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Community-Based Clinical Traineeships: Exploring Physicians' Perceptions on the Transferability of Learning to Practice

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Abstract

Literature identifies several ways in which a traineeship in a non-traditional community-based clinical setting might positively impact medical trainees. However, little is known about physicians' ability to transfer the learning gained from such experiences into other clinical contexts. This qualitative study explores, from physicians' perspectives, the application of learning gained from a traineeship within La Maison Bleue, a community-based primary care organization in Montreal, Quebec, Canada, designed for women and families experiencing social vulnerability. The study is based on 12 semi-structured interviews with primary care physicians (n=10) and residents (n=2) who completed a medical traineeship in this setting. NVivo software was used to support thematic analysis. Results show that most participants aimed to apply the learnings gained from their experience, despite organizational and structural barriers often impeding their efforts. Learning pertaining to the relational and patient-centered approach tended to be the ones more integrated into practice. Because these learnings unfold on a more personal and interpersonal level, doctors appeared to have more control over how they apply them in practice. Factors facilitating the application of learnings were perceived more on the human level but ultimately had only a marginal effect on physicians' actual ability to apply learning.

Keywords: Clinical learning; Community-based, Healthcare transformation; Medical education; Transfer of learning.

Introduction

The training of healthcare professionals has long held the promise of transforming healthcare practices systems. In the early 20th century, facing the fact that "physicians ... varied tremendously in their medical knowledge, therapeutic philosophies, and aptitudes for healing the sick" (Beck, 2004, p. 2139), medical education reform was seen as the preferred route to standardizing practices and aligning them with the

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principles of scientific medicine, and was highly valued given the scientific effervescence of the time (Beck, 2004; Duffy, 2011; Pelaccia & Triby, 2011). More recently, health professional training remains a promising avenue to address contemporary health and social issues such as the demographic and epidemiological transitions leading to an aging population and growing incidence of chronic diseases, new environmental and behavioral risk factors and the persistence of health iniquities (Frenk et al., 2010). The transformative potential of health professional training has been acknowledged by the Ottawa Charter (World Health Organization [WHO], 1986) which emphasized it as an essential target for reorienting health services towards health promotion, beyond the provision of medical care to individual patients. Similarly, the Commission on Social Determinants of Health (WHO, 2008) recommended making social determinants of health a standard and compulsory part of medical and health professional training to formalize healthcare responses to ongoing social and health iniquities.

Despite these high expectations, some authors highlight the ongoing mismatch between health curricula and the challenges of providing care and services tailored to the evolving and complex needs of patients and communities (Dubé, 2024; Frenk et al., 2022; Frenk et al., 2010; WHO, 2013). In particular, most medical training curricula tend to remain fundamentally biomedical, curative and individualistic in their approach to care. They thus exhort health - and especially medical - educators to adopt innovative teaching approaches (especially those implemented within complex teaching and learning environments, such as placement environments) for training to pursue broader objectives and better actualize potential to transform health practices and systems (Dubé, 2024; Fernandez, 2017; Frenk et al., 2010).

A large part of medical training takes place in care settings, through student placements. In recent decades, innovative models of delivering care have emerged, providing traineeships in placement settings that differ from the traditional clinical environments (e.g., hospitals, traditional primary care clinics). Against the backdrop of great challenges faced in the delivery of socially, culturally adapted and equitable care, a number of these innovations have emerged in the health and social services sector, in Quebec and elsewhere in Canada. For instance, these innovations have taken the form of community-based social paediatric and geriatric centres, and student-led or low-threshold primary care clinics.[1] These organizations share characteristics such as: (1) being based in the community (Hay et al., 2006); (2) employing staff in flexible professional roles and using interdisciplinary collaborative practices that are not physician-centered (Bienkowska-Gibbs et al., 2015; Contandriopoulos et al., 2015) and (3) their great sensitivity and adaptability to economic, cultural and social diversity (Canadian Institutes of Health Research [CIHR], 2012).

In the field of medical education, the literature identifies several ways in which placements in such unconventional community-based clinical training environments may positively impact trainees. Studies suggest these settings foster a renewed vision of oneself (Barrett et al., 2011; Crampton et al., 2013; Lacy et al., 2005; Nyangairi et al., 2010) and critical reflection on one's own limitations, power and privileges (Massé et al., 2020). The potential for traineeship experiences to foster a new vision of medical practice (e.g., based on the principles of equity, continuity, proximity, interdisciplinarity and intersectorality) and the medical profession has also been identified (Chin et al., 2003; Loignon et al., 2016; Massé et al., 2020; Mlonyeni et al., 2024; Nyangairi et al., 2010). Studies have also mentioned learners' development of critical perspectives regarding the healthcare system and its (in)ability to respond adequately to patients' and communities' needs and expectations (Massé et al., 2020). Students' who have completed placements in these setting have reported renewed perceptions of others (i.e., patients, communities and other professionals), their reality, their expertise and their specific life and practice context (Holmqvist et al., 2012; Lie et al., 2006; Loignon et al., 2016; Massé et al., 2020; Mayer et al., 2016; Mlonyeni et al., 2024; Sheu et al., 2011). Consistently, the development of genuine reflection about the lived experience of others, especially on how the social determinants of health affect people's real life, is also highlighted as a positive impact of unconventional community placements (Bellicoso et al., 2021; Kirubarajan, 2021;

[1] Low-threshold clinics are care settings where there are very few criteria limiting access for marginalized or disaffiliated people or groups.

Mlonyeni et al., 2024). Furthermore, how community-based traineeship experiences allowed students to adopt a more congruent, competent, human and holistic approach to care (Loignon et al., 2016; Mapukata-Sondzaba et al., 2014; Massé et al., 2020; McNair et al., 2016; Nyangairi et al., 2010) is also evident. Studies have also mentioned how such traineeship experiences tend to promote the development of professional basic skills (Mat Nor et al., 2021), of strengthened professional identity (Massé et al., 2020) and fostering of commitment to further engage as an agent of social change (Massé et al., 2020, Ross & Cameron, 2021). These findings justify the relevance of unconventional community-based traineeship experiences given the key transformative learning they can convey (Massé et al., 2020). However, most previous studies have focused on the individual learner and the immediate gains from the learning experience, with few exploring the transferability of these learnings to conventional settings and their broader transformative potential (Crampton et al., 2013). The frequent use of quantitative measures of the educational impact of traineeship experiences, which is privileged in medical education research, (Hodges & Kuper, 2014) might also limit our in-depth understanding of the "how's" and "why's" of the transfer processes involved.

This article presents the results of a qualitative study exploring practising physicians' perspectives of the applicability of learning gained from traineeship experiences within unconventional community-based clinical training environments. This article is intended as both a thought-provoking piece and a source of actionable ideas to help realize the full transformative potential of community-based clinical traineeships.

Methods

Research Setting

The research setting is *La Maison Bleue*, a community-based primary care organization offering perinatal care to women and families experiencing extreme social vulnerability in Montreal, Quebec, Canada. *La Maison Bleue* operates under the status of a charity and non-profit organization but is linked to the Quebec formal health and social services system by agreements with a healthcare facility – CIUSSS (Centre Intégré Universitaire de Santé et de Services Sociaux) – of the territory. CIUSSS is a public organization responsible for the direct provision of healthcare and social services in each health region. *La Maison Bleue*'s care and intervention model emphasizes the complementarity of medical, psychosocial and educational services, under a single roof. The approach to care fosters empowering and supportive professional practices that mobilize patients' personal and collective resources and adapt to their particular realities and trajectories (Dubois et al., 2015). Interdisciplinarity is considered the linchpin of this approach to care. The interdisciplinary team includes, among others, family physicians, midwives, nurses, social workers, and specialized educators/psycho-educators. A non-hierarchical partnership model of shared responsibility – in which the doctor is not considered as the central actor – is privileged (Dubois et al., 2015). Furthermore, training and teaching are central to *La Maison Bleue*'s organizational mission. Several students, residents and medical fellows experience its approach through traineeships every year.

Research Design

This study was conducted using a qualitative, exploratory and descriptive design. Data collection relied on 12 semi-structured interviews with family physicians (n=10) and residents (n=2) conducted between September 2017 and April 2018.

To reach a participation rate allowing theoretical saturation, the inclusion criteria were quite unrestrictive while at the same time enabling us to target potential participants who could help us achieve our research objectives. Recruited participants (physicians and medical residents) had completed a traineeship at *La Maison Bleue* during their medical training and were actively practising within a Canadian primary care organization at the time of the research. Recruitment involved an email request submitted to *La Maison Bleue*'s former trainees (from internal lists maintained by *La Maison Bleue* and some of its partners) and complementary snowball techniques.

All interviews were conducted by the first author (JM), in person or online, according to each participant' preferences and availability. Face-to-face interviews were held in a location of each participant's choice,

where they felt at ease and free to express themselves about the subject under study. Physicians and residents participated in a single interview lasting about 60 minutes. The interview guide was developed in line with research objectives, to collect participants' narratives of their perceptions of the applicability and experience in trying to transfer the learning gained from the traineeship at *La Maison Bleue* to their subsequent medical practice. Consequently, we used a set of questions with fairly broad formulations to allow participants to tell their stories and speak out about what was particularly important to them. Table 1 provides the interview questions addressed to participants. All interviews were recorded with the participants' consent and transcribed for further analysis.

Table 1:

Interview questions

Questions	**Sub-questions**
Following your traineeship experience at *La Maison Bleue*, did you intend to apply what you had learned to your medical practice?	If so, how important was this prospect of updating your learning for you? If not, to what do you attribute it?
Do you actually apply this learning in your primary care practice setting(s)?	If so, how is this application concretely articulated? If not, skip the two next questions
Could you tell me, if applicable, about the barriers and challenges you perceive in applying the learnings from your traineeship experience at *La Maison Bleue* to your current practice?	Do these challenges vary according to the practice settings in which you work?
In return, could you tell me about some of the things that make it easier to apply what you've learned from your traineeship at *La Maison Bleue*?	Do these facilitating elements vary according to the practice settings in which you work?

We performed a thematic analysis (Braun & Clarke, 2006) to seek insights into the transferability of learning gained from the community-based clinical traineeship experience at *La Maison Bleue*. The approach to coding was mostly inductive. That said, we acknowledge that we approached this research from a critical and transformational posture, promoting social change. This posture has necessarily influenced the way we looked at the data, and hence the creation of themes and the interpretative avenues. The first author (JM) was primarily responsible for the analytical process. At first, JM reread the interview verbatims using the audio recordings for validation. The interviews were then listened to carefully while reading the verbatim to familiarize with the corpus. It was also an opportunity to take detailed notes on impressions and ideas about potentially emerging themes.[2] At this stage, all interview transcripts were imported into NVivo for coding. We first sought to identify the smallest descriptive or thematic data segments that could be meaningfully interpreted in relation to the phenomenon under study. Some more general patterns were gradually drawn through an exercise of classification and grouping of those data segments. We refined the coding grid until the identification of key themes (Braun & Clarke, 2006). Throughout the process, JM reported regularly to EM and SD on the status of her analytical work

[2] For an initial verbatim, this step was taken jointly by JM and EM, to encourage the development of a concerted analysis strategy. For the following verbatims, this step was carried out by JM only, taking into account what had been discussed.

in order to strengthen the description of emerging analytical categories and gradually improve the coding strategy and coding grid.

Participation was voluntary. All participants were explicitly informed that they remained free to withdraw from the project up until data were analysed, and that they could refuse to answer certain questions asked during the interview, without prejudice. No participants withdrew from the study or refused to answer questions. Particular attention was paid to maintaining the confidentiality of the data collected. Ethical approval for this study was issued by the West-Central Montreal CIUSSS Research Ethics Committee in May 2017 (17-043 31-05-2017) and by the Université Laval Research Ethics Committee in July 2017 (2017-193 25-07-2017).

Findings

This section highlights the demographic and professional profile of the interview participants and the main themes that emerged from analysis. These main themes refer to (i) the concrete application of learning gained to medical practice; (ii) barriers to the application of the learning gained and (iii) factors facilitating the application of the learning gained. These themes are broken down into sub-themes, which are described below.

Participant group profile

Our 12 participating physicians and residents all had 4 years or less of medical practice experience at the time of interview. Most were between the ages of 25 and 29 (n=8) and were women (n=10). Most participants currently practised exclusively in urban areas (n=8); the others in rural practice (n=1) or a mixed urban-rural setting (n=3). Almost all participants (n=10) were practising in Family medicine groups (FMGs) or University family medicine groups (U-FMGs)[3] at the time of the research. The others (n=2) were working either in a primary care setting elsewhere in Canada, or in a hospital setting providing primary care.

The length of the placement participants had completed at *La Maison Bleue* varied greatly depending, for example, on the University programme from which the learner came and its specific requirements, the time of year the placement was carried out, the organisation's capacity to receive trainees at that time, and the philosophy of the supervising physician. For half of the participants (n=6), the clinical traineeship at *La Maison Bleue* lasted just a few days. For the other half, it lasted a few weeks.

The concrete application of learning gained to medical practice

At the time of interview, the majority of participants reported that they were trying to apply the transformative learning gained from their community-based clinical traineeship experience at *La Maison Bleue*, to their current practice, within certain limits. Participants described concrete ways in which they were doing this in their current workplace settings, with these examples falling into two sub-themes: (i) reinventing the physician-patient relationship and (ii) integrating non-hierarchical interdisciplinarity.

Reinventing the physician-patient relationship

Several participants mentioned the long-lasting impact their traineeship experience had on the way they interact with patients in their current practice and the objectives they pursue through these interactions.

[3] FMGs and U-FMGs are the main organizational model of primary care services in Quebec. A FMG is a group of family doctors and other health and social services professionals who work together to provide care for the populations. A U-FMG is a FMG where residents in family medicine, students and interns in various disciplines can receive training and be supervised.

Rather than their experiences and formal protocols dictating the style of questions that they asked, and how they asked them to obtain information relevant to decision-making within the diagnosis and care process, participants reported a heightened sensitivity to psychosocial factors that enabled them to adapt their approach to the expectations and needs of the person, from a less stigmatizing perspective. For example, Participant 14 described this when they discussed meeting with a family new to the area: 'How to approach [such] family… Are they shy? Do they have difficulty communicating? Look for situations of isolation or vulnerability. Make sure: Are you seeing people? Are there opportunities [for the family] to get out and about?'

For some participants, it also meant that they needed to trust their instincts and be open to new ways of doing things. It sometimes translated into putting aside formal rules, protocols and procedures, especially when dealing with patients experiencing social vulnerability. Participant 4 illustrated this when they discussed their time management strategies: 'I'm not the fastest physician in the world. I'm often late. But I think my patients understand that when they need time, I have time for them.'

Integrating non-hierarchical interdisciplinarity

Participants also reported sustained efforts to integrate non-hierarchical interdisciplinarity as promoted at *La Maison Bleue* – i.e., a non-hierarchical partnership model of shared responsibility in which the doctor is not considered as the central actor –, into their medical practice. They perceived such interdisciplinarity as a means to optimize problem solving by considering all facets of the patient's reality, and by distributing the responsibility of heavy and complex cases among all members of the team. Participants also reported trying, on a day-to-day basis, to foster practices that promoted smooth and effective communication about patients' situations, as well as developing trust and respect among all team members involved in the care delivery. This is illustrated here by the words of Participant 12:

> The aim is for everyone [i.e. every professional] to get to know families from a certain point of view. Everyone has a role to play. Then, we can use everyone's data collection to move forward together in solving problems, in providing solutions, and in helping others.

Participants focused on the application of learning related to the patient-physician relationship and to interdisciplinarity practice. It appeared that those learnings, that involved the physician on personal and interpersonal levels and were situated within one's area of control (and have less to do with the organizational context), were those that were easiest to actually implement in practice. That said, a number of factors were still seen to be involved in the applicability of this learning to medical practice. The next sections will explore these factors.

Barriers to the application of the learning gained

This section presents, from the participants' point of view, the perceived barriers to further applying the learning gained from their traineeship experience at *La Maison Bleue*. These barriers related to two main sub-themes: (i) system philosophy and the resulting constraints on medical practice and (ii) organizational characteristics, psychosocial resources and communication**.**

System philosophy and the resulting constraints on medical practice

Participants identified the Quebec health and social services system's philosophy as a major barrier to applying their learning from their community-based clinical traineeship at *La Maison Bleue* into medical practice. Some described this philosophy as favoring a biomedical approach focused on diagnosis and curative objectives, formalizing medical acts within standardised and rigid protocols and procedures, and prioritizing patient volume as well as short-term budget efficiency and accountability. Participants pointed out that this philosophy dominates the system given that it strongly influences performance evaluation strategies, clinical priority setting, remuneration modalities and medical education curriculum orientations. Participant 3 highlighted how, from their perspective, this philosophy tends to impair quality of care and access-to-care equity for patients: 'Sometimes we cut things out because it's seen as more important to ask for an ultrasound, for example, than to talk about a patient's particular social context. It's as if we [as doctors] had to make that trade-off.'

Participants also mentioned that their ability to meet the needs of vulnerable populations and adequately consider issues arising from their life course and particular context is limited by the time constraints imposed as a consequence of the system's philosophy, as illustrated here by Participant 10:

> Having to see so many people, when you have 20 to 30 minutes, sometimes it's not enough to really understand the person's history and context ... If I took an hour with all the patients who need an hour, I wouldn't be able to make it [i.e., meet Ministry of Health and Social services requirements in terms of volume of patients seen].

Some participants described experiencing stress and frustration at the lack of recognition of the value of spending more time with patients to understand their social context and of prioritizing quality and equitable access to care over volume of patients seen. For instance, Participant 7 described this when they shared their fear of reprisals, while still managing to offer care in line with their principles and values:

> I still have the opportunity to take one or two hours per patient, but I don't know how long it's gonna last. I feel like at some point they [i.e., the Ministry of Health and Social services] will find me: 'ah, you, you don't see enough patients!' Then I'm going to get a slap on the wrist. I'm gonna have to choose between continuing to do as I do… and get[ting] cut off a piece of my salary or go against my principles and see more patients.

Organizational characteristics, psychosocial resources and communication

At a more local level, participants also mentioned experiencing barriers related to the organizational characteristics of their clinical setting, namely: difficulties in accessing interprofessional resources, the complexity and rigidity of communication and information exchange processes, and the limited scope of knowledge held by existing interprofessional sources.

Several participants identified performance-based organizational culture and objectives, siloed practice governed by rigid protocols, cumbersome administrative processes, organizational size and complexity, and high patient volume as barriers to the deployment of a flexible, responsive and individualised service. In addition, some physicians identified heavy and rigid structures and policies as obstacles to innovation, preventing the implementation of new ways of doing things – for instance those inspired by their community-based clinical traineeship at *La Maison Bleue* – as expressed here by Participant 4:

> We are in a very heavy structure. When someone comes in with an innovation project... unfortunately, there is politics and there is an impressive administrative thickness. We're in a hospital, so sometimes you have a good idea, but it dies on the order paper because you're just out of breath.

Participants also raised the deleterious effects of limited access to psychosocial resources at the local level. They highlighted that while the collaboration with nurses was often prioritized in the care delivery in Quebec, the scarcity of other resources resulted in the psychosocial component failing to be well integrated into interdisciplinary practice. This is illustrated here by Participant 10 when they discussed the reality of their own care organization: 'We have two social workers for about 100 physicians and a population of 30,000 patients. Anything interdisciplinary, forget it.'

Furthermore, complex and non-fluid modes of communication between professionals were noted as barriers to the application of the learnings gained from their community-based clinical traineeship at *La Maison Bleue*, particularly in interdisciplinary practice. In the hospital context, participants noted that communications often followed a formal, hierarchical pathway that tended to constrain the fluidity of exchanges between professionals concerned with a patient's situation and limited the possibility to receive a timely response to requests for information.

The hyperspecialization of psychosocial resources, who tended to develop narrow fields of expertise and networks around certain specific clientele, was identified as a barrier to the deployment of effective

interdisciplinary practice, especially in the specific cases of patients experiencing social vulnerability. This is illustrated by Participant 5 who described a situation they had experienced:

> When I have a 19-year-old patient who has her 5-year-old daughter with her, who goes outside twice a day to smoke pot and her boyfriend sleeps in the hospital bed with her… The social worker, it's just not in her skill set... Here, they [the social workers] know about seniors' residences, home care and palliative care units.

Factors facilitating the application of the learning gained

Participants also described the factors that facilitated or had the potential to facilitate the application of the learning gained from their community-based clinical traineeship experience at *La Maison Bleue*. These factors fell into two sub-themes: (i) factors associated with the care setting and (ii) factors at the personal and interpersonal level.

Factors associated with the care setting: mission, vision, location and work organization

At the level of the care setting, participants practising in University Family Medicine Groups (U-FMGs) emphasized that an organizational mission centered on knowledge creation and dissemination supported the application of interdisciplinarity and innovation principles learned during their community-based traineeship at *La Maison Bleue*. In this regard, Participant 4 noted:

> Here [at the U-FMG], of course, we're a little more interdisciplinary because we're in a university environment. ... In theory, we're one of the best environments for this because of our vocation, so that helps. ... Also, within our structure, we have mechanisms for innovation.

Similarly, other specific care settings, such as community clinics and social pediatric centers, were identified as conducive to applying the learnings gained from the community-based traineeship at *La Maison Bleue*. Participants noted that these settings often shared similar principles and values, and had similar organizational characteristics to *La Maison Bleue,* as mentioned by Participant 5: 'At the community center, there are lots of facilitating factors because it's a community center. It's based on a lot of the same principles [as *La Maison Bleue*].'

A shared and mobilizing vision, deployed at different levels of the organization and based on openness, innovation and commitment was also identified as a factor facilitating the application of the interdisciplinary principles retained from their community-based traineeship at *La Maison Bleue,* as illustrated by Participant 5:

> It takes people at all levels, not just doctors: managers, all the other professionals who want the same thing. Professionals with whom we can talk about these cases, who have a particular interest in deviating from the usual path to succeed in gaining access to these people and then helping them, sometimes without being on the beaten track.

A final facilitating factor at the care setting level was associated with work organization. According to participants, being part of an interdisciplinary team tended to facilitate exchanges that were essential for applying the principles of interdisciplinarity learned at *La Maison Bleue*. Furthermore, physical proximity to other professionals fostered informal exchanges and the development of familiarity, making collaboration easier. This is highlighted here by the words of Participant 10: 'I think it also works well because we work in the same building. When you pass the social worker in the corridor, everyone is able to stop for just 5 minutes to discuss a case.'

Factors at the personal and interpersonal level: commitment and spaces for reflexivity

Some participants noted that their own attitude as caregivers played a crucial role in applying the values and learning gained from their community-based clinical traineeship at *La Maison Bleue*. In a context where organizational support for new ways of doing things is often lacking, their personal willingness to commit and act on these values and learnings was considered vital. As Participant 4 emphasized: 'I have a

daily role to play: to come and live it, do it, talk about it.' For instance, participants highlighted the importance of informal individual engagement in collaborative processes, established outside formal and usual procedures, to take advantage of the richness and complementarity of multiple professional views, expertise and capacities, as described here by Participant 8:

> The social worker, I learned to go, knock on her door, then we talk about cases. She does the same thing now: she comes to see me. We don't have to send each other e-mails or tasks through formalized procedures: she comes to see me; we sort it out.

In the same vein, while day-to-day practice was sometimes reported to cause participants to forget what they had learned from their unconventional community-based clinical traineeship, some mentioned how opportunities for reflection and discussion about patient situations helped refocus their ideals of practice. For some participants, these reflective spaces took the form of informal exchanges between practitioners sharing common vision and values. For others, supervision and teaching duties provided an opportunity to reflect and step back from the patient situations presented, as illustrated here by Participant 10: 'Once you're a supervisor, the resident arrives and is overwhelmed with his hepatitis C patient from Congo, and all hell breaks loose. As for you, you have a bit of distance, so you can think more clearly.'

Discussion

This study explored how the learning gained from traineeships in non-conventional community-based clinical settings can be applied in more conventional care settings from the perspective of practising physicians, and how this impacted on health practices and systems. It complemented previous studies showing that such traineeship experiences are conducive to transformational learnings. More specifically, this study explored the applicability of the learning gained from a community-based traineeship at *La Maison Bleue*, a clinical setting offering perinatal care to women and families in extremely vulnerable situations in Montreal, Quebec, Canada.

Our results highlighted that systemic and organizational factors significantly impacted whether participants were able to apply the learning gained during their traineeship to their current clinical setting. The study identified these factors mainly as barriers to such applicability. Participants' assessment of the importance of these systemic and organizational barriers aligned with conclusions from the literature related to access-to-care equity, which emphasize the need for organizational support in providing care and services tailored to the needs and expectations of socially vulnerable populations (Fiscella, 2011; Loignon et al., 2015). This also resonated with major transfer of training theoretical models, applied to the medical field (Choi & Roulston, 2015). Indeed, those theories identify several critical factors from the broad organizational context that influence the transfer of learning to practice (Choi & Roulston, 2015). For instance, they suggest that signals interpreted as organizational (and systemic) resistance to the transfer of learning (e.g. standard protocols) and perceived constraints on medical practice strongly influence one's decision and ability to apply the learning (Choi & Roulston, 2015). Our results indicated that such signals existed in several clinical settings, hindering physicians' willingness and ability to practice medicine differently, based on the learnings gained from *La Maison Bleue*. These finding highlights how constraining philosophies, policies and procedures can be detrimental to achieving the broad transformational potential of medical education.

The results of this study also revealed the use of individual and collective initiatives and strategies led by physicians to overcome organizational barriers and adopt a care approach inspired by their community-based traineeship experience. Mostly informal, these initiatives and strategies were being implemented "off the radar" to navigate the ethical dilemmas arising from the gap between participants' desires to provide services that were based on strong collaborative processes, patient's complex realities and social contexts and formal requirements (such as the need to see a certain number of patients) (Centeno & Bégin, 2015). This was well represented in our results, as we highlighted frustrating situations and a sense of psychological insecurity arising from such ethical dilemmas.

These physician-led initiatives and strategies arising from navigating the ethical dilemmas associated with medical practice align with the work of Godrie and collaborators (2015, p. 17) who reported the

implementation of "invisible practices" involving a certain delinquency against rigid rules and processes imposed by the system. These invisible practices aim to overcome such rigid rules and processes that might restrict access-to-care and/or hinder quality of care. McAll (2017) proposed that the implementation of such invisible practices derive from the inconsistency perceived between the health systems' dominant philosophy and daily clinical practice. These practices thus constitute a critical distancing of physicians from institutionalized practices, to initiate alternative practice frameworks based on both social and health science knowledge, better aligned with the *real world's* requirements (McAll, 2017). Considering these alternative frameworks could be valuable for decision-makers aiming to deliver healthcare practices and systems that are more equitable and adapted to the needs of socially vulnerable people and communities. Indeed, our results could be an incentive to mobilize those physicians, whose practice models remain under-represented and -recognized in our health systems, as transformational champions and role models. There is considerable evidence from multiple disciplines pointing to the key role of change champions in the implementation of innovations in organizations (Bingham, 2007; Evans, 2012; Scott & Rantz, 1994; Shaw et al., 2012; Wolverton, 1998). Furthermore, valuing these renewed practice models underscores the need to review healthcare performance indicators to prioritize the social impact of an innovative, flexible, sensitive and reflexive medical practice over the volume of patients seen, to better meet the needs of people and communities experiencing social vulnerability.

Limitations

Our study is not without limitations. This is a relatively small-scale, exploratory, qualitative study with perspectives from 12 trainees who shared *La Maison Bleue*'s values and loved their positive traineeship experience. We unfortunately did not get the input of those who may have had a less positive experiences and whose contribution could have counterbalanced our results. The relatively homogeneous sample also limited our ability to assess the influence of different individual characteristics (e.g.: gender, age, medical specialty, number of years of practice) on the variability of participants' perceptions and experiences. This was also an experience at one community facility, so findings may have limited applicability to other community organization in Canada or beyond. That said, the results of this exploratory study are in line with Ross & Cameron's (2021, p. 116) conception of medical education as a contextual and place-based enterprise, "grounded in historical, geographical, social, political and cultural local approaches that are developed, implemented and assessed through and by local contexts". Our findings also justify future larger-scale studies on the impact of community-based traineeship experiences in medical education. In particular, future research could consider integrating a range of perspectives (e.g.: physicians', patients', decision-makers').

Conclusion

This study sought to understand, from practising physicians' perspectives, how the learnings gained from their traineeship experience within a community-based care setting were transferable, or not, to their medical practice in other clinical contexts. The findings of the study highlight the critical role of systemic and organizational factors in enabling or, more often, hindering the application of transformative learnings in medical practice. We found that, given the organizational and structural barriers to the application of learnings, it is rather the learnings relating to the relationship and approach to the patient that are effectively actualized in practice. Facilitating factors were perceived more at the human level but ultimately seemed to have only a marginal effect on physicians' actual ability to apply learning. This study highlights the ethical and political responsibility of healthcare decision-makers in realizing the transformational potential of medical education and the value of physician's community-based traineeship experiences for the implementation of transformational practice models. Furthermore, it calls for a broader revaluation of healthcare policies and practices to better support physicians to ultimately improve care for vulnerable populations. The insights gained here should also inspire further research and concrete policy changes aimed at achieving greater equity and effectiveness in healthcare delivery.

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