Twelve tips for community-based medical education

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SUMMARY Teaching and learning in primary care and community settings is now a very common aspect of most medical trainings, and there is a growing expertise and evidence base related to the contribution of primary care practice to the reform of medical education. This article in the ‘12 tips’ series touches on both practical and political aspects of community-based medical education, addressing the context in which this contribution has developed, its impacts to date, and some core essentials of effective educational practice.

Introduction
Motivated by the need for medical schools to reflect the requirements of future healthcare systems, and to ensure that doctors in training acquire appropriate aptitudes (Boelen, 1993), there has been a worldwide trend to reform medical education. One consistent aspect has been the emphasis on balancing the university and hospital with more use of community and primary care as learning settings. Much is expected of this trend: Habbick & Leeder (1996) suggest that community oriented programmes can:

- create more appropriate knowledge, skills and attitudes;
- deepen understanding of the whole range of health, illness, and the workings of the health and social services;
- deepen understanding of the contribution of social and environmental factors to the causation and prevention of illness;
- promote a more patient-oriented perspective;
- make better use of the expertise and availability of staff and patients who are in primary care settings;
- enhance multidisciplinary working;
- offer a broader range of learning opportunities;
- increase recruitment into primary care and generalist specialties.

A multiplicity of models have now been described in the literature, ranging from family case studies (McCrorie et al., 1993), to development of professional attitudes through early clinical exposure in primary care (Hampshire, 1998), acquisition of clinical skills (Murray et al., 1997), and even parallel community-based clinical programmes (Worley et al., 2000). In practice, the outcomes will depend on the specific use to which the community setting is put, and on the quality of the learners’ experience. Nevertheless, there are some overarching guiding principles of good practice in community-based learning, which this article aims to summarize. The first three tips set an evaluative context: the next six consider different aspects of the learners’ experience: and the last three address factors pertaining to the tutor and their peer setting.

Tip 1
Consider how you can best convey the values for which you have chosen to become involved in learning in the community
The discipline of family medicine is characterized by the following:

- a whole-person orientation, including social and family context;
- a clinical method that utilizes relationship skills;
- longitudinal care;
- generalist and integrated practice of medicine.

Whatever the specific learning objectives of the placement, the learning experience of students while in primary care should be used wherever possible to develop their understanding of health and illness in a broad context, and their relationships with the practice-based staff and patients used to assist the students’ professional development, as well as their knowledge and skill base.

Tip 2
Be aware that community-based staff are seen as alternative role models
Role modelling in medicine predominantly works at an affective level, with caring respectful teaching and abusive episodes both remembered (albeit not necessarily perpetuated) in the long term (Matthews, 2000). There is evidence that students value the different approach of community-based staff to both teaching and clinical care (Howe, 2001). Enthusiasm for teaching, and genuine effort to assist students, may be as valuable as specific teaching skills, and the importance of modelling the behaviour one wishes them to adopt is crucial. For students who are not attracted to secondary care as a culture, the potential to develop a vision of a community-based career during a primary care placement is considerable (Howe & Ives, 2001). Similarly, staff may find that students uncertain about their professional identity are initially antagonistic to the unfamiliar primary care world-view, because…

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Tip 3

Community-based learning is a culture shock: induct students into it

Whether students enter community settings early in their course or after a number of years in training, they may find the combination of undifferentiated clinical problems, the less hierarchical environment and the emotional nature of the patient’s world-view a considerable personal challenge. This is particularly the case if they have been located away from their peer group or usual lifestyle: for example, if an individual is attached to a primary care team on a residential rural placement. Prior sensitization training afforded to many professional workers entering new cultural settings is often neglected by central curriculum planners, so the need to brief (and debrief) students early in the attachment may make a considerable difference to their attitudinal adaptation, and to their understanding of the factors influencing community staff behaviour. The first contact with a community can be a marvellous learning experience if well handled, and especially if the peer group can compare and contrast their experiences within the learning setting, thus ‘bringing unsystematised personal experience under critical control by developing greater awareness of how it is used, and re-examining taken for granted assumptions’ (Eraut, 1994). This does not imply a need to convert the students to your own values, but to be open and reflective about their developing understanding.

Tip 4

The curriculum—know why the learners are there

Many medical staff in primary care have not adjusted to the changes in community-based teaching since they were sent to a GP for a two-week ‘sit in and see what we do’ course of the opportunistic (and often counterproductive) kind. Although learners differ, there is a clear educational imperative to understand the nature of the curriculum, and to arrange the learning opportunities accordingly. It is essential that staff and students establish a common view of their learning needs; that tutors appreciate any core objectives for the community placements; that they know something of where the placement fits within the broader curriculum; and that the basic facts are also conveyed to other staff who play a role in the learners’ experience. While structured teaching may be challenging to the vagaries of the clinical setting, it is known that community-based teaching can both be valued for this (Howe, 2000) and criticized if the placement opportunities appear to depart from the placement’s goals (Roberts et al., 2000).

Tip 5

Ensure some precious protected time—it is essential to teaching and learning

Each course organizer should specify the extent to which learners can work unsupervised (senior student clinic), in conjunction with you (shared learning), or need 100% commitment (group tutorial). In any placement, the learner(s) will require some protected time with the lead tutor, and this will require preparation by both parties, especially if the course objectives are complex or require technical equipment. Students will also need protected time with appropriate and consent-given patients, and the tutoring staff will themselves need protected time to develop their skills, plan teaching sessions, and evaluate their impact. With a small team in a community setting, there will be little likelihood that staff can teach at short notice, so forward planning and resource input are both essential for genuine availability of protected time. Community staff therefore need to be proactive in their approach to the learning programme, in order to assure its quality.

Tip 6

Support and guidance—make the most of the exceptional potential of community-based learning for pastoral care and personal mentoring

The clinical method of primary care-based staff lends itself to the use of relationships to extend learners’ potential. They often see students in smaller cohorts, making the learners’ needs and abilities more visible. Students value personal feedback on their performance greatly, often having unwarranted concerns about their own abilities. Community staff should make the most of their considerable interpersonal skills to develop student insight into their performance (both strengths and weaknesses), and can also be valuable to central staff in picking up students with problems.

Many community staff have responded to their new role with a touching concern for the personal well-being of the students (Howe et al., 2001). A tendency to advocate on behalf of students may need to be moderated in discussion with central faculty, who will have a broader view of both the statutory regulations and the need to be equitable across the peer group. Nevertheless, taking up issues on behalf of individuals and the group may be immensely valuable, and can bring about important quality improvements.

Tip 7

Assessment—take it seriously

There are many developments in medical education designed to make assessment both an adequate reflection of the eventual professional role, and reliable across different settings and assessors. It is, of all the key elements of a medical curriculum, the one that is particularly scrutinized by external bodies such as the General Medical Council. One of the biggest challenges to face community-based tutors and their academic colleagues is the role of such a dispersed group in assessment, given the challenges that this brings to reliability. Community-based staff, unlike hospital or university staff, rarely get together, and are often even more diverse as individuals than those operating in secondary care. The tip here is to ensure that you understand what your role is in assessment. Faculty should train you for this task as much as for the teaching, as the consequences of an inaccurate or unjustifiable summative
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assessment are considerable, and the role of formative assessment an essential one for the student’s efficacy. It is perfectly legitimate to ask for advice on this, and it is good practice for novice assessors to be ‘double marked’ until the consistency of their assessments is established. So make sure you do understand the assessment model and your role within it, and use more experienced colleagues to develop your expertise in this area. Although inclusivity may favour asking all the team their opinion of the student, this should not form part of the feedback to the medical school unless both requested and systematized. It may also be daunting for more junior students, and any feedback from staff needs to be given via the ‘filter’ of an experienced tutor.

Tip 8
Practical resources—get your kit in

The central course organizer should inform community-based staff very clearly as to what information technology, texts, CD-ROMs, cameras and technical equipment are needed, and should tell you about any learning resources available to staff to assist learning. Community-based staff need to be proactive about familiarizing themselves with the material available to students that is relevant to the placement, and to be demanding of resources that may be needed to invest in the required infrastructure.

Many community practices will be too small to accommodate large numbers of students but it is rare that the building of new additional premises can be justified, especially in settings that are owned by the doctors rather than the health service or university. Successful teaching can occur in other locations (e.g. a community hospital) if they are easy and safe to access, familiar to patients, and similarly equipped.

Tip 9
Learning from experience—the value of being involved in education for the tutor’s own professional development

All key community staff who take responsibility for medical education should be given appropriate staff training and regular updates, with provision of guidance for other staff who make an occasional contribution. If this is not available, the programme organizers should be reconsidering their position! Staff training, new contact with one’s peer group, the constant stimulus of being involved with students, and the role of reflection and evaluation in developing one’s own skills are all valuable opportunities for continuing professional development, and can be accredited towards revalidation. The quality uplift of practitioners’ skills by becoming involved in teaching is well established (Murray et al., 1997), and the policy of using active educational environments as an incentive to recruitment of staff is widespread in Europe and Australasia (Worley et al., 2000). The ‘cycle of satisfaction’ experienced by community-based tutors (Howe, 2000) is a potential protection against burnout, because it reduces the professional isolation inherent in community practice, and can also unite teams in a new common task. Which relates to the need to …

Tip 10
Make the most of the multidisciplinary community team

Not only can education bring team members together, it can also make their skills and roles more visible to each other and to the students, whose view of the larger intersecting teams in hospital settings is often partial and fragmented. The community setting provides great opportunity to see the whole patient care pathway across all agencies (Lennox & Petersen, 1998), and for students to experience teaching by staff who hold non-medical qualifications (Howe et al., 2000). Community-based staff should be able in the longer term to extend the impact of the multiprofessional team on medical students to supporting courses for an interprofessional student body.

Tip 11
Celebrate working at the margins and being leading edge

Community-based courses have been almost universally acclaimed in peer-reviewed settings, and the number of general practitioners active in medical education is disproportionately high compared with the amount of time in medical courses that is devoted to community settings. Primary care not only offers new clinical opportunities but has also been a major player in achieving a modern curriculum for communication skills, medical humanities and population health (to name but a few). To the author, the current crisis in professional confidence is harsh for all disciplines, but undermining the motivation of primary care teams to teach would be an unjustifiable outcome given the burgeoning evidence base of good practice by this sector. Nevertheless, there continues to be a sense in which community-based courses are marginal to the positivist bioscience that dominates most medical schools, and the pendulum of power may swing the other way. This may sound overly political, but there is an international agenda for medical schools about their …

Tip 12
Social accountability—community-based learning is in the frontline

The moral imperative to move medical schools from ivory tower to public reciprocity is one with which the majority of primary care staff will have some sympathy. As patient advocates, and with the daily experience of our patients’ socioeconomic sufferings, family medicine has been key to confronting the dehumanizing aspects of both medical care and medical education. One of the key roles that community-based learning can play is to show students real life; for staff, this means supporting students in their dawning awareness that doctors should be socially accountable (and ensuring that this leads to a moral challenge rather than despair!). Staff often cannot articulate why it is that they feel students should have more community exposure—but it may be that it is only when exposed to the humour and courage of people in their everyday interactions with health and illness that we can truly see the limits and the great opportunities which becoming a doctor affords to us.
In conclusion

Community-based medical education is not the solution to all the ills of a clinical culture that does not integrate and manifest the same values as many primary care staff. Nevertheless it is an essential component of the modern medical course, and by and large community staff have been successful in delivering effective learning. These twelve tips are a brief guide only—the rest is a question of learning from experience (Kolb, 1984).

References


