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Phillip G. Clark
The University of Rhode Island

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SERVICE-LEARNING EDUCATION IN COMMUNITY-ACADEMIC PARTNERSHIPS: IMPLICATIONS FOR INTERDISCIPLINARY GERIATRIC TRAINING IN THE HEALTH PROFESSIONS

Phillip G. Clark
Program in Gerontology and Rhode Island Geriatric Education Center,
The University of Rhode Island, Kingston, Rhode Island, USA

Major changes are taking place within the health care system that have important implications for health professions education in geriatrics. The forces driving these changes are also affecting academic settings, where trends supporting the development of community-academic partnerships, service-learning models, and interdisciplinary education are all evident. These trends have major implications for health professions educators working to develop academic programs to prepare students for future practice with older adults. This article explores the impacts of these changes, in particular, on the design of interdisciplinary or collaborative education programming, including the following dimensions: assessment and definition of the problem, emphasis on functioning and quality of life, professional identity, changing roles of faculty and students, and institutional-organizational implications. General recommendations on how to respond to the challenges represented in these trends are also explored.

Ideally, the development of educational programs for training geriatric health care professionals should be like trying to hit a moving target. Educators must anticipate current and emerging trends affecting the knowledge and skills requirements of health care professionals working with older adults, and they should design and implement new educational programs that prepare students with the resources needed for the future practice settings in which they will work. Health professions educators and administrators must project the effects of these trends on educational goals and outcomes, help to

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Address correspondence to Phillip G. Clark, Sc.D., Program in Gerontology and Rhode Island Geriatric Education Center, White Hall, The University of Rhode Island, Kingston, RI 02881-0814, USA.

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shape their direction if possible, and deal creatively with their impacts on curricula and educational programs in colleges and universities. If educational institutions fail to practice this type of proactive educational forecasting—and instead deal reactively with change once it has occurred—then they may be preparing their graduates for antiquated jobs, careers, or work settings.

As major changes sweep through the U.S. health care system, there are parallel transformations occurring in health professions education. One of these trends is the advent of new community-based models of health sciences education. Two forces are converging to create this development: the advent of community-academic partnerships and the ascendancy of service-learning as an important educational model. These forces, in turn, reflect a recognition of the changing nature of major health problems and their solutions from acute to chronic diseases, from curative to preventative interventions, and from such institutional treatment settings as hospitals to community-based programs and clinics. Important also is the grassroots realization that many of today's major health problems are related to broader social ills, such as illiteracy and poverty, and also to high-risk individual behaviors. Geriatrics and gerontology share in these changes because of the recognition that health care practice with older persons must increasingly address health promotion, maintenance of functional ability, and quality of life issues that rely on a much broader basis than traditional health care has embodied in the past.

A second trend is the growing recognition that interdisciplinary geriatric health care teams and other methods of collaborative clinical practice are increasingly considered essential in the care of older adults with multifaceted and chronic health problems. The growing influence of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) approaches to improve quality of clinical care, as well as the advent of managed care, promote an increased reliance on interdisciplinary teams as a vehicle to achieve their aims. Future care for older persons will be based increasingly on collaboration among the health professions in the pursuit of cost-effective and high quality services.

These two forces converge in higher education in support of the development of new educational methods combining the preparation of students to work in interdisciplinary teams or collaborative settings, with the need for them to experience service-learning opportunities that are community-based. This situation represents a departure from the past, in which health professions education occurred in academic health science centers and institutions in

which the disciplines were largely kept separate in their respective departments or schools. The purpose of this discussion is to analyze what implications the conjunction of these trends has for the development of interdisciplinary educational programs for health professions students, including (1) an exploration of the background for these trends and the precise definitions of interdisciplinary collaboration, service-learning, and community-academic partnerships; (2) an analysis of the impacts that the rise of service-learning and community-academic partnerships likely will have on the preparation of students to work in interdisciplinary contexts; and (3) recommendations for the development of new educational approaches embodying these trends.

BACKGROUND AND SOME DEFINITIONS

Higher education in general is being subjected to increased pressure by federal and state governments and accreditation organizations to become more accountable for the learning outcomes of its students. In the health care arena, growing emphasis on prevention and community- and population-based health care services is supplanting the more narrowly focused biomedical, acute care model. As a new paradigm of health and health care emerges, health professions educators are being forced to develop new models of education that prepare their students to work in community settings emphasizing primary care, service quality and cost effectiveness, teamwork, and the prevention and management of chronic health problems (Headrick et al., 1996; Moore, Balestreire, Chessman, & Harman, 1996). Importantly, these trends are consistent with the health care needs of growing numbers of older persons, who are more likely to benefit from this "new" model of care than the "old" one.

These changes have important implications for the competencies of the graduates of health professions schools. Three specific responses to these trends have been the following: (1) to recognize the need to prepare students to work together in interdisciplinary teams, (2) to develop partnerships between academic institutions and the surrounding community, and (3) to implement expanded service-learning opportunities for students to enable them to work toward meeting health needs articulated by members of the community themselves.

Interdisciplinary Education and Teamwork

"Multidisciplinary" and "interdisciplinary" are two similar, yet dif-

ferent, concepts associated with education and training in the field of aging. Gerontology and geriatrics are frequently considered as essential *multidisciplinary* fields: the input and perspectives of multiple disciplines or professions are needed to understand the complex nature of the aging process on the one hand, and the best ways to treat the chronic, multifaceted health problems of older adults on the other. A metaphor for this kind of understanding is the phenomenon of parallel play in children: they may be "playing" together in a particular activity, but they are not really interacting or interrelating. They are simply running along parallel tracks.

In contrast, *interdisciplinary* education or practice connotes intersecting lines of communication and collaboration, in which integration and modification of the contributions of different professions occur in light of the contributions from other disciplines. Participants have mastered an understanding of each other's basic cognitive and normative structures that contribute to the independent identities of different professions. They understand the basic mind-sets and frameworks of the different disciplines in such a way that an interdependency in thought and action emerges that is more powerful than any simple sum of the participating professions (Clark, 1993).

At the level of preparing students to work in health care teams, interdisciplinary practice connotes a higher order of integration and interconnection than is usually achieved by simple groups of persons working together. An interdisciplinary team is a "group of persons who are trained in the use of different tools and concepts, among whom there is an organized division of labor around a common problem with each member using his own tools, with continuous intercommunication and re-examination of postulates in terms of the limitations provided by the work of the other members and often with group responsibility for the final product" (Luszki, 1958; cited in Given & Simmons, 1977, p. 16). This is a team with flexible roles and responsibilities, in which players take into account the contributions of other members in making their own.

Many educational programs use the term "interdisciplinary" when they really mean "multidisciplinary." They have the multiple contributions from different departments or disciplines, embodied in different courses on various aspects of aging, but they fall short of the level of integration of perspectives demanded in the interdisciplinary context. Similarly, many so-called "interdisciplinary" clinical teams are actually operating at the more parallel level of "multidisciplinary" practice, with contributions from multiple disciplines but without the higher degree of collaboration and interdependency necessary for a truly interdisciplinary dynamic.

Community-Academic Partnerships

Most simply and generally put, community-academic partnerships are organizational structures in which the academic center, university, or college actively incorporates the surrounding community, state, or region into its programs. Importantly, the issues, concerns, and problems of this community serve to guide the research, teaching, and service agendas of the academic center. An interesting and partially relevant example would be the land grant universities established by the Morrill Acts of 1862 and 1890 and their affiliated Cooperative Extension programs. Land-grant institutions have traditionally recognized their responsibilities to develop knowledge through research and to disseminate this knowledge to improve the quality of life of residents in the surrounding community or state. This traditional role of the higher educational institution suggests, however, a more one-way flow of information: discovery by the researcher and dissemination by the educator to the community. In contrast, the community-academic partnership requires a two-way flow of information: the needs and problems of the community are transmitted to the university—where they are incorporated into the research, teaching, and service agendas of the institution—and, in turn, resources and solutions are redirected outward into the community to address these needs and problems. The increasing emphasis becomes one of service to the community, a goal that has traditionally been the lowest on the academic priority list.

The development of community-academic partnerships has a broader base in the general literature in higher education (e.g., Ferguson & Kamara, 1993; Kennedy & Stone, 1997), but there has emerged recently a specific call in the health professions literature for moving education from the academic health center into the community. In particular, these recommendations are linked to a recognition that many unmet health care needs continue to exist in rural areas and among traditionally underserved populations from minority and low-income groups. In the academic medical literature, for example, there have been pronouncements on the immediate need to refocus the education of physicians on community health and the underlying determinants of poor health (Foreman, 1994; Habbick & Leeder, 1996; Hensel, Smith, Barry, & Foreman, 1996; Maurana & Goldenberg, 1996). The emphasis is not on "doing to" the surrounding community, but "doing with" that community—out of a sense of social responsibility, empowerment, and the need for social change (Maurana et al., 1997). Similar calls have been made in the nursing profession (e.g., Oneha, Sloat, Shoultz, & Tse, 1998). That this theme

is not a new one is evident in earlier discussions of such partnerships (e.g., Bracht & Anderson, 1975; Carlton, 1977; Couto, 1982), which also tend to link community-based approaches with interdisciplinary education, team-building, and service-learning methods.

Service-Learning

Service-learning is often equated with all forms of experiential education. However, there are several key differences between service-learning and such other experiential learning methods as clinical training, volunteerism, internships, and field study. One major national program defines service-learning as a structured learning experience which combines community service with preparation and reflection. Students participating in service-learning activities are expected not only to provide direct community service, but also to learn about the context in which the service is provided, and to understand the connection between the service and their academic coursework (Seifer, 1998; Seifer & Connors, 1997). The following are additional, critical elements of service-learning:

- development in collaboration with the community
- enhancement of the standard curriculum by extending learning beyond the classroom
- fostering of civic and social responsibility and of caring for others by the student
- application of what is learned by students to real-world situations
- provision of time for reflection, discussion, and leadership development
- identification and meeting of community needs and assets

Importantly, these criteria suggest a central theme of learning that is based on the community's identified needs, issues, and problems—not those defined by the school or institution. Service-learning requires reciprocal and mutual benefits for all the stakeholders, not just the students. Importantly, it depends on a true partnership in the development and implementation of a program, with equal involvement by students, faculty, administrators, and community participants. In this regard, Cooperative Extension's traditional emphasis on the development of "learning partnerships"—associations in which the people involved learn from each other and generate knowledge together—effectively captures the spirit of this collaborative

effort (ECOP & CSREES, 1995). The community-academic partnership becomes the "holding company" within which service-learning can be housed.

Additionally, service-learning approaches are usually tied to the promotion of interdisciplinary teamwork and collaboration among students from different health professions (e.g., Bracht & Anderson, 1975; Carlton, 1977; Connors, Seifer, Sebastian, Cora-Bramble, & Hart, 1996; Couto, 1982). It is argued that community-based and multifaceted health care needs are best met by health care professionals who are skilled in collaboration, communication, and teamwork. When the focus of such efforts is on health promotion, the management of chronic health conditions, empowerment in the health care system, and the eradication of the underlying socioeconomic causes of poor health, a team approach is clearly necessary to address all these multifaceted needs.

IMPLICATIONS FOR THE INTERDISCIPLINARY EDUCATION OF GERIATRIC HEALTH CARE PROFESSIONALS

Recent discussions of the importance of preparing health care professionals for the unique demands of interdisciplinary practice (e.g., Klein, 1995) have highlighted the importance of recognizing the impacts of national trends for the future of interdisciplinary education. For example, and as mentioned earlier, the advent of managed care and the growing reliance on CQI methods promise to provide new opportunities in support of interdisciplinary training. Similarly, the development of service-learning experiences and community-academic partnerships have major implications for the design of new models for educating health care professionals in collaborative practice, as well as for redefining the traditional focus of practice within each of the health professions.

For example, traditional methods for educating health professions students in interdisciplinary collaboration and teamwork have tended to emphasize the academic structure of a standard course, perhaps based at a clinical site such as a hospital, nursing home, or other health care center (Allen, Koch, & Williams, 1984; Bennett & Miller, 1987). Indeed, many national programs—such as the Veterans Administration's Interdisciplinary Team Training program (ITTP)—have been based at major hospital sites. Health professions students with various levels of preparation and from different academic degree programs have been introduced to the basic principles and techniques

of teamwork in these programs. Now, however, with the focus shifting away from acute care and academic medical center-based programs, educators are about to enter a new world with expanded options for the roles played by students, faculty, teams, and training programs. Such a world is equally exciting and frightening, with both opportunity and the potential for "getting lost" in a radically expanded set of options for teamwork education.

The implications of these shifts may be summarized under the following headings: (1) assessment and definition of the problem; (2) emphasis on functioning and quality of life; (3) identity of professionals; (4) changing roles of faculty and students; and (5) institutional-organizational implications. Examples will be drawn from a 15-year-old program at the University of Rhode Island (URI) in which health professions students, working collaboratively in interdisciplinary teams, have developed and delivered a health education and promotion program to older adults living in senior housing sites—an example of a community-based, service-learning project (Clark, Spence, & Sheehan, 1986).

Assessment and Definition of the Problem

Traditionally, health care professionals are trained in the unique assessment concepts and methods characteristic of their discipline. Many of these approaches rely on the professional's domination over the definition of the "problem" to be solved, and then his or her presentation of both the problem and its appropriate solution to the patient or client. The role of the professional is to be the "expert" and the role of the patient is to follow the professional's recommendations and to be "compliant." This power of the professional to determine the problem has been reinforced by the institutional setting (e.g., hospital) in which the professional has traditionally practiced and dominated the care delivered there. This model of care may have been appropriate when dealing typically with acute health care problems, which could be treated with technologically advanced methods and the individual restored to normal health.

However, taking the health professions student into the community, where the patient actually lives, tends to shift this power to the individual in his or her social context. Traditional methods of clinical assessment may lose their relevance as the basis for the problem moves increasingly to the individual's interpretation. By entering the world and community of the patient, the student is forced to broaden his or her scope of understanding of the "problem,"

and to recognize perhaps for the first time that the bases for many health problems are essentially social, economic, or political conditions. For example, physicians are typically trained in assessment and diagnosis to "rule out" as many alternative interpretations of the problem as possible until only one option remains, with a corresponding solution. In this process, objective data, such as laboratory results, are emphasized. In contrast, social workers are taught to "rule in" other dimensions of a "problem" that expand on the possible explanations and causes of it. For example, a problem of noncompliance with medication use by an individual may be broadened to include such additional social factors as low income and family support dimensions (Qualls & Czirr, 1988).

Similarly, moving from the academic medical center or other institutional setting into the life world of the patient or client makes it more difficult for the health professions student to remain in the "culture" of the traditional educational setting. Much as an anthropologist might leave his or her own society and live with another group of people in their own culture, so students are forced to leave behind the familiar and comfortable setting they know best and to enter the world of the person in the community. This action breaks down the traditional barriers that have been shown to exist between certain health care providers, especially physicians, and their patients. As research has demonstrated, in the traditional medical encounter, the "story" told by the patient is redefined and recast into the scientific cognitive structures of medicine, thereby depersonalizing the patient and preventing the provider from seeing that person holistically (Mishler, 1984; Poirier & Brauner, 1988; Roter & Hall, 1992). The patient's story is altered to conform to the assessment structures of the professional, and consequently it may no longer represent the actual concerns or lived reality of that person.

Such a recasting and (re)presentation of the individual's health-related concerns may be much more difficult in community-based programs. Listening to the life stories told by patients (Rybarczyk & Bellg, 1997) and the development of innovative models of community-based assessment (Gearing & Coleman, 1996) promise to expand the range of methods for capturing the lived reality of the patient and to improve quality of care. For example, a dental hygiene student on our community-based health promotion team consisting of different health professions students found that her traditional approach of assessment—relying on having the patient open his or her mouth, with the professional conducting the assessment—was no longer appropriate. Instead, she had to rely on the individual presenting her own life issues and definition of the problem to be solved, and the

student had to meet the individual "where she was in her life." In this case, the individual said that difficulty eating was her problem, as she defined it.

Similarly, in this same project, we found that faculty were no longer able to call individuals "patients" in the traditional clinical sense; rather, they had become "residents" at a senior housing project. The more dependent title of "patient" was replaced with the more neutral one of "resident." This simple name change reflected a more profound shift in how program participants and their "problems" were seen by the project students and faculty alike. The restoration of personhood and a more holistic approach to program participants revealed an internal shift in thinking that was a direct response to the community basis of the project.

The implications for teamwork learning are related to this shift away from more narrowly defined professional roles—based on traditional methods of clinical assessment, for example—to a broader base for understanding the nature of health concerns and problems. Cognitive dissonance may be introduced within student and faculty thinking as education shifts away from the academic culture, where there is more control over the parameters associated with learning, to the community setting, where traditional definitions of provider and patient may no longer be relevant. Working together, students may find that their comfortable assumptions about the appropriate roles and labels assigned to them begin to break down, and a new sense of overall team mission and purpose emerges. A more holistic and realistic picture of the lives of real people, their needs and concerns, becomes apparent—along with a clearer focus on the individual's quality of life.

Emphasis on Functioning and Quality of Life

As Mold (1995) pointed out, when clinical care shifts from a "problem-based" approach to the health concerns of older persons, to a more "goal-based" approach in which their own particular and unique life objectives are the major focus of a team of health care professionals, there are major implications for greater collaboration among its members. By placing the individual at the center of the team's efforts, its members' roles shift to that of consultant to the individual. As most older persons' health-related concerns are with everyday function and quality of life, rather than with their specific diagnosis or set of diagnoses, the result is that the basis for collaboration is substantially broadened (Clark, 1995). In this shift, medicine's traditional

domination of defining the problem through a "label" or diagnosis is weakened, and other health professions' contributions are strengthened. For example, physical or occupational therapy may become more central as functional ability emerges as the major life goal of the older person. Similarly, emphasis on personal "deficits" is reduced and replaced with a greater recognition of the individual's strengths and resources.

For example, in our health promotion program at URI, a simple but extremely important contribution to one participant was made by a nursing student, who helped an older person with severe arthritis in her hands develop a new technique to hold a special pen, so that she could write notes in her holiday cards—a major goal in her life. This individual had been unable to write easily for several months, but because of our program she was given a whole new avenue for communication that enhanced her quality of life. A simple contribution was made that had a profound effect on one person's overall happiness and life satisfaction!

An increasing focus on quality of life issues also highlights the importance of values in defining quality of life for both individuals in the community and the students. Many health professionals do not examine the underlying value assumptions that constitute their definitions of quality of life, leading to communication problems among collaborating health care providers (Clark, 1995). Moving interdisciplinary teamwork learning into a broader context for increased interplay among different values and the greater likelihood of ethical clashes between competing values will lead students to a realization that such conflicts are fundamental to health care practice with older persons (Kaufman, 1995). For example, the classic tension between autonomy and safety in the lives of older persons who want to remain living independently in the community, even though they may pose a risk to themselves and others by this choice, illustrates this conflict. Such value tensions are more likely to arise in community than institutional settings.

Thus, teaching for teamwork in geriatrics in a community context necessitates exploring ethical principles, conflicts, and resolution strategies with student health professionals. As Schön (1987) suggested, we need to train students to become "reflective practitioners," who feel as comfortable dealing with the "artistic" aspects of practice (i.e., those gray areas where the precise course of action is not clear due to value conflicts) as with the more "scientific" aspects (i.e., those based on the more "objective" areas of the profession, where specific knowledge and skills must be mastered). Indeed, reflection in general on the meaning of the community-based service-learning

experience is seen as a critical element to the success of this educational experience (Olson & Bush, 1997), and it has been integrated into interdisciplinary instructional models through such techniques as the use of journals (Clark, 1994).

Professional Identity

The identity of health care professionals is acquired as a result of the process of socialization—a dynamic, interactive, and reflective process based both on formal education and subsequent workplace experience with colleagues, supervisors, patients, and their families. The nature of differing types of identities among the different health professions has major implications for the ways in which they collaborate and communicate in interdisciplinary settings (Clark, 1997). The increasing reliance on community-based sites and programs for health professions education promises to alter the sense of identity of health professionals-in-training, shifting their role from that of "expert" in defining the problem to "facilitator," "consultant," or "educator" in helping the individual develop solutions to the problems he or she has defined.

Thus, placing students in community-based service-learning programs may substantially alter the perceptions of their roles in promoting the health of individuals, putting the students at odds with the "traditional" professional educational curriculum that trains them to be the experts. The implication for interdisciplinary educational programs in the community is a greater potential for role confusion and ambiguity, a problem that is already encountered in interdisciplinary curricula that expose students to health professions other than their own. Students working in community settings are more likely to discover a broader base of overlap among the different professions they represent than if they were practicing in more narrow clinical contexts, such as hospitals.

For example, in our community-based health promotion program, we found that both nursing and nutrition students thought their appropriate role was as nutritional expert and educator. Although these roles might have been kept separate in their traditional clinical settings, when nutritionists are called in for specific evaluative or counseling needs, in the community-based program setting these roles came into much more direct and obvious conflict. This required some effort at role negotiation on the instructor's part, and the recognition on the students' part that, indeed, there was an area of overlap in their professional roles—and that this was all right and, indeed, appropriate. In spite of the fact that students are taught in standard

academic programs about the uniqueness and importance of their different professions, in real practice settings in the community they soon discover substantial shared areas of expertise (Netting & Williams, 1996).

Interdisciplinary service-learning experiences in the community must build in specific opportunities for discussion about the emerging identities and roles of the participating professions. Importantly, depending on the context and population with which the team is working, different issues relating to identity may arise, and instructors must be sensitive to instances of identity confusion. However, just as in the case of adolescent development, identity confusion in the formative stages of discovering who and what you are is not necessarily bad. Indeed, it is only by "trying on" different identities that the adolescent and (we might argue by analogy) the health professional-in-training really come to understand who they are and what are their unique skills and contributions.

Changing Roles of Faculty and Students

The advent of new settings in community-based education also alters the appropriate roles of faculty and students. Faculty members have been trained and socialized into particular roles with which they feel comfortable, usually modelled on their own experiences as students. Similarly, students themselves bring into a particular learning experience expectations based on other courses and a generalized image of what are appropriate student responsibilities for learning.

Most faculty are comfortable with the role of "expert" who transmits information to students, who then "learn" it and assimilate it into their knowledge base. This is essentially the "banking" model of learning, in which faculty make knowledge "deposits" into the mental accounts of their students. In community-based service-learning experiences, however, this role no longer exists. Rather than being seen as the "informant" that passes on important information to the students, faculty members are more likely to adopt the role of "facilitator," helping students to see a much broadened basis for health in the "real world" of the individual older person. In addition, there is less control over the educational setting, now that the relatively predictable classroom or clinic context has given way to a much more unpredictable community-based site where many things are happening.

Indeed, members of the community themselves may now become the educators, as they teach the students about their health concerns,

their lives, and their community. Many of the best learning experiences for our students in the interdisciplinary health promotion project at URI were based on individual senior housing residents sharing their insights and stories about growing older. These are what the students remembered, not the concepts or theories discussed by the instructors.

Faculty responding to the need to design new community-based educational models must receive encouragement and support (Carl, Brooks, & Brooke, 1997). The additional time needed to develop and supervise student placements in the community, as well as changes in the ways in which students are evaluated—all these functions demand more time and energy. Overcoming faculty inertia and anxiety about embarking on a new educational "adventure" requires support and reward. Discomfort over incorporating the needs and perspectives of the community itself, and thereby relinquishing traditional academic control over the learning process, can become evident among some faculty. A support system or center to advocate for these changes may be necessary.

Similarly, for the student, the traditional role of passive participant is transformed by the need for active, reflective learning—often in settings that can be unpredictable and uncomfortable. Learning in the "real world" is fraught with unexpected problems, unanticipated issues, and unresolved conflicts that may initially be seen as "getting in the way" of learning. In reality, they become the learning itself. For example, two students in our course were placed in a community agency that was fractured with internal conflict and staff hostilities. Instead of a learning experience in an agency that was smoothly functioning, the students received an important lesson in how to deal with conflict within an organization and still be productive in meeting their own objectives.

In the same vein, students may find themselves in the unaccustomed role of "teacher" as they discover that they can also learn from each other. For example, on our interdisplinary team health promotion project, the student participants often taught each other about what such concepts as "assessment" meant in their own disciplines. They were made aware of how the same concept is developed and applied differently in differing health professions. Peer learning is an essential element in small group, collaborative instruction (Bruffee, 1987; Whipple, 1987).

In addition, and as already discussed, an integral part of service-learning is the requirement for reflection on what is happening. "Service-learning is based on the pedagogical principle that learning and development do not necessarily occur as a result of experience

itself, but as a result of a reflective component explicitly designed to foster learning and development" (Seifer & Connors, 1997, p. 14). Such a need for reflection has been highlighted as an essential ingredient in experiential education in general (Kolb, 1984) and in education for continuous quality improvement in particular (Cleghorn & Headrick, 1996). Students need to be given the opportunity and the structure to practice such reflective thinking in order for service-learning to truly occur.

Thus, it is essential that faculty designing new models of community-based service education in geriatrics respond to this need for reflective learning. Methods such as journals and specifically designed self-administered inventories have been proposed (Clark, 1994). Certainly, specifically set-aside time each week for group discussion and reflection on "what has been happening" in the experience for the student is essential—just as such "process time" is essential for every functioning clinical team, regardless of its setting. For example, in our community-based health educational program we developed a weekly, two-hour seminar for students to discuss their experiences, compare notes and perceptions of what was happening, and to "check in" with the instructor regarding their reactions and feelings. Additionally, journaling was used as a method for the instructor to "see inside" each student's reactions and thinking as revealed in his or her written notes. Through this mechanism individual and confidential communication was established with each student.

Institutional-Organizational Implications

Most universities are not organized around community-academic partnerships. Research and teaching have traditionally been the primary priorities, with service a distant third. In spite of such programs as Cooperative Extension, higher education has largely relegated service to a low priority, with faculty rewards for promotion and tenure based primarily on research and instructional achievements. Reorienting academic programs toward a more overtly service-based objective, especially one involving the direct and significant input of the community into the definition of academic objectives, is a massive and daunting undertaking—especially given the resistance to change in academic institutions in general.

In health professions education in particular, moving student learning experiences into the community will mean a major shift in the ways in which curricula are organized and coursework delivered. In particular, the interdisciplinary and collaborative basis of service-

learning will mean reversing years of systematic isolation of different health professions in higher education and the dismantling of the rigid, vertical structures that have come to characterize health professions schools and departments in universities and academic medical centers. Deans and other academic officials responsible for maintaining these structures will not welcome such change and will probably resist it unless rewards and resources are distributed differently than in the past. The importance of leadership for change at the highest level of the university administration has been highlighted for this reason (Connors et al., 1996).

In addition, if we are to accomplish the objective of developing innovative programs that combine interdisciplinary education with community-based service, greater incentives will have to be developed for faculty who venture into the potentially dangerous waters of designing curricula and educational experiences in this area. Resources, recognition, and rewards will have to be offered to those willing to take the risk of venturing outside their accustomed and comfortable disciplinary and educational boundaries. Most importantly, administrators must offer support—tangible as well as intangible—if such efforts are to succeed. Otherwise, health professions education will continue to lag far behind where the general field of health care is moving, now and into the future.

Within our experience at URI, we found that the lack of support by one crucial dean impeded the continuation of our interdisciplinary program and made it more difficult for it to be offered on a regular basis. However, when the University President's Office announced a new initiative in support of interdisciplinary collaboration, and our program was awarded funding and recognition, it became much easier not only to continue it but actually to expand it beyond its original format. Nevertheless, generally it remains difficult to sustain the kind of commitment and energy needed to continue such initiatives (Clark, Spence, & Sheehan, 1987). When the academic system is subjected to a stress, such as reduced budgetary resources, there is a tendency for it to revert to its previous, more stable structure—which is the traditional, discipline- and classroom-based model of education.

GENERAL CONCLUSIONS AND RECOMMENDATIONS

Perhaps more so than with other disciplines, health professional education must keep pace with the current political, economic, and social forces that are changing the face of health care in the United States today. As the population ages and the health care issues of older persons become more prominent in their influence on the

nature and delivery of health care services, educators in geriatric health professions education will be challenged to respond by rethinking the content and structure of the curricula and settings used to train their students. Because change in higher education occurs only slowly, now is the time to begin this process with regard to the development of community-academic partnerships, service-learning models, and interdisciplinary education.

Support for change will be needed from both "top-down" and "bottom-up" directions. Leadership from top-level administrators will be crucial in making these changes a reality. Only they control the resources essential to redirecting the academic health professions mission and structure necessary for making the vision a reality. In particular, they can wield the power necessary to overcome opposition from "middle management" level administrators, such as deans, who usually have the most to gain from maintaining the status quo. In addition, they can use their influence and resources to set into place the kinds of reward structures essential to motivate faculty to take risks and to change their own behavior.

Similarly, "bottom-up" forces are needed as well. Faculty and key members of the community itself will have to work together to make the case for needed change and to develop the kinds of networks that will make access to student placement sites and community programs possible. A coalition of groups from the community and key faculty visionaries and entrepreneurs must be put into place to convince the academic institution of the necessity and feasibility of such an effort. The real needs of the community will have to shape the mission of the university programs.

Faculty members, however, remain the key players in this unfolding drama of new educational models. They are the major agents responsible for designing and delivering the curriculum, supervising students, and evaluating the outcomes of educational efforts. They will have to be convinced of the advantages and necessity for change, and be empowered to take on new roles and responsibilities and to forge new educational networks very different from the old, comfortable ones to which they have become accustomed. Given the right circumstances and incentives, they can develop the new models and methods necessary to respond to these changing social forces. It is important to emphasize, however, the necessity of providing the motivational methods to change faculty behavior.

In the field of geriatrics, health professions educators must become more attuned to the implications of these broader social forces for the education of their students. We must be more proactive in anticipating what is happening in the larger society and be held more

accountable for preparing our students to work in the health care settings and contexts that are under construction for the future. Part of this responsibility means constantly revising and updating what we teach, how we teach it, and what we define as the essential outcomes of our instruction. Only by striving to "hit the moving target" of health professions education can we be reasonably sure that we are preparing our graduates for the contexts in which they will be practicing.

Predictions are that these contexts will be increasingly community-based, grounded in service-learning approaches, and interdisciplinary in nature. By preparing now to design new educational models and programs that incorporate these themes, educators can start putting into place the types of academic structures that will be necessary to educate the health care professionals needed to provide effective health care services to an increasingly elderly population. The vision of what these structures will be like has been articulated, but the details of how to build them and implement the programs they support have yet to be worked out in detail. This is the goal that should drive geriatric health professions education over the next several years as we prepare graduates who will have the skills to work together in the community to serve its increasingly elderly members.

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