

Teaching & Learning in the Community

Authors:

Dr Anita Berlin MBBS MRCGP MA (Institute of Education)
Senior Lecturer, Department of Primary Care and Population Sciences
Royal Free & University College Medical School

Dr Frances Carter BSc MBBS MRCP MRCOG ILTM
General Practitioner and Honorary Senior Lecturer,
Faculty of Medicine, Imperial College London

This paper was first written in 2003 as part of a project led by the London Deanery to provide a web-based learning resource to support the educational development for clinical teachers. It was revised by Judy McKimm in 2007 with the introduction of the Deanery's new web-based learning package for clinical teachers. Each of the papers provides a summary and background reading on a core topic in clinical education.

Aims

This paper:

- Provides a framework for understanding the educational opportunities in the community
- Illustrates the learning potential of community settings
- Offers practical tips for community-based teaching and learning

The paper is aimed mainly at teachers of medical students but many of the background issues, educational opportunities and tips described can be applied to the community-based education of postgraduates and professions allied to medicine.

Learning outcomes of the paper

After studying this paper you will be able to:

- Describe the key learning opportunities provided in the community
- Understand the advantages and disadvantages of the different approaches to Community based education
- Plan clinical teaching in a range of service settings in the community
- Apply a range of teaching approaches including role modelling

Content

- Introduction to Community based education and Learning
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Note on practical exercises & teaching scenarios

The reflective exercises and teaching tips for this paper are based on a series of five teaching scenarios or case studies chosen to reflect the interests of those clinical teachers studying the paper. Choose the scenario closest to your current or future clinical teaching practice and return to the same scenario for the suggested exercises. If you are maintaining a reflective diary or log, then keep your answers as a record of your learning for use in a teaching and learning portfolio.

Initial self-assessment activity

Try to attempt this activity before you start to read the paper.

Think about the last Community based education session you did (or imagine a session if you do not currently teach in the community).

Fill in the answers to the questions below in your learning log.

- *How did you prepare for the session?*
- *What was the content of the session*
- *Which teaching methods did you use?*
- *What did you do at the beginning of the teaching session?*
- *What did you do in the middle of the session?*
- *What did you do at the end of the session?*
- *Did you do anything after the session?*

Introduction to Community based education and Learning

"Community is a value-laden term which, like democracy, can be taken by different people as a description of, or justification for, widely differing activities."

(Brookfield, 1983 p 67)

The term "community based education" (CBE) in the context of medical education in the UK usually refers to all learning activity that is based outside the hospital setting. Most commonly this means general practitioner surgeries. However general practice is only one location for CBE - albeit a very substantial one - not as is often implied the *only* one. Other typical examples include community clinics, pharmacies, and patients' homes. In some courses community organisations such as patient groups and voluntary bodies are involved. The proportion of undergraduate teaching based outside traditional hospital sites in the UK has risen from about 3% in 1992 to around 12% in 2002.

The General Medical Council, through its decennial recommendations on medical education, promoted the shift from hospital to community based medical education, and was actively supported by the NHS.

Some medical schools also describe their curriculum as *community oriented*. This differs from community-based medical education in referring to a curriculum *strategy* rather than a *location* for learning. Through community-orientation the curriculum or a course gains relevance to the community in which the institution is situated by developing key partnerships.

It is defined as education that is *"...focused on populations, groups and individual persons which takes into account the health needs of the community concerned"* (TUFH), see Appendix 1 for more details.

Factors influencing the increase in community based education

LEARNING ACTIVITY AND REFLECTION

Why is community based education (CBE) more common nowadays?

Write a list of your thoughts on this topic

Our thoughts:

The factors driving the growth of CBE can be broken down under three inter-related headings

Service change

- Reduction in number of hospital beds
- Patients in hospital for much shorter periods undergoing more investigation so less available for teaching
- Increasing reliance on day care and outpatient procedures not geared up to accommodating students needs

- “Primary care led NHS” - transfer of some services to community practitioners
- Inflexible funding of teaching in hospitals means less able to respond to service changes
- New funding for CBE allows greater creativity and flexibility
- Policy to increase numbers of all health professionals leading to overcrowding with a variety of students
- Increased emphasis on educational aspects of junior doctors training means competition for teaching from senior staff

Population changes

- Ageing population
- People living longer with chronic conditions but staying relatively well
- In-patients are more severely ill nowadays
- Patients with chronic conditions (and stable physical signs) best seen in the community where they live
- Rising patient expectation may make in-patients more likely to refuse to be seen/examined by students than community

Educational or philosophical

- “Traditional” curricula have not adequately prepared graduates for their responsibilities – especially for chronic illnesses
- Predominantly hospital based teaching distorts students’ understanding of health needs and patients unique experience of illness
- Primary care offers view of diseases at all stages of evolution
- GPs have long track record in post graduate education – in particular regarding the doctor-patient relationship and communication which can be transferred
- As population based and public health interventions are poorly understood by most doctors need for better learning opportunities at undergraduate level
- Social influences on health and health care need more emphasis for undergraduates

CBE - Pragmatic forces versus positive choices

You should note that the huge expansion in CBE has arisen from a combination of pragmatic forces (solutions to practical and logistical problems) and positive choices (thoughtful strategies to improve the learners’ experience). The inability of traditional hospital sites to cope with the rising volume of students with a diminishing in-patient base has been the foremost pragmatic force.

Community providers, predominantly GPs, when asked to step in and fill the gaps jumped at the chance of increasing their contribution to the curriculum. Many initiatives born in this way - notably the Medicine in the Community firms at Kings and University College (both started before the publication of Tomorrow’s Doctors) - have proved popular with students and teachers.

However their sustainability rests with the value they added to clinical teaching. When planning CBE it is important to consider what is the *positive added value* of the community as a locus for learning over and above the purely pragmatic forces –merely reproducing hospital teaching in the community does not add value for students and does not satisfy community based teachers – as a result it may not be sustainable in the longer term.

As the volume of education undertaken in the community increases (undergraduate, post graduate and continuing for all professions allied to medicine, not just doctors) and recruitment remains difficult, the community may also become saturated. As a community based teacher or curriculum planner you will need to keep reminding yourself what strategies make CBE popular and which learning outcomes truly add value to the future doctor and monitor the evidence to support your choices.

LEARNING ACTIVITY AND REFLECTION

Why is Community based education popular and practical?

Write a list of your thoughts on this topic

Our thoughts on why CBE is popular with students, teachers and patients

- Teaching is more often in small groups or one-to-one which students enjoy if well done as it is increasingly rare in other parts of the course
- Greater potential for student- teacher relationship and tailoring teaching to individual needs
- Good access to relatively well patients who often enjoy the experience and learn more about their own illness during the course of teaching sessions
- Potential for hands-on experience
- Places some key (previously neglected) concepts in context (eg epidemiology, sociology, multidisciplinary care, health promotion and disease prevention)
- Students can become part of the community team and make a contribution
- Students can observe professionals at work in a variety of real situations and acting as role models
- Teachers are often enthusiastic about their subject and teaching which raises morale and stimulates their own learning
- Funding allows some clinical teaching in protected time (very rare in hospitals)

Choosing learning outcomes

There have been many claims about a very wide range of educational aims that might be achieved through learning in the community.

LEARNING ACTIVITY AND REFLECTION

Identify 2 or 3 ways in which CBE could enhance and add value to a medical curriculum with which you are familiar.

Make some short notes from your own experience and from your reading.

For each topic you have identified consider

(1) Learning outcomes

(2) Where the teaching should take place

(3) At which point in the curriculum the community element should be introduced.

Keep your notes and refer to them as you read on through the paper.

Through CBE students may acquire specific skills, knowledge and appropriate attitudes, these are listed in the table below.

Potential learning outcomes of community based medical education

Important or unique opportunities for student learning are said to include:

1 The community

- Increased overall relevance of curriculum
- Awareness of the social influences on health
- Assessing patients in their own environment

2 The individual

- Understanding help-seeking behaviour and the unique experience of illness
- Biopsychosocial approach
- Patient-centred approach
- Living with chronic diseases
- The natural and treated progression of diseases through the continuity of care

3 The family

- Social relationships and systems
- Hereditary and genetic conditions

4 Clinical skills, clinical method and clinical reasoning

- Acquiring basic clinical method
- Doctor-patient communication skills
- Integrating knowledge and skills

5 Clinical specialties, disease management and procedures

- Broadening or substituting experience of specialties e.g. paedcs, O&G, ENT, etc
 - Appreciating range of normal
 - Dealing with uncertainty and using time as treatment/diagnostic tool
 - Involving patients in treatment decisions and care
 - Ethical aspects of care (e.g. confidentiality, patient autonomy and adherence etc)
- 6 Concepts of health and illness
- Health promotion and disease prevention
 - Disability and handicap
 - Medically unexplained symptoms
- 7 Provision of health care – especially primary health care and public health medicine
- Primary / secondary care interface
 - Management skills
 - Teamwork skills
 - Public health and community interventions
 - Inter-sectoral interventions
 - Role of voluntary/non governmental/ social care agencies
- 8 Social responsibility and moral reasoning
- Increased capacity to address health needs of medically under-served communities
 - Increased willing to take socially responsible action
- 9 Approaches to learning
- Cultivation of self-directed, lifelong learning
 - Application of learner-centred methods
- 10 Increased interest in primary care careers

When choosing your learning outcomes or goals you will need to consider the stage the students have reached in their curriculum, (see next section) what other courses they are taking at around the same time and how your teaching links with previous and future CBE.

As the proportion of time students spend in community placements increases the need for selecting clear goals for each placement becomes increasingly important. This will help you choose the most effective teaching and learning activities that reinforce rather than repeat activities. Having an idea of a spiral “CBE curriculum,” where some goals are revisited while new and more complex ones are added. Remember the spiral curriculum when making decisions about introducing new opportunities and when existing courses appear to have lost relevance.

Evidence of the impact of CBE

As with many aspects of medical education, robust research evidence that interventions achieve the desired outcome is difficult to generate.

Nonetheless CBE has been subjected to considerable scrutiny over the years and the following findings have been made:

- Broadly speaking, well planned and properly funded CBE interventions produce similar outcomes when compared to traditional hospital based teaching – for example when teaching basic internal medicine (see work by Murray).
- CBE can add value to learning in particular a broader understanding of the patient's experience of illness and health and the population dimension (for example the family studies undertaken in Newcastle for the last 20 years).
- CBE has positive effects on tutors' morale.
- Evidence that CBE influences primary care career choice in the UK is scant but may be linked to the length of attachments.
- On the other hand there is evidence from abroad that poorly executed CBE has lasting negative effects on students views of primary health care practitioners and careers.

A CBE curriculum - what to teach when

The growth of CBE means there are now examples in the UK of CBE in each year of medical school – from the first day students arrive till the day they sit their final exams: at least one medical school now has an intercalated BSc in primary health care.

Figure 1: Key curriculum areas, the development of clinical expertise and the place of community based education.

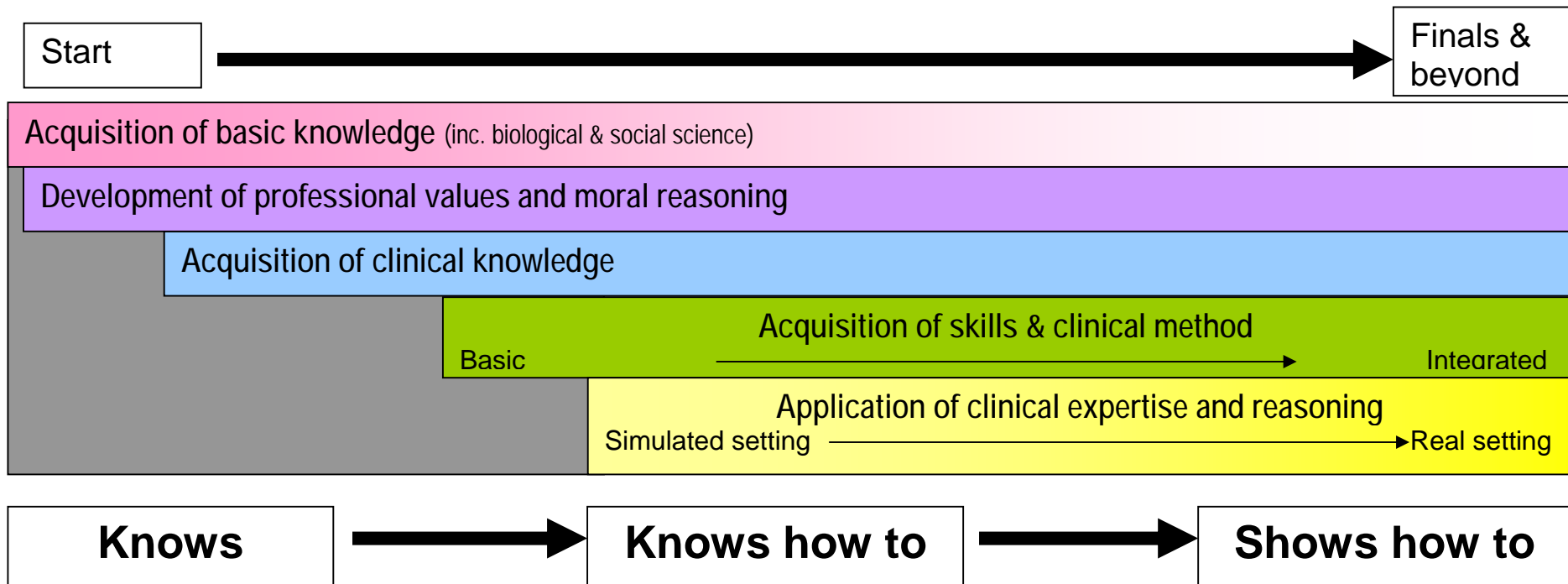


Figure 1: The development of clinical expertise can be seen as a transition for the student over time from the acquisition of basic knowledge, skills and values through to the application of these in real settings. This transition can be subdivided under contemporary curriculum areas. Examples of successful **Community based education** can be found at each stage and in each area of the curriculum.

There are no hard and fast rules about what to teach when but here are three tips that may help you identify the most appropriate goals and teaching method for your setting

Tip 1. Development of clinical expertise

Know → knows how → shows how

The first tip is considering where the learners are in their journey towards clinical expertise. (see figure 1) Are they early on - in need of an opportunity to deepen their understanding in a basic area such as sociology or are they ready to learn how to examine a patient? Are they so near to assuming real responsibility as a PRHO that they need supervised opportunities to rehearse and show the range of their expertise with real patients?

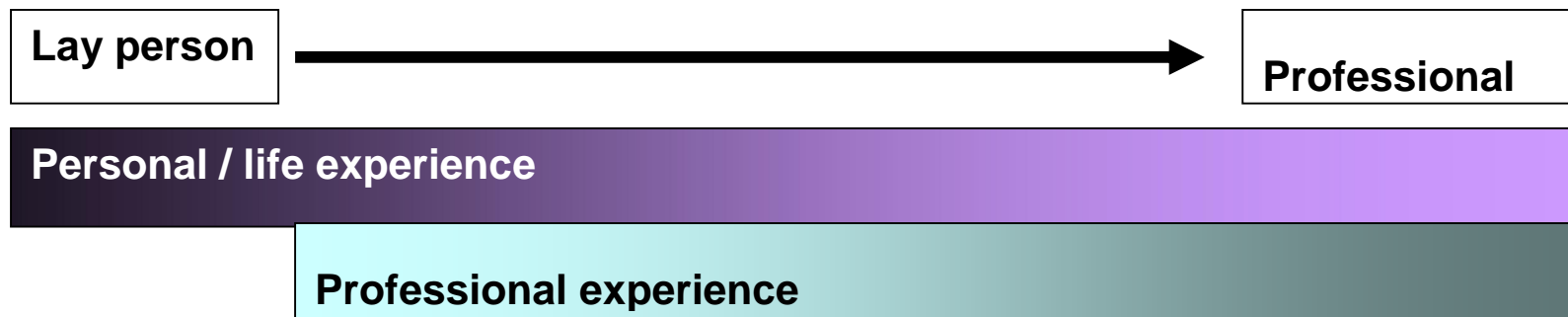
Tip 2. Professionalisation

Lay person → Professional

The second tip is considering whether CBE might be an opportunity to strengthen (or preserve) the student's appreciation of the lay experience of health, illness and health care, see Fig 2.

Figure 2: Lay - to - professional transition

Figure 2: In addition to the transition the student goes through in order to develop professional expertise s/he will also pass through a transition of identity from lay person to doctor. It has been suggested that the speed at which medical students become socialised into their professional identity means that they lose touch with the lay perspective and ultimately patients' needs early in their careers. Experience in the **community** – particularly involving patient-teachers, non clinical settings and reflective tasks - can be designed to ensure learners focus on the personal aspects of health and health care as it effects others and themselves.



Successful examples of this type of CBE tend to be found in very early stages of the curriculum – often linked to medical sociology and psychology courses or papers. However well chosen CBE can also help to sustain medical students' personal awareness and insight at later stages. Detailed case studies using the patient's narrative, or reflective diaries and significant event analysis can be used at later stages.

Tip 3. The CBE Experiential learning cycle

This may sound like a bit of unnecessary jargon but the experiential learning cycle is a useful concept and helpful for planning your CBE. The cycle is a basic educational concept which simplifies ways of getting the most out of a learning experience into 4 steps. For every CBE experience you provide your student:

Step1 - think carefully about how you will ensure that all 4 steps are also provided for. The more active the initial experience the greater the learning potential – make observation active too.

Step 2 - ensure there is time built in for reflection and feedback .In our experience students greatly appreciate and benefit from good feedback from and discussion with teachers and peers. Some students are resistant to evaluating themselves and undertaking reflective tasks. Training them to evaluate and give feedback to peers as early as possible in the curriculum may help to overcome this resistance to self -evaluation. Look at the e-learning module *How to give feedback* for some tips on giving feedback.

Step 3 - reflection and feedback broadens and deepens general learning from the specific experiences. At this stage students are making connection between existing knowledge and skills and revising or modifying these in the light this new experience

Step 4 – providing opportunities to apply what has been learned - needs to be as soon after feedback as possible when mastering skills. CBE is ideally suited to ensuring learning involves a range of patients and settings.

In summary some experiential learning works well in one-to-one contexts but at other times you may need to brief and debrief students in groups with their peers for the students to get best value.

Once you have considered these 3 tips you will have a good idea about the activities necessary for your students to achieve the learning outcomes that you have identified. You will be able include the “resources” you will need (teachers, patients, time and materials) in your plans.

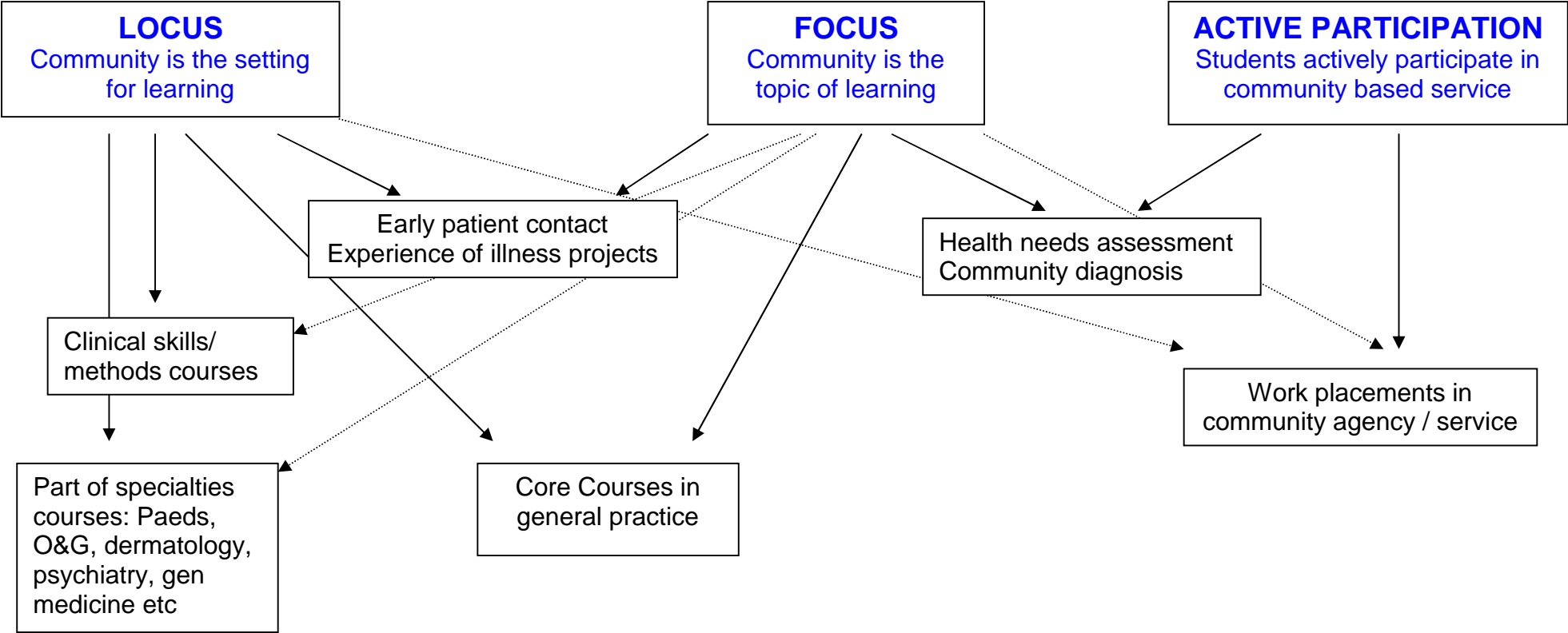
Golden rules for choosing learning activities

When considering which activities are best suited to your teaching you should bear in mind 4 golden rules.

1. *Combining locus and focus*

As described earlier much of the recent growth in CBE began as a way of maintaining patient contact for students when hospitals were unable to cope. Often this led to using the community merely as an alternative locus to plug gaps in hospital based student experience. One golden rule is to ensure that CBE adds value to learning by for example focussing on multi-disciplinary care and visiting people at home thus ensuring that community is part of the key focus of the learning.

Figure 3: Community based education – an overview



2. *Collaboration and Administration*

Apart from some Core Courses in general practice all CBE relies on good links with other parts of the curriculum. It is a golden rule to collaborate closely and openly with colleagues from other disciplines especially over aims, material, assessments and timetables. It is also important to invest in your own administrators and make friends with central medical school personnel. Last but not least course planners need to work hard to create, support and maintain a large, dispersed and varied *virtual* campus of potentially isolated teachers. Regular meetings, training and good course materials can all help. Some areas have developed community based education facilitators supporting teachers in the field.

3. *Community participation*

Learning activities which involve students directly in real work for community agencies have great appeal but have had widely varying success with students and the agencies involved. Medical students can find it hard to see the relevance and agencies can feel "used". On the other hand the learning may be deep and very satisfying as students are introduced to new and real community experiences. The golden rule is don't introduce community participation without providing good support for agencies and clear briefing and debriefing for students.

4. *Role modelling & one-to-one placements*

Every contact with a teacher has the potential to influence the learner in subtle but lasting ways – both positively and negatively. With the growing number of medical students, some CBE courses, notably GP core courses and to some extent clinical method teaching now represent the only true small group or sustained one-to-one student/teacher contact. Make it a golden rule to be aware of the attitudes and behaviours you are modelling especially in your dealing with colleagues and patients.

Preparation

Time invested in preparation and anticipating problems is always well spent. For some situations effort put in early reaps later benefits – for example re-using lesson plans for structured teaching, adapting timetables from course to course and having contingencies in case plans go awry.

1. *Prepare & train yourself*

Many medical schools provide specific or generic courses for community based teachers. Find out what is available – it may be free and cover your expenses. Having previous teaching experience (for example being a PG trainer or a nurse tutor) is a great help. Make no assumptions – think carefully about the differences in motivation and experience of each type of student.

For specific structured teaching sessions use lesson plans. See the e-learning modules: *Setting learning objectives*, *Small group teaching* and *Assessing educational needs* for examples and ideas. They are simple to use and you can revise them in the light of experience. Keep notes of your teaching and any feedback you get in your learning log and put it in your Professional Development Portfolio! See Annex 2 for some sample lesson plans.

2. *Prepare practice*

A medical student is for the whole practice – not just for Christmas. Try to create a teaching and learning culture. Make sure your nursing, administrative and medical colleagues are informed of your teaching commitments. Get your practice manager on your side to help draw up timetables, confirm arrangements with patients and other members of the team (remember most medical schools include a small element for administrative costs in your funding).

Prepare a file of things to do with students if patients booked for a protected teaching slot don't show up – blood results, photos from medical magazines, etc. Similarly – think about tasks students can do if you are unexpectedly delayed. CDROMS and a library come in handy here.

Look carefully at the space and time you have – is it adequate?
Have you booked out enough patients to make teaching realistic?
Can you avoid interruptions?

3. *Prepare patients*

There is growing evidence that patients enjoy contributing to teaching students but they need to be informed clearly as to what type of commitment they are making. Some are happy to be examined, some prefer only to talk about their conditions and experience.

As soon as you have decided to teach in the community start asking patients if they might like to be involved and set up a register of suitable volunteers. Many patients are happy to contribute regularly but there are reports of patients becoming fatigued so watch out for this.

In all cases gain clear unpressurised consent from patients. When teaching in routine consultations seek consent BEFORE the patient meets the student – it is easier for the patient to refuse if they so wish. Put a sign up in the waiting room/reception area informing patients of your relationship with the medical school and the patients' right to refuse to see students. You could display the student's name if appropriate

4. *Prepare Students*

Ground rules are essential for happy relationships. Be sure to give clear information about your expectations about their attendance, timetables, assessment, what to do in an emergency and car parking at the outset. Give them advice about your area and staying safe. Expect to know where they are. Make them feel at home – pastoral care creates a great impression.

While you should get good notice of your students' attachment you may not receive much information about the individual(s). Make sure that you spend time taking a learning "history" and making an educational "diagnosis". Use similar skills as you would if finding out about someone's health needs and if possible prepare a management plan with students on their arrival. Be sensitive – occasionally students on one-to-one attachments share their personal worries with GPs/nurses – encourage them to contact their personal

tutors or GPs as appropriate. Think twice before offering advice or treatment – combining an academic and a therapeutic role may lead to blurring of boundaries which ultimately may not be in the student’s (or your) best interest. Contact the medical school or GP course co-ordinator if you think there is a major concern.

When your student(s) arrive in the practice, make sure they have a corner to nest in, if possible allow them appropriate access to a PC (with a firewall). Note – students far away from base may have a “learning contract” with the medical school to check their email every few days – look into how you might deal with this.

Don’t introduce students as doctors if they are not!

Teaching methods & learning activities

As there is such a wide range of potential learning outcomes associated with CBE many examples of teaching methods and learning activities have been developed over the years. These include short free - standing projects, fully developed independent courses (typically GP “core courses” – one-to-one for up to 8 weeks) as well as courses that that have developed in collaboration with hospital specialties and other disciplines.

Summary of key types of CBE

TYPE	SPECIAL FEATURES
1. Early Patient Contact:	Focus on lay person’s expectation and experience
2. Community participation:	Students make a direct contribution to community
3. Clinical Skills/ Method	Structured small group teaching in protected time with selected patients
4. Specialty Teaching	
5. Core General Practice Courses:	One-to-one attachments
6. : Population oriented tasks	Health Needs Assessment
7. Longitudinal attachments:	“Adoption” of student by single GP/community for 1 year of more

We have expanded this list as in Fig 3 (above) and in a table of successful examples, see Annex 4 *Summary of examples of successful CBE in UK – with tips for teachers.*

LEARNING ACTIVITY AND REFLECTION

Seven teaching scenarios

Each of the scenarios describes a teaching activity in a different setting some involving nurses or postgraduate. Read through all the scenarios and choose ONE that relates most closely to your own actual or projected teaching experience. Follow the instructions in your chosen scenario and use the learning log to record your answers

Scenario 1 Sociology & epidemiology (yr 1)

Scenario 2 Clinical method or basic clinical skills (yr2 -3)

Scenario 3 Core general practice course (yr 4-5)

Scenario 4 Specialty (paeds) Medical Student with Health Visitor (yr 4)

Scenario 5 District Nurse with nursing student (yr2)

Scenario 6 Postgraduate GP registrar

Scenario 7 Overseas visiting doctor

For each scenario:

- read the relevant sections in the text
- answer the questions.
- look in the Golden Rules section (above) for teaching activities and preparation
- look in the Tips Section above

Scenario 1

1st year medical students undertaking a foundation course including an introduction to medical sociology and epidemiology.

You have been asked to consider a single or series of community placements (up to 6 half days) to complement this course. You have 12 students and you can place them in any size group.

You need to decide how you should brief and debrief them

Scenario 2

2nd or 3rd year students learning basic clinical skills or method as part of a introductory clinical firm or course You are a general practitioner preparing to teach a group of four students how to examine the cardiovascular system in your general practitioner's surgery. They will be coming for a two-hour teaching session (in protected time) in four days time. This is the first of a series of six weekly sessions and your brief from the medical school is to teach them basic clinical examination skills. They are on their first clinical firm at the local teaching hospital.

Scenario 3 a

Core General practice course (yr 4)

Your practice has decided take a 4th year medical students for 4 week Core Course. You note that much of the emphasis of the aims is help the student learn through consulting.

Scenario 3b

Core General practice course (yr 4-5)

You feel it is appropriate for your students to learn to reflect and think critically and at the suggestion of the department of general practice in the medical school you ask the student to undertake a reflective task in the "significant

event analysis". What is your role in mentoring and what are the possible pitfalls?
(see the paper in this series: *Mentoring: theory and practice* for more ideas)

Scenario 4

A health visitor takes a medical student as part of a paediatric attachment on a home visit.

What specific learning related to child health can be achieved teaching in the community for this scenario?

What are the practical and educational issues? Outline how you organise the student's time with you to maximise her learning

Scenario 5

A community nurse has a nursing student work shadowing for two days.

What might the learning outcomes be for this short intense attachment?

What are the practical and educational issues? .

Scenario 6

Your partner's GP registrar asks you about a sensitive case

What is specific to teaching in the community for this scenario? Outline how you would respond to this request.

Scenario 7

A general practitioner has a colleague from abroad sitting in a morning surgery.

What is specific to teaching in the community for this scenario?

Outline how you organise your colleague's time with you

Quality assurance

Monitoring the quality of CBE is notoriously difficult. Students will usually be given evaluation forms to complete either (a) by you at the end of the attachment (b) in the medical school at debrief sessions (c) at the time of exams or assessment.

If you are asked to hand out forms – make sure you do it – otherwise you won't know how well you are doing. Make sure you follow good practice –, give them out AFTER any assessment and allow students to complete them anonymously. Stress the need for the feedback to be constructive and specific. Feedback should be anonymous (if there's a group) – make sure the medical school department responsible for your course gets copies.

For more about educational quality monitoring and evaluation see the paper in this series: *Evaluating teaching and learning*.

If you don't get feedback, ask for it, from students and the medical school! If your feedback identifies problems ask for help. This should be ensured through medical school teaching quality assurance arrangements and you should be offered help automatically.

Assessing students in community

For detailed information about assessment of students' performance, see the e-learning module *Workplace based assessment* and the *Assessment* paper in this series.

Methods for assessing students will rest largely on the intended learning outcomes. As a general rule the key methods used are as follows:

TYPE	ASSESSMENT
1. Early Patient Contact:	Student written report +/- Tutor assessment forms
2. Community participation:	Student written report +/- Tutor assessment forms
3. Clinical Skills or Method	Structured tutor assessment forms + OSCE/ OSLER +/-MCQ or MEQ exams
4. Specialty Teaching	
5. Core General Practice Courses:	Structured tutor assessment forms + written work (ie case study, SEA) + tasks (ie audit,)

Assessing attitudes

It is worth noting that much CBE provides very close contact between students and tutors. There is an increased emphasis on the assessment of attitudes and values and the students' approach to patients and colleagues in real settings. CBE tutors are, in our opinion, quite reasonably expected to comment on these aspects. Make sure the students know this. Assessment of attitudes is an imprecise procedure so therefore provide evidence to support your view.

See also *Facilitating professional attitudes and personal development*.

Final self-assessment activity

Now that you have studied the paper, plan your next Community based teaching session using some of the ideas incorporated in this paper (or imagine a session if you do not currently teach in the community).

When you have carried out the session, carry out this activity and fill in the answers to the questions below in your learning log.

Compare your answers for the initial self-assessment with your final self-assessment

- *How did you prepare for the session?*
- *What was the content of the session?*
- *Which teaching methods did you use?*
- *What did you do at the beginning of the teaching session?*
- *What did you do in the middle of the session?*
- *What did you do at the end of the session?*
- *Did you do anything after the session?*

Web links

There is little on the web that is specifically for CBE teachers but try the following:

See the GMC website for their take on CBE – especially Tomorrow's Doctors 1993 and 2002 at <http://www.gmc-uk.org>

For more info on Community Oriented Medical Education try Towards Unity for Health Network: Community Partnerships for health through innovative education, service and research
<http://www.network.unimaas.nl/>

References and Further reading

Brookfield, S 1983. Adult Education & the Community Open University Press, Milton Keynes

There is a rapidly expanding literature so a Medline search will yield plenty – as will a hand search of the journals Medical Education and Medical teacher

Overview : Anything by edited by John Bligh, Carl Whitehouse or Robin Fraser will give good background as they have years of experience in the undergraduate community based field. (both have edited books on the topic)

For specific topics

Core general practice attachments – various papers over the years see for example Rosenthal and Lloyd

Teaching Clinical skills/general medicine in the community search for papers by Elizabeth Murray et al for a range of aspects (outcomes, impact on teachers and patients) Also look at Parle and Booton/Fine/Seabrook . Also Oswald (although his parallel track course is now defunct)

Reviews of teaching by departments of general practice in the UK John Spencer and colleagues at Newcastle have undertaken, amongst other aspects

Professional development and Public Dimensions Amanda Howe and Anne Stephenson amongst others

Reflective practice through Significant Event Analysis – see Henderson, Berlin & colleagues

Career Choice & primary care – see JM Morrison and (for general data) try Goldacre/Lambert/ Parkhouse

Appendix 1

Community-oriented medical education

Community-oriented medical education differs from community-based medical education in that it refers to a curriculum *strategy* rather than a *location* for learning. Through community-orientation the curriculum or a course gains relevance to the community in which it is situated. It is defined as education that is "...*focused on populations, groups and individual persons which takes into account the health needs of the community concerned*".

Knowledge of the local health needs is paramount as are linkages and partnerships between the medical school, health services and local community. Local epidemiology is an essential resource for *focusing* courses or curricula and *orienting* them to the needs of the host community and community-participation in the management and design of the curriculum is advocated as an important objective.

There is a strong theoretical link between community orientation and community-based teaching. In addition the application of problem-based learning is commonly associated with community oriented programmes. Thus the community is both the principal *focus* and *locus* of the curriculum in truly community oriented medical schools.

For more information try:

The Towards Unity for Health Network (TUFH): Community Partnerships for health through innovative education, service and research

This is a Non-Governmental Organisation in official relationship with the World Health Organization (WHO). It promotes the dissemination of new ideas, experiences, and results from research relevant to its aims.

TUFH Network also publishes the peer-reviewed, unique online open access journal, Education for Health.

www.network.unimaas.nl

Annex 2

ANNOTATED LESSON PLAN FOR SKILLS TEACHING		
Subject/Title _____ Length _____		
Objectives _____ _____		
Time	Content	Aids/Tasks/Exercises
Introduction		
	<p>O= share objectives – make them clear and do-able</p> <p>M= establish mood with ground rules, providing comfort</p> <p>M=Motivate , share your enthusiasm, relate to real clinical situations you and the students have seen</p> <p>U = utility – explore with the students why the topic is important</p> <p>C = outline the content of today’s sessions</p> <p>K = establish the student previous knowledge and experience</p>	<p>Flip charts</p> <p>Provide refreshments, start on time....</p> <p>Give a clinical example form your own experience</p> <p>Discuss evidence-base and epidemiology</p> <p>Take an educational “history” – what has already been done – to what level of expertise</p>
Body		
	<p>Vary the activities – deconstruct, part teach, talk through</p> <p>Ensure understand equipment Introduce patient</p> <p>Use examples & relate to basic science</p> <p>Use interaction & questioning</p> <p>Check understanding frequently</p> <p>Involve all the group</p> <p>Provide plenty of</p> <ul style="list-style-type: none"> • time to think • opportunities to practise skills - overtrain • specific feedback 	<p>Ensure patient(s) are invited and confirmed</p> <p>NB work hard to attend to patients needs while focusing on the students</p> <p>Diagrams (get students to draw on a flip chart)</p> <p>Rotate tasks – get some giving feedback while other tries out</p>
Close & Summary		
	<ul style="list-style-type: none"> • No new material • Summarise –involve students & provide sense of achievement ! • Plan ahead - Set homework 	

EXAMPLE LESSON PLAN

Subject: Heart Sounds

Date 08/09/02

Objectives: By the end of the session each student will have:

- Reviewed anatomy and physiology of heart valves
- Related this to the mechanism by which heart sounds are generated
- Heard the heart sounds in a patient with Aortic Stenosis (AS) concentrating on the 2nd sound
- Related these findings to the patient's history

Time	Content	Tasks/exercises/aids
<i>Introduction</i>		
14.00	<ul style="list-style-type: none"> • Check they are all comfortable, and that there are no 'burning issues' • Introduce subject • Check whether they have heard any murmurs yet and do they know what they heard and why? (<i>checking prior knowledge</i>) 	<ul style="list-style-type: none"> • Present case of Mrs F, to show why knowing about murmurs is important and remind them that they are common short cases in finals
<i>Body</i>		
14.15	<ul style="list-style-type: none"> • Go over anatomy • Look at relevant physiology 	<ul style="list-style-type: none"> • Use diagram of heart • Get students to explain cardiac cycle and normal heart sounds
14.25	<ul style="list-style-type: none"> • Look at what damages heart valves • Get students to think how this could affect blood flow 	<ul style="list-style-type: none"> • Picture of stenotic valve • Use diagrams in text book
14.30	<ul style="list-style-type: none"> • How does damage affect heart sounds? • Learning to pick out changes in heart sounds 	<ul style="list-style-type: none"> • Use CD of heart sounds and phonocardiograms
14.50	<ul style="list-style-type: none"> • What symptoms might arise in valvular disease? • What questions would we want to ask in a history? 	<ul style="list-style-type: none"> • Get students to think logically, (causes and haemodynamic effects) • Brainstorm list onto flip chart and order it
15.00	<ul style="list-style-type: none"> • Introduce patient (Mrs A with AS) <p>Giving feedback on specific skills Encourage students to give feedback to peers</p>	<ul style="list-style-type: none"> • Student take a history and then examine her in turn*. • Students draw (flipchart) what they heard and make diagnosis
15.40	<ul style="list-style-type: none"> • Discuss findings 	<ul style="list-style-type: none"> • Re-examine Mrs A as necessary
<i>Summary</i>		
15.50	<ul style="list-style-type: none"> • Summarise important points <p>Remind them: asthma next week!</p>	<ul style="list-style-type: none"> • Get each one to say what they learned from the session • Give handout

Based on original by Dr Sarah Hartley

BLANK LESSON PLAN-

SUBJECT

Objectives _____ -
_____-
_____ -

DATE _____ -

TIME	CONTENT	EXERCISES
<i>Introduction</i>		
<i>Body</i>		
<i>Summary</i>		

Annex 3 Examples of learning activities in GP core courses

All UK curricula now include at least one (sometimes two) primary care/GP Core Courses (CC) of between 3 and 8 weeks in the 4th and/ or final year. Increasingly the *only* one-to-one clinical attachment. CCs provide sustained CBE and may be linked to other courses such as public health, rehabilitation medicine and care of the older person.

GROUP WORK: 1-to-1 attachments are enhanced by some group work (in briefing/ debriefing sessions or seminars) to (i) allow exchange of experience with peers (ii) add some “theory” to the practice based learning. (see notes marked with asterisk)

	Description of activity	Notes
1. Setting scene <i>Individualising learning</i> <i>Personal development</i>	Personal learning objectives, learning styles and ground rules	Essential for 1-to-1 attachment – some students & GPs email before start
2. Consultations <i>Clinical method (including communication skills)</i> <i>Integration of skills & knowledge -> expertise</i> <i>Application of advance communication and clinical reasoning skills</i> <i>Disease management</i> <i>Students attitudes to patient observable</i>	Interview patient re: expectation before & satisfaction after observing consultations Involve student in consultations <ul style="list-style-type: none"> • Active observation of consultations) with a specific task • 3-way consultation (patient, teacher, student) • student conducting consultation - observed by teacher • student conducting consultation audio taped or video taped - for later analysis with teacher 	Focuses student on the lay (rather than medical) perspective This is the “bread & butter” of GP attachments. It is essential to tailor to the stage of student’s development of clinical expertise Rare opportunity for senior students to do whole consultations including information sharing, decision making and management planning
3. Service provision – impact on patient <i>Continuity & Primary/secondary interface</i>	<ul style="list-style-type: none"> • Assessment & Follow • Arranging Referral & Admission to hospital • Hospital discharge planning 	Understanding the place of community service core topic * Especially important for senior students

4. Multidisciplinary team <i>Skills mix and team working</i>	Active observation of range of professionals working in clinic or patient home Attending meetings	Essential element to a CC* Careful thought needed to keep learning active, prepare & support staff
5. Case studies – visiting at home <i>Patient's/carer's narrative</i>	Chronically ill person or disabled adult or child Life of a carer, Pregnant or new mother	Brief patients – they can be expert teachers . Good vehicle for understanding teamwork & lay perspective
6. Reflective practice (eg. Diaries, significant event analysis, portfolios) <i>Students narrative</i>	Identifying the personal / ethical dimensions of patient encounter	Valuable way to promote insight in own values and actions BUT students resist – train tutor to support & debrief in groups *
8. Practice studies, <i>Population medicine, governance & audit</i>	Evaluation of care provided by practice team e.g. diabetes, hypertension, needs assessment	Ensures community orientation , puts in context unpopular topics. Making a presentation adds value*
7. Opportunistic learning	A patient death, complaint , modelling good practice etc	Too numerous to mention but tutor input needed

Annex 4 Summary of examples of successful CBE in UK – with tips for teachers

Year	CBE Type	Links to	Format/group size	Description	Tips
1 & 2	Early Patient Contact	Sociology, psychology, epidemiology, comm skills, specific body systems, PD	Visit patients in pairs often at home/ GP surgery Briefing & debriefing in groups . Single or series of visits	Focus on lay persons expectations & experience of health & illness e.g pregnant woman, disabled person, chronically ill adult & carer	<ul style="list-style-type: none"> • Ask students to write-up patient narratives • Pool data from individual patients to give population perspective
any	Community participation	PD, sociology, epidemiology	Placement in small groups +/- larger group meetings	Students devise intervention for real need identified in community e.g supporting teenagers mothers, encouraging over 75's to go to gym etc	<ul style="list-style-type: none"> • Brief students carefully • Support non-medical agencies • Identify & train agency based facilitator
2 & 3	Clinical Skills or Method	All early clinical attachments	Small groups 4-6 From half day to full time 4 – 8 weeks	Structured teaching in PROTECTED time Patients with illustrative stories & physical signs selected specially for teaching	<ul style="list-style-type: none"> • Train yourself/ teachers • Focus on patient –centred approach & giving feedback • stress importance of students attendance
3 – F	Specialty Teaching	Examples inc. Int medicine, O&G, ENT, dermatology, paed, rheumatology, psychiatry, care of the older person	Small groups 4-6 Usually half or one day during each week of specialty course. May completely replace course	Structured teaching in PROTECTED time Opportunities for learning skills, problem solving clinical management.	<ul style="list-style-type: none"> • Collaborate carefully with specialists re: aims, assessment & timetables • beware of patient fatigue • stress importance of students attendance
4 – F	Core General Practice Courses	All other CBE – often stress com skills. May inc. link to specialties e.g. dermatology, rehab	One-to-one placement with Brief/debrief in groups . May inc. small group sessions e.g. comm skills, chronic diseases	See Annex 3	See Annex 3
Any	Health Needs Assessment	Epidemiology and public health, sociology . May be part of Core GP course	Varies Usually attached to a GP surgery	Students put together a HNA using routinely available data & interviewing key informants	<ul style="list-style-type: none"> • Brief /debrief well about methodology & implications • Ask students to present findings
Any	Longitudinal attachments	Varies	Ones or twos	Attachment to a single GP surgery or agency on regular basis for a year or more. Allows for mentoring & long tem view of community	<ul style="list-style-type: none"> • Difficult to organise with large student numbers • most likely to influence career choice

Notes:

F = final year of study , this is usually the 5th year but an increasing number of schools have a optional or mandatory 6th year because of a BSc

PD = Professional Development course (specific title varies form school to school).

Comm Skills = communication skills