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Sustaining Engagement and Rural Scholarship

Randall Longenecker

Abstract

The Ohio State University Medical Center, a large urban academic medical center, and Mary Rutan Hospital, a rural community hospital in Logan County, Ohio, have been linked through a series of scholarly engagements spanning more than thirty years. What emerges from a qualitative study of key informants with personal knowledge of this interaction is a complex web of relationships, built with perseverance one strand at a time and marked by explicit agreements from time to time—always evolving, ever fragile, yet remarkably strong. The continuing dialogue around a scholarship of engagement must include the perspective of those on the outside reaching in, recognizing the important contributions of the engaging community.

The scholarly activities of academic medical centers, even in the post-Boyer days of scholarship broadly defined, often seem a world apart from the day-to-day activities of rural medical practice *(Boyer 1990; Fear and Sandmann 2001-2002)*. Nevertheless, individuals and institutions in these two environments have bridged the gap between the "high ground" of academia and the "swamp" of clinical work, engaging each other in collaborative projects that have been sustained over many years *(Schön 1987, 3)*. Such interactions could be characterized in postmodern terms as the fusion of academia and praxis *(Fear et al. 2001)*. These relationships are foundational to "restoring the social contract between medicine and society" and addressing the "quality chasm" described by the Institute of Medicine *(Ludmerer 1999, 399; IOM 2001)*. One such relationship is that between Mary Rutan Hospital and the Ohio State University Medical Center.

Background

The histories of institutional relationships are difficult to trace, arising as they often do from multiple streams involving many individuals over years and decades. The relationship between Mary Rutan Hospital (MRH) and the Ohio State University Medical Center (OSUMC) is no exception. MRH was founded in 1919 as a city-owned and operated facility in rural Logan County in west central Ohio. As is true for many small community hospitals, it was a struggle for MRH to survive, let alone establish a reputation for excellence in patient care among community members

locally and among tertiary referral centers regionally. In 1965, however, a small general medical group practice was established just south of town, and from that group came physicians intent on improving the quality of patient care and transforming their relationship with consulting physicians in the university medical center an hour away. In the words of one of these physicians:

> I was very embarrassed at what I saw. The standard was not there. . . . It occurred to me, "If you want change, do something about it." I have been one of those people—rather than run from a problem, I analyze it and roll up my sleeves and do something. There were three or four of us who did that. We had opposition but we did it anyway. That was the beginning.

"It occurred to me, 'If you want change, do something about it.'"

Starting in the late 1960s and early 1970s, physicians at MRH increasingly used the university for informal and formal consultations. In 1974, one of the physicians, at the encouragement of a university cardiologist, enrolled in a cardiology fellowship and eventually completed that fellowship in 1979. In the almost three decades since, an increasingly complex relationship between MRH and OSUMC has evolved. The relationship centers around four major streams or strands that are interdependent personally and administratively in both formal and informal ways.

The Cardiology Stream: From the formation of an intensive care unit, to the founding of a group cardiology practice, first affiliated with and later joined to the university Division of Cardiology, the cardiology department at Mary Rutan Hospital has grown into a unique three-person cardiology practice with a highly sophisticated noninvasive diagnostic cardiology laboratory and an active program in cardiopulmonary rehabilitation. Just this year, the group has begun to perform low-risk cardiac catheterizations. Although primarily grounded in patient care, the relationship between cardiologists in the two institutions has yielded important and ground-breaking research. Out of that initial cardiology fellowship in the 1970s, a family study of individual victims of sudden death, conducted in concert with university researchers in Columbus and Boston, has culminated in the gene sequencing of one of the first fully genetically described congenital cardiomyopathy.

The Internal Medicine/Oncology Stream: Beginning with personal consultations by the university's director of clinical oncology in the mid-1970s, a formal oncology clinic and satellite of the James Cancer Hospital came into being in 1983. Now, with the help of full-time oncology nurses, patients from the rural community are able to receive chemotherapy close to home, and university oncologists staff the clinic on a regular basis each week. The general internal medicine group in Logan County is closely affiliated with the university's Department of Internal Medicine, and physicians from the university residency program rotate at MRH monthly.

The Regional Health Network Stream: In the late 1980s the university hospital board, through a process of strategic planning, explored possibilities for network development with small hospitals across the state of Ohio. Out of this emerged the Ohio State Health Network, which now includes nine hospitals and four affiliated health care organizations. The CEO and the medical director of MRH are, respectively, president and medical director of this incorporated entity.

Rural Family Medicine Residency Stream: Beginning in 1990 with medical student rotations and summer externships, conversations with the university's Department of Family Medicine eventually led to the development and provisional accreditation of an integrated rural training track that began 1 July 1998. The residency program and teaching practice is located within the same medical group practice that formed in 1965, truly making it a rural "practice with a residency" *(AFPRD 1999; Magill and Kane 2001)*. In September 2001, the program received full accreditation from the Accreditation Council for Graduate Medical Education (ACGME).

Intrigued by the durability of this academic-community partnership, which has thrived in spite of various challenges along the way, the author initiated a qualitative study to explore this relationship in greater detail.

Methods

The objectives of this study were (1) to identify key attributes in a successful thirty-year affiliation between an academic medical center and a rural community hospital, and (2) to elaborate a scholarship of engagement from the perspective of the engaging community. Eighteen (18) key informants with personal knowledge of these two hospitals, their medical and support staffs, and events over the

past thirty years, were interviewed on digital media. The informants included physicians, administrators, and community members, both at Mary Rutan Hospital and the OSU Medical Center. Sixteen (16) were live interviews in person or by phone and two were by written questionnaire. The interviews were transcribed and then explored using the qualitative software tool QSR NVivo. In a semi-structured yet open-ended interview, the informants were asked:

1. Why has this relationship, the relationship between The Ohio State University Medical Center (now Hospitals) and Mary Rutan Hospital, survived these thirty-plus years?
2. Who are/were the people that were instrumental in both initiating the relationship and sustaining it?
3. What environmental factors have played a role?
4. What defining moments do you remember (moments of pivotal change or significant growth)?
5. What have been some of the successes and failures, and what has been learned from them?

In addition, each informant was given the CCPH Principles of Good Community-Campus Partnerships and asked to speak to the relevance of these principles to this particular partnership *(CCPH 1998; Maurana, Beck, and Newton 1998; Seifer and Maurana 2000).*

Emerging Themes from the Engaging Community

Although all of the informants affirmed the CCPH principles as important in a general sense and many were able to cite examples from personal experience that demonstrated their relevance, some questioned their specific applicability in real-life practice. The principles, when modified in light of their comments, take on a more dynamic, pragmatic, and personal flavor. For example:

> "Partners have agreed upon mission, values, goals, and measurable outcomes for the partnership." *(CCPH 1998)*

> "I am sure OSU's interest was maybe 90 percent different than MRH and theirs is probably 90 percent different from OSU—but the part they shared was solid. . . . What I maintain by that is—there are core elements that they must be together on." *(University physician)*

That is, partners have *at least some* agreed-upon mission, values, goals, and measurable outcomes for the partnership.

"The relationship between partners is characterized by mutual trust, respect, genuineness, and commitment." *(CCPH 1998)*

"I think that has been part of cardiology success, the fact that we have built our program on previous successes and have gained the trust of the people who have to help us get those things done." *(Rural physician)*

That is, the relationship between *institutional* partners is characterized by mutual trust, respect, genuineness, and commitment *between key individuals.*

As these interviews were explored further, additional principles regarding successful and sustainable partnerships emerged. Following are these principles, with quotes representative of themes found woven into the fabric of the interviews.

"I think that has been part of cardiology success, the fact that we have built our program on previous successes and have gained the trust of the people who have to help us get those things done."

- Successful partnerships emerge from seeming chaos, yet they are built on very tangible relationships. Serendipity and improvisation play major roles—being in the right place at the right time and, in the moment, creatively adapting.

"... sort of almost like natural paths develop into county roads, ... and state roads, ... and interstate highways, people going where they want to be going. If there is enough traffic, it keeps the trees down, the brush down and pretty soon you blacktop it, and I think that is kind of what happened there." *(University physician)*

"I smiled when I was sitting there as a board member and I looked at the names of the hospitals and the first one on the list was MRH and I thought, 'Oh—I know that hospital and I know those people!'... Butch was a next-door neighbor and Dad was on the committee that found Butch and, you know, ... life is always interesting. It had kind of swirled around us at that particular moment and we thought, 'Okay, we can go right there to that hospital because we have this sort of serendipitous moment, where

we have some people who all know each other and trust each other.'" *(Urban community board member)*

- All relationships, even institutional relationships, are fundamentally personal. Making personal contact (even physical presence) is critically important.

"Personalities are a part of it. . . . You look at all of the frustrations that we have had, and continue to have, with OSU. If you don't have a few personalities who have the patience to work through those, you write it off and go about your business. I think we have at least been a little more patient." *(Rural administrator)*

"A lot of relationships or affiliations . . . happened just administratively, and I think it has to be kind of a partnership from the medical physician side as well as administration for it to be successful."

"They were just a wonderful group of doctors—very receptive, very open and looking out for the well being of their patients. And when their patients were not well taken care of or did not meet expectations, we heard from them as well." *(University physician)*

"I returned to OSU to upgrade my training. . . . In going back on site to OSU, it allowed them to see me perform and I think . . . that is a good way. You physically went there—I went there." *(Rural physician)*

- Sustainable partnerships are anchored to a purpose greater than either partner's mutual interests alone, such as excellence and quality in patient care.

"One of the other reasons that I think it has been successful is that it was driven from the medical side. A lot of relationships or affiliations, whatever the joint venture kind of things that happened, happened just administratively, and I think it has to be kind of a partnership from the medical physician side as well as administration for it to be successful. I think the need came from the medical side of serving the patients. It is always better to have it start there and then you can add the other pieces. . . . But, because it came to benefit the patient in the beginning, I think it has been positive." *(Rural administrator)*

- The partnership is embedded in community and built upon personal stories.

> "My family obviously has had some firsthand experience with it—with Mary going through a heart attack. She was over at the university a couple of times and it was just amazing—they speak highly of this relationship. They can't say enough good things about it." *(Rural community Board member)*

- The partnership is framed around affiliation and influence rather than ownership and control, preserving healthy distance and autonomy.

> "The 'Bellefontaine model' is a term that is used at OSU—is used down there in many conversations, in many different areas and is held up as a way. . . ." *(Rural physician)*

> "In order to be mutually beneficial, we had to do some things in a completely different way from what an academic institution and academic physicians usually do." *(University physician)*

"The partnership is embedded in community and built upon personal stories."

> ". . . a way that local smaller hospitals might feel more comfortable—having a relationship rather than thinking, 'Geez, we're going to be swallowed up!' You know, not unlike banks or other places where all of a sudden there isn't anybody local anymore. It is done a different way." *(Urban community board member)*

> "I think it puts more balance in the power part of the relationship. When it is an affiliation as opposed to ownership." *(University physician)*

> "There is not really a fear of a take over and that has helped it flourish. . . . that fear kind of goes away so everybody can focus on what they want to accomplish rather than worry about an ulterior motive behind any services offered." *(Rural administrator)*

- Sustainable partnerships are many stranded.

> "The wheel [of the "spin-offs"] is really big now—a lot of spokes. . . . An additional string would have to be broken in order for [the relationship] to disintegrate." *(Rural administrator)*

•Successful and sustainable partnerships demonstrate seamless continuity.

> "What jumped out in my mind was the continuity of our administration over the years . . . [but] I have to assume that in order for this relationship to work, it is not just administration. It has to be the relationship between the physicians, maybe even more so. The administration would set it up, but the physicians, I think, are probably the ones that have to work together and probably do more communication back and forth. We have had some continuity there." *(Rural community board member)*

> "I think there was a phase that we [in medicine] went through, philosophically, where primary care wasn't as important as it is today. So, I think we failed to capture what we talked about earlier, and that is the crossover, the overlapping of primary care physicians and sub-specialty people so that we mutually respect, give and take from each other and—not—you have your abilities and I have mine. You draw those lines of demarcation—you have a crack in the seam. You don't need that seam. It needs to be a seamless provision of care." *(Rural physician)*

"The best partners are learning institutions, with learning individuals, in a learning relationship—that is, engaged in the pursuit of scholarship."

•The best partners are learning institutions, with learning individuals, in a learning relationship—that is, engaged in the pursuit of scholarship.

> "I think you and your group, taking a part in the educational process . . . is key for both places. It is key for their trainees; it is key for us. I think I am better because I have been involved almost every day with a resident. . . . So, I think having an academic mindset—if I can use that phrase—having an academic mindset . . . [is important]." *(Rural physician)*

> "It has also provided us some opportunities to be involved in some research activities that a rural program could not be involved in—if they didn't have this connection to a

larger learning institution, if you will." *(Rural community board member)*

Summary

In summary, for academic institutions and communities to successfully engage one another and sustain that interaction over time requires a "different way" than has been followed in the past. These individuals, through their participation in sustained personal and institutional relationships, have learned a way of affiliation, rather than control—a way embedded in community and narrative and one characterized by persistent effort on multiple levels, improvisation and adaptability, and commitment to a purpose higher than simple mutual interest—all in the pursuit of improvement, learning, and scholarship.

The continuing dialogue around a scholarship of engagement must include those on the outside reaching in, recognizing the important contribution of the engaging community. Although the CCPH principles are very legitimate as an idealized framework and an espoused theory, there is a theory in action that warrants further exploration *(Schön 1983, 57)*.

Epilogue

While enjoying the view from a bird blind at Maumee Bay State Park in northern Ohio along Lake Erie last fall, I noticed with interest a leaf suspended in mid-air. It brought to mind this bit of rural wisdom I once heard: "When you see a turtle on a fence post, you know he didn't get there by himself!"

Intrigued, I took a closer look. What at first glance, and at a distance, appeared to be a magical act of levitation, on closer inspection revealed a supporting web of some complexity—the work of an industrious spider, and I remembered the expression "supported by an institutional framework, in the right place and at the right time." I began to realize that "rules of engagement" are less often about armies drawing battle lines, engaging in mortal combat over self-interest and territory, and eventually reaching a formal and explicit truce; they are more often about less dramatic and less violent interactions. Although never completely without conflict, engagement occurs in pleasant and often chaotic and serendipitous ways. What emerges from this process are complex webs of relationships, built one strand at a time and with perseverance. Following simple rules and values, marked by explicit agreements from time

to time, these relationships are always evolving, ever tenuous, and yet remarkably strong.

This is a scholarship of engagement.

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About the Author

Randall Longenecker has been a family physician in rural practice in Logan County, Ohio, since 1982. In the past five years he has created, implemented, and refined a fully ACGME-accredited rural track residency program in family practice. He is currently associate rural program director and clinical associate professor of family medicine at the Ohio State University College of Medicine and Public Health. A graduate of the University of Pennsylvania School of Medicine and the University of Wisconsin—Madison Family Practice Residency Program, his special interests lie in family-oriented perinatal care by family physicians, medical ethics, complexity and facilitating organizational change, rural graduate medical education, and a reflective practice model of professional development.