EDITORIAL

Inspiring Trends in Medical Education: Emphasizing Community-Based and Community-Oriented Approaches

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Medical education is continuously changing, grounded on the fundamental need of communities to ensure "health for all"[1,2,3]. Traditional hospitals, the proverbial "ivory towers", which are gradually evolving into vast intensive care units, are no longer treated as the best places to train doctors for the 21st century as they fail to ensure the health needs of society[2,4,5,6]. Society expects that in addition to being a good care provider, tomorrow's doctors should be good decision-makers, communicators, leaders and managers, which has been advocated by WHO as five-star doctors[2,4,7]. Internationally, it is recognized that undergraduate medical education must adapt to the changing needs of society[2,8]. To meet the expectations of society, the past few decades have seen medical schools introducing innovative trends of community-oriented and community-based medical education in their undergraduate medical education programs[1]. Although there is a clear distinction between community-oriented and community-based medical education, many schools are not clear, assuming that both are the same even for institutions involved in both[1]. Community-oriented medical education (COME) means teaching community-related problems inside the school that are relevant to community health needs. On the other hand, community-based medical education (CBME) refers to teaching-learning activities based on or taking place outside the boundary wall of tertiary care schools, where a large group of people resides. This paper highlights the difference between COME and CBME, provides a brief example of approaches of CBME used in medical schools around the Globe, and summarises the benefits and barriers of CBME.

Community-Oriented Medical Education (COME)

Community-oriented medical education (COME) involves the teaching and learning of medical students, emphasizing both population groups and individuals, stressing the community's health needs. Here, the objective of the school is to stress the community's health needs[1]. It was developed in the late 1960s and 1970s to provide community-oriented education for medical students alongside their understanding of clinical and scientific aspects of patient issues. Here, the importance is given to the community's health problems and how they affect the patients and their clinical problems. However, the student's learning occurs at the university, not in the community setting[9].

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Students understand patients' social context without necessarily exposing to the patients.

Community-Based Medical Education (CBME)

Community-based medical education was developed out of community-oriented medical education in the 1980s and the 1990s, where students learn not just about the community context in the classroom but also about it in different social and clinical environments[9]. According to Worley and Couper (2013) community-based medical education can be defined 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"[10]. Here, medical students learning is based on community needs and takes place in a community setting. Thus, the learning activities employ the community as a learning environment that involves students, teachers, members of the community, and other representatives. Clinical placements are not limited to large teaching hospitals; they also occur in vital community and health service settings. This broad approach enhances the learning experience by exposing students to diverse healthcare environments[1,9,11]. Examples of clinical learning sites include mental health services, long-term care facilities and family practice clinics, as well as hospitals and health services in remote, rural and urban communities[9]. In community-based medical education, medical students' learning is enhanced by an acquaintance with the community settings and an understanding of the underlying factors affecting health problems in daily life[12]. Community-based medical education is characterized by an interchange and partnership with community stakeholders[13].

Longitudinal integrated clerkship (LIC): Canada approach to CBME

One model in community-based medical education (CBME) is the longitudinal integrated clerkship, initially started in Australia in the late 1990s. Northern Ontario School of Medicine in Canada has followed this approach, placing third-year medical students in rural communities for 'clinical clerkship'. They work closely with a small group of clinicians, forming strong connections and becoming integrated into their professional community. Students gain strong communication skills and excellent clinical reasoning and management skills through this LIC. The long-term working relationships between the students and their clinical supervisors foster an apprenticeship-like environment, allowing for meaningful growth and learning[14]..

Residential Field Site Training: Bangladesh Approach to CBME:

In Bangladesh, Residential Field Site Training (RFST) is a community-based education approach for year-4 medical students. They are placed in groups of 20-24 at primary healthcare facilities for two weeks, guided by the Community Medicine Department. The first week focuses on clinical medicine, and the second on community medicine, with students rotating groups. A teacher from the community medicine department accompanies the students at the health centre. During clinical medicine week, students visit different sections of the primary care facility to observe their functions, participate in case discussions with in-patients and out-patients, and engage in evening group discussions with faculty about their experiences. In community medicine week, students conduct socio-demographic surveys of rural families, organized into smaller groups to complete five questionnaires each. They are guided by teachers from the Community Medicine Department and field staff, visiting rural health centres and interacting with local health workers. In the evenings, they share experiences in a community hall, compile and analyze data individually and in groups, and present their findings at a seminar on the closing day of the RFST program with institutional heads and facilitators present[2].

Community and Family Case Study (CFCS): Malaysian Approach to CBME

In Malaysia, the Community and Family Case Study (CFCS) is part of the undergraduate medical curriculum as an approach to CBME at Universiti Sains Malaysia, conducted during phase II (years 2 and 3) and phase III (years 4 and 5). In phase II, the CFCS program involves small subgroups of students staying with rural families as community residents for two weeks twice, once in year-2 and the other in year-3.[4,15]. During their community residency, students identify health problems, assess community health resources, and conduct

interviews with local leaders and health personnel. They also perform health screenings and dietary surveys. This phase focuses on detecting and resolving the health needs of the families and communities. In phase III, students select a patient/case to study and manage individually while also selecting another case in small groups to study and manage in groups. The cases are usually from low socioeconomic backgrounds and chronic illnesses in nature, requiring regular home visits starting from year 4 to the middle of year 5 with a learning contract. A learning contract is a negotiated agreement between students and their supervisors on learning objectives to be achieved through the CFCS programme. The focus in phase III is on the health needs of the patients and families[4].

Approaches of CBME and COME in a few other Developing and Developed Countries

Medical schools like Khartoum in Sudan mainly have community-based activities. In contrast, medical schools like Newcastle in England and Maastricht in the Netherlands have more community-oriented activities than community-based ones. Suez Canal University in Egypt is an example of a community-based community-oriented school[1,16]. In developed and developing countries more than 150 medical schools offer either an entire CBME curriculum or COME curriculum that allow students to use primary care site as a learning environment for at least four weeks[1].

Benefits of CBME

In CBMEs, students are exposed to real-life situations by coming in close contact with rural people, which helps them to be aware of their norms, beliefs, prejudices, financial problems, housing problems, illiteracy, violence, ignorance, and many other practical things and also be aware of the role of these factors in the causation and management of illness[2]. To meet the expectations of society, the development of the mindset and attitudes of "tomorrow's doctors" are essential. Attitudinal development can be best taught in the community educational setting, where students demonstrate social accountability in the communities they serve. Thus, medical schools are able to produce highly competent professionals capable of demonstrating a positive effect on the communities they serve[11]. The CBME also benefits students by promoting a more patient-orientated perspective, offering a broader range of learning opportunities for students to acquire knowledge, skills and attitudes, and providing students with the opportunity to learn about general and family medicine practice in a rural setting[17].

Barriers in implementing CBME

One of the main barriers to community participation is the financial issue. Implementing CBME needs to cover the costs of developing the curriculum, faculty recruitment and training, transport, office and accommodation costs for fieldwork, and salaries for faculty and field staff [18]. Community distrust in the health system is another major obstacle. The other barriers to community participation include the inadequate ability of community health workers and community members and inappropriate health education with community needs. Moreover, lack of proper communication, long-distance, and lack of participatory groups in society also add to the problem. The administrative bureaucracy, inability to interpret goals for people, and cultural barriers are remarkable barriers[19].

CONCLUSION

Educational setting is one of the important factors that may influence the outcome of the education. COME is the involvement of teaching-learning on community problems i.e. health needs of the both population groups and individuals at the university setting i.e. tertiary care setting. CBME is the involvement of teaching-learning on community problems at the community setting i.e. primary care setting. Preserving health is as important as treating diseases. Moving undergraduate education away from tertiary care hospitals into the community at large, students get the advantage of real-life exposer, be aware of the socio-cultural factors, such as norms, prejudices, beliefs etc. in the causation and management of illness. Thus, making students better able to meet the needs of the diverse people of the society emphasising on health promotion and disease prevention. CBME addresses real-world health problems that need community stakeholders' involvement. To get real benefits from CBME, the entire learning process and the institutional involvement must be programmed as one entity.

For effective implementation of CBME there should be close collaboration between health and educational administration. The way medical schools incorporate the objectives into the curriculum will depend on the situation, program, implementation strategies and resources of a particular country.

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