The developing role of Community-Based Medical Education

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Abstract

Not required for this editorial.

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Introduction

The mantra that undergraduate medical education is best provided in a tertiary referral teaching hospital still enjoys international currency. Many medical schools across the world continue to retain a traditional curriculum which can be defined as being teacher-centred, information gathering, discipline-based and hospital-based, having a standard programme and being apprenticeship-based.

One route to revising a curriculum, popularised more than 30 years ago now, is the SPICES approach (Harden, Sowden & Dunn,1984). In this model a move towards the opposite end of the spectrum was described for each of these traditional elements. They proposed a curriculum with the acronym SPICES which could be Student-centred, Problem-based, Integrated and Community-based, having Electives and being Systematic in approach. This SPICES model has become a method by which a curriculum can be evaluated and on which a new curriculum or course can be designed (Dent 2014). While each of these elements is interesting in its own place we are concerned in this themed issue of MedEdPublish with exploring ideas and examples of just one, Community-Based Medical Education (CBME).

What is CBME?

Community based teaching has been described as “medical education that is based outside a tertiary or large secondary level hospital (and which) is focussed on the care provided to patients both before the decision to refer to a tertiary hospital and after the decision to discharge the patient from such care” (Worley & Couper 2013). In 2014 Simon Stevens, the Chief Executive of the NHS in England, emphasised the role which community hospitals have to play by saying that more patients should be treated in their own communities rather than in centralised specialist hospitals. As always, student teaching should go to where there are patients to see, so venues available for teaching in the community may now include a community health care clinic; a regional diagnostic and treatment centre or cottage hospital; a general / family practice centre; as well as patient’s homes, schools or work places.

Why teach in the community?

Increasing student numbers in teaching hospitals are not matched by an increase in the number of in-patients suitable for student teaching. This overcrowded environment does little to foster either student teaching or patient care and may contribute to additional risks by increasing student stress and teacher burn-out. In contrast, CBME allows students to experience a more personal relationship with patients, to recognise the importance of treating people instead of ‘a disease’ and in addition can show how the social environment has a significant impact on health and healthcare (Howe 2001). The benefits of a community-orientated programme have been described by Habbick & Leeder (1996) as:
Offering a broader range of learning opportunities for students to acquire knowledge, skills and attitudes
Promoting a more patient-orientated perspective
Deepening the range of health and illness issues and the working of the health and social services
Deepening an awareness of the contribution of social and environmental factors to the causation and prevention of illness and an enhanced view of multidisciplinary working and possibly of increased recruitment into primary care

In addition Worley and Couper (2013) suggests that students can learn about:

- general and family medicine
- a particular specialty
- multiple disciplines concurrently as their whole curriculum may be based in an extended rural programme

Senior students in prolonged rural placements found that they had increased patient contact, increased time in clinical settings, increased time spent being supervised and were better prepared for their forthcoming FY1 year as a junior doctor (Dent et al 2007). It was also shown that undergraduate medical education can safely be delivered in ambulatory and community settings without compromising academic standards (Worley et al 2000).

Examples

Examples of successful curricula based on or including significant elements of CBME have been described ranging from an increased use of ambulatory care teaching venues (Dent 2005, Latta et al 2013), through extended placements in General Practice (Oswald et al 2001), to emersion programmes in rural clinical practice (Worley et al 2000, Rourke & Frank 2005). Recent papers in MedEdPublish from UK, Australia and the USA report a variety of examples of CBME. Bourke & Wright (2015) from Melbourne, Australia, affirmed that a rural background is a predictor of future rural practice and went on to report a change in student-attitude towards a rural career in those who took a rural health module. From Glasgow, UK, Mullen & Smith (2016) report a Student Selected Component (SSC) which assessed student attitudes to addiction by placing them in a community-based initiative which provided experience in managing these patients. A further paper from Baltimore, USA, (Rios et al 2015) reported on the role of community service in contributing to personal and professional growth.

Conclusions

Whether further appreciation of the role of CBME by medical schools can still occur is debatable. Does the initiative lie with individual faculty members who see the advantages of this and have the enthusiasm to pursue an “bottom-up” approach to curricular reform? Or does a change in this direction on the SPICES spectrum require the explicit directives of senior faculty and curriculum committees before it can take effect? It would be interesting to hear the opinion of readers on this question. If you have an example of CBME which you would like to report, or an opinion to contribute for discussion, then please make use of this exciting new facility on MedEdPublish to share this with us.

Take Home Messages

Notes On Contributors

Dr John Dent is Honorary Reader in Medical Education and Orthopaedic Surgery at University of Dundee, AMEE International Relations Officer, an Associate Editor of Medical Teacher and an International Member of the editorial board of the Korean Journal of Medical Education. His main research areas relate to ambulatory care teaching and the development of community-based education. He is currently a tutor for AMEE on the ESME–Online and the new ESME-Student course. With Professor Ronald Harden he co-edited the internationally acclaimed, multi-author text, “A Practical Guide for Medical Teachers” (4th ed), Elsevier, which was Highly Commended in the annual BMA Book Awards, 2010.

Acknowledgements

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Appendices

Declaration of Interest

The author has declared the conflicts of interest below.

I am the Guest Editor of AMEE MedEdPublish for the theme of Community-based Medical Education.