools and of their graduates who will become the doctors of

the future. There is an expectation by the community that doctors will possess a broad range of skills both clinical and interpersonal skills. Further, communities expect that, as a collective, doctors will possess and exhibit the values of the broader community and also of specific communities such as rural, regional and remote communities.

Medical schools have the capacity to meet these expectations through involvement of community members in the selection of students into medicine. Active participation and decision making in the selection process results in many benefits to the medical schools, students and the community.

Ownership of the selection process can go beyound participation. With ownership community members have reponsibility for representing the views of their communities and are responsible to them for their decisions. In the case of the CLC they also have the added responsibility of making life changing decsions for a small group of rural origin students with whom they have a specific empathy.

Overwhelmingly, community members saw their involvement with the university in the selection of students into medical school as positive. There were no negative comments made nor negative feelings reported by any person interviewed. Even the issue of non-payment for their time was considered positive by community members who said that payment would be seen as 'tainting' the process.

Given the opportunity, community members are willing participants in selecting students into medicine. Community members bring different skills and perspectives to the selction process from which they can influence the future medical workforce.

References

1. World Health Organisation. *Reorientation of medical education and medical practice for health for all*. (Online) 1995. Available: www.who.int/entity/hrh/resources/WHA48-8_EN.pdf (Accessed 1 June 2011).

2. Strasser R, Lanphear J, McCready W, Topps M, Hunt DD, Matte M. Canada's new medical school: The Northern Ontario School of Medicine: social accountability through distributed community engaged learning. *Academic Medicine* 2009; **84(10):** 1459-1464.

3. Woollard RF. Caring for a common future: medical schools' social accountability. *Medical Education* 2006; **40(4):** 301-313.

4. Poole PJ, Moriarty H, Wearn A, Wilkinson TJ, M. WJ. Medical student selection in New Zealand: looking to the future. *New Zealand Medical Journal* 2009; **122(1306):** 89-100.

5. De Vries E, Reid R. Do South African medical students of rural origin return to rural practice? *South African Medical Journal* 2003; **93:** 789-793.

6. Neusy AJ, Palsdottir B. A Roundtable of Innovative Leaders in Medical Education. *MEDICC Review* 2008; **10(4):** 20-24.

7. Pálsdóttir B, Neusy AJ. *Transforming medical education: Lessons learned from THENet*. (Online) 2011. Available: http://www.healthprofessionals21.org/docs/TransformingMedEd.pdf (Accessed 1 June 2011).

8. Health Canada. *Social accountability: a vision for Canadian medical schools*. Ottawa. ON: Health Canda, 2001.

9. Flinders University School of Medicine. *Flinders University School of Medicine overview*. (Online) 2010. Available: http://www.flinders.edu.au/medicine/about/overview.cfm (Accessed 28 July 2010).

10. Frenk J, Bhutta ZA, Chen LC-H, Cohen J, Crisp N, Evans T et al. Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World. *Lancet* 2011; **376(9756):** 1923-1958.

11. Stagg P, Greenhill J, Worley P. A new model to understand the career choice and practice location decisions of medical graduates. *Rural and Remote Health* **9: 1245**. (Online) 2009. Available: www.rrh.org.au (Accessed 26 June 2012).

12. Australian Medical Association. What makes for success in medical education? Submission to *Department of Education, Science and Training Medical Education Study: Medical Education in Australia*. Canberra, ACT: Australian Medical Association, 2006.

13. Stagg P, Rosenthal D, Worley P, DiSisto N (Eds). Reflections of nine years of community based medical education. In: *Proceedings, ANZAME Annual Conference in conjunction with APFM: Mind the Gaps*; 30 June 2005; Auckland, New Zealand; 2005.

14. Worley P, Silagy C, Prideaux D, Newble D, Jones A. The parallel rural community curriculum: An integrated clinical curriculum based in rural general practice. *Medical Education* 2000; **34:** 558-565.

15. Worley P, Prideaux D, Strasser R, Magarey A, March R. Empirical evidence for symbiosis medical education: a comparative analysis of community and tertiary-based programs. *Medical Education* 2006; **40:** 109-116.

16. Worley P, Martin A, Prideaux D, Woodman R, Worley E, Lowe M. Vocational career paths of graduate entry medical students at Flinders University: a comparison of rural, remote and tertiary tracks. *Medical Journal of Australia* 2008; **188(3):** 177-178.

17. Worley P. Flinders University School of Medicine, Northern Territory, Australia: achieving educational excellence along with a sustainable rural medical workforce. *Medical Education* 2008; **10(4):** 30-34.

18. Walters LK, Worley PS, Mugford BV. The parallel rural community curriculum: is it a transferable model. *Rural and Remote Health* 3: 236. (Online) 2003. Available: www.rrh.org.au (Accessed 26 June 2012).

19. Rosenthal D, Worley PS, Mugford B, Stagg P. Vertical Integration of medical education: Riverland experience, South Australia. *Rural and Remote Health* **4:** 228. (Online) 2004. Available: www.rrh.org.au (Accessed 26 June 2012).

20. Stagg P. Future doctors of the Riverland. *National Networks* 2000; **2:** 8-10.

21. PublicHealthFourms.com. *PublicHealthForums.com-Be Educated not Medicated*. (Online) 2011. Available: http://www.publichealthforums.com/pp-your-health/motivation/define-motivation/ (Accessed 1 October 2012).

