
Community and Family Case Study: a community-based educational strategy to promote Five Star Doctors for the 21st century

Abdus Salam

Abstract

Introduction: Community and Family Case Study (CFCS) is an approach to community-based education (CBE) in the undergraduate medical curriculum in the School of Medical Sciences (SMS), Universiti Sains Malaysia (USM). CBE is a means of achieving educational relevance to community needs and subsequently in implementing a community oriented educational programme. The objective of this paper is to disseminate medical students' perceptions of CFCS as an approach to CBE.

Materials and Methods: a survey on CFCS was carried out in 2003 among 4th year undergraduate medical students of the USM belonging to the academic session 2002-2003. Sample size was 78. Data was collected utilizing a mixed type questionnaire containing different attributes of CFCS as a strategy of CBE and presented as numbers and percentage distribution.

Results: Fifty nine to eighty percent of the respondents perceived that leadership skills, positive attitude towards rural community, team building skills, communication skills and in-depth understanding of the health beliefs of socio-culturally diverse people have developed from the participation in the CFCS.

Conclusion: CFCS is a good approach of CBE, which promotes the development of leadership, team building and communication skills and an in-depth understanding of the socio-culturally diverse population which are the criteria for five star doctors advocated by the World Health Organization (WHO). Curriculum planners should give due importance on CBE and its effective implementation through close collaboration between health and educational administration. This paper offers other medical schools who wish to shift their curricula towards community based education, an opportunity to use the approach.

Introduction

The traditional teaching hospitals, the proverbial "ivory towers" are gradually turning into huge intensive care units and are no longer the only place to train the doctors for the 21st century (Benor, 2002; Lowry, 1992) as they fail to meet all the needs of society. Society expects tomorrow's doctor to be a good manager, leader, decision maker, care provider and also a good communicator. These characteristics are advocated by World Health Organization (WHO) in the five star doctors (Boulen, 1993).

Much of healthcare is now provided entirely in the community and with emphasis on epidemiology, health promotion and preventive medicine. Maintaining health is as important as treating diseases (Jira, 1994). Evidence-based studies show that a doctor's interpersonal and communication skills have a significant impact on patient care (Salam *et al.*, 2008; Rider & Keefer, 2006; Nobile & Drotar, 2003; Stewart, 1995).

Patients, public and even colleagues are dissatisfied with medical professionals due more to poor communication than to any other professional deficiency (Salam & Rabeya, 2004). CBE is an important strategy of the WHO in the education of health personnel for achieving the goal of Health for All (WHO, 1987). It happens outside the boundary walls of tertiary care hospitals, which makes health personnel responsive to the needs of the

Correspondence: Abdus Salam
School of Medical Sciences
Universiti Sains Malaysia
Email: salabdus@gmail.com
salam@ppukm.ukm.my

population they serve. CBE encourages a patient centered attitude (Lowry, 1993; Engle, 1992). Moving undergraduate education away from tertiary care hospitals into the community at large, gives students the advantage of getting real life experience, making them better able to meet the needs of the society.

Community and Family Case Study (CFCS) is a community-based educational (CBE) program conducted in the undergraduate medical education of the School of Medical Sciences (SMS), Universiti Sains Malaysia (USM), since its inception in 1980 (Rogayah & Hashim, 1990). The SMS, USM is the third medical school to be established in Malaysia and is situated in Kelantan, the Northeastern coast of the country. The USM undergraduate medical curriculum comprises of three phases of a total of five years duration leading to a MD. Phase I includes year-1, phase II includes years 2 and 3, and phase III includes years 4 and 5. The CFCS programme is carried out during phase II and phase III. In phase II, small subgroups of students are placed to stay with rural families as a community residency for two periods of 2 weeks each, once during the 2nd year and the other during the 3rd year of the course.

During the first two week community residency, students have to identify the health problems of the family with whom they are staying. They also have to observe the profile of the community and identify health resources available, what resources are utilized by the community and study the knowledge, attitude, practice and probable health and social problems that exist in community. The students carry out interviews with community leaders, traditional healers, midwives, and health personnel. They do health screening, anthropometrical measurement, dietary surveys, and stool and blood examination. The students observe and understand the psychosocial dynamics, communication patterns, pattern of health knowledge, skills and attitudes, and cultural and social patterns. During the second community residency, students plan and implement interventional programmes such as preventive, promotive, social, motivational, and educational health programmes.

Students usually work in groups of around 20 in different villages in an operational area. Each operational area usually has a health center, community clinic, a school, or a community hall. Lecturers supervise the groups and supporting staff such as the public health inspector, public health nurse and medical technologist assist the programme. Students do community diagnosis

and provide community treatment through organizing health educational programmes during phase II.

In phase III, students have to choose or adopt one patient, known as an individual case. They have to study this patient regarding his or her problem and provide proper management through relevant organizations or institutions and also provide health education. In addition, students have to choose another patient in a small group, known as a group case and need to follow-up this patient. Students usually choose patients either from the adopted family, an adopted community, a nearby health center, a university hospital or from a general hospital. Cases selected are usually from low socio-economic backgrounds and chronic in nature requiring regular health education, follow-up, rehabilitation or special coping arrangements. The follow-up of patients either individually or by group occurs through several home visits starting from year 4 to the middle of year 5 with a learning contract.

A learning contract is basically a negotiated agreement between students and their group supervisors on learning objectives which they will have to achieve in the CFCS programme. Problems and needs of the patients are to be identified and to be followed up according to learning contract. Hence, phase III programme is named as CFCS and contract learning.

The focus of CFCS in phase II is to identify and help to resolve the health needs of the family and their community whereas in phase III the focus is on the patients and their families. The objective of this paper is to identify students' perceptions of CFCS as an approach to CBE.

Materials and Methods

A cross sectional study on CFCS was carried out in 2003 among 4th year USM undergraduate medical students of the academic year 2002-2003. A mixed type instrument containing different attributes of CFCS as a strategy of CBE was used to collect the data. Sample size was 78. Students were asked to rate their response on different CFCS attributes. The rating scale used in this instrument ranged from strongly agree to strongly disagree. Students' rating of strongly agree and agree were combined together and considered as agreed whereas disagree and strongly disagree were combined together as disagreed. The data was then compiled, analyzed and presented as numbers and percentage distribution.

Results

Out of a total of 78 respondents 62 (80%), 55 (71%), 51 (65%), 49 (63)% and 46 (59)% respondents felt that CFCS provided them an

opportunity for in-depth understanding of the rural people, offered them an opportunity to develop communication skills, group management skills, positive attitudes and leadership skills respectively (Table 1).

Table 1: Students' Perception on Different Attributes of CFCS n=78

CFCS as an approach to CBE provided an opportunity to	Agree		Unsure		Disagree		No response		Total	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
in-depth understanding of rural people	62	(80)	6	(8)	10	(12)	0	(0)	78	(100)
develop communication skills	55	(71)	12	(15)	11	(14)	0	(0)	78	(100)
learn group management skills	51	(65)	11	(14)	15	(19)	1	(2)	78	(100)
shape positive attitude	49	(63)	13	(17)	14	(30)	2	(3)	78	(100)
develop leadership skills	46	(59)	18	(23)	12	(15)	2	(3)	78	(100)

Discussion

All medical professionals need to develop generic competencies or transferable personal skills such as management and organization, team work, communication and problem solving (Salam & Rabeya, 2004). To solve a health problem, it is necessary to understand the norms, beliefs, and prejudices of the diverse people of the community and also necessary to be aware of the role of social-cultural factors in the causation of disease. In the present study, 80% of the students felt that CFCS provided them an opportunity to come into close contact with rural people, which helped them to gain an in-depth understanding of the socio-cultural dimensions of the rural people. Once students have a better understanding of the diverse community population, they will be in a better position to handle community problems (Salam & Rabeya, 1997). The World Summit on Medical Education (WSME, 1993) recommended that to achieve community awareness, students need to develop skills in observation, reflection and communication. During the CFCS programme, students were encouraged to develop awareness on sensitive issues and empathic response to the needs and circumstances of people in the community.

The aims of the physicians are to cure sometimes, relieve often, and comfort always

(Loid & Bor, 1996; Salam *et al.*, 2008). To comfort always, tomorrow's doctors have to be skilled communicators. It is now established that patient satisfaction, compliance with medication and disease outcome are all associated with good communication (Ley, 1982; Simpson, *et al.*, 1991; General Medical Council, 1993; Royston, 1997; Salam *et al.*, 2008). Good communication is not an easy job; only a few can master it with special intuition and constant attention. Doctors who are skilled communicators are better able to listen, understand and comfort patients, liaise with the public and colleagues and speak for the community and society. Formal teaching sessions in communication skills in the classroom were not shown to be very effective in learning communication (Royston, 1997). In the present study, the CFCS programme as an approach to CBE, provided students a real exposure where they communicated with patients, families, different health personnel and also personnel from other sectors. Seventy-one percent of the students were of the opinion that the CFCS helped them to develop their communication skills. This finding indirectly supports Royston's statement where majority of the students learnt the communication skills outside the class room. Communication skills can be learnt and developed by 'doing' rather than by teaching or reading books (Loid & Bor, 1996).

Group management or team building and leadership skills are important skills that every future doctor needs to possess. This will enable them to work as a member of a team and to share their knowledge and skills with other members of the team (Jira, 1994). In this CFCS program, students worked in groups and subgroups with different assigned tasks and responsibilities with other healthcare professionals engaged in development activities in the community. This study revealed that as a result of participation in CFCS, 65% developed team building and 59% developed leadership skills, which are important attributes for future doctors to master in order to address community health problems.

Knowledge, skills, and attitudes, the three domains of education and training considered separately, do not exist independently. The affective domain relates to emotions, attitude, appreciation and values. Through close contact with the people of the community the students learn to appreciate their varying socio-cultural norms and beliefs and develop a caring attitude towards the rural community (Stewart, 1984; Royston, 1997). This study indicates that 63% of the students developed positively towards the rural community.

CBE programmes have two pragmatic outcomes. First, students can learn from the community. Second, the community benefits from the services given by the students. This study gives an insight of students' perceptions. A further triangulated study seeking feedback from adopted patients or patients' families or from the adopted community is suggested to verify the students' perception of the attributes required for five star doctors. Implementation of CBE programme requires much effort. Adequate fund allocation, appropriate utilization of funds and integrated policies need to be outlined through close consultation and coordination between the health and educational administration.

Conclusion

CFCS is a good approach to CBE. It offers medical schools who wish to shift their curricula towards a community-based approach a window of opportunity. Educational managers should give due importance to CBE. A conscious decision by curriculum planners regarding the organization and effective implementation of CBE through close collaboration between health and educational administration is of utmost importance, in order to produce five star doctors as advocated by the WHO.

Acknowledgement

The author would like to thank the group of CFCS phase III students of the academic session 2002-2003 of USM who assisted in data collection. Thanks are also due to the CFCS Chairman who supported this study.

References

- Benor, D.E. (2002) Faculty development, teacher training and accreditation in medical education: twenty years from now, *Medical Teacher*, 22, pp. 503-512.
- Boulen, C. (1993) The challenge of changing medical education and medical practice, *World Health Forum*, 14(3), pp. 213-216.
- Engle, C.E. (1992) Problem-based learning, *British Journal of Hospital Medicine*, 48, pp. 325-329.
- General Medical Council (1993) *Tomorrows Doctors—Recommendations on Undergraduate Medical Education*, (London, GMC).
- Jira (1994) Community-based team teaching program at Jimma Institute of Health Services, *Annals of Community Oriented Education*, 7, pp. 131-38.
- Ley, P. (1982) Satisfaction, compliance and communication, *British Journal of Clinical Psychology*, 21, pp. 241-254.
- Loid, M. & Bor, R. (1996) *Communication skills for medicine*, (New York, Churchill Livingstone).
- Lowry, S. (1992) Medical Education, *British Medical Journal*, 305, pp. 1277-1278.
- Lowry, S. (1993) Medical Education, *British Medical Journal*, 306, pp. 255-58.
- Nobile, C. & Drotar, D. (2003) Research on the quality of parent provider communication in paediatric care: implications and recommendations, *Journal of Developmental & Behavioral Pediatrics*, 24, pp. 279-290.
- Rider, E.A. & Keefer, C.H. (2006) Communication skills competencies: definitions and a teaching tool box, *Medical Education*, 40, pp. 624-629.
- Rogayah, J. & Mohd Hashim, M.H. (1990) Community and Family Case Study Program at the Universiti Sains Malaysia: An experience in self directed, contract learning, *Annals of Community Oriented Education*, 3, pp. 129-132.
- Royston, V. (1997) How do medical students learn to communicate with patients? A study of fourth year medical students' attitudes to doctor-patient communication, *Medical Teacher*, 19, pp. 257-62.

Salam, A., Ahmad Faizal, M.P., Siti Harnida, *et al.* (2008) UKM medical graduates' perception of their communication skills during housemanship, *Medicine & Health*, 3, pp. 54-58.

Salam, A. & Rabeya, Y. (1997) SPICES-an educational strategy for curriculum reform in medical school, *Journal of Medical Teachers Federation*, 3, pp. 25-26.

Salam, A. & Rabeya, Y. (2004) Education for capability, *The Healer*, 11, pp. 37-38.

Stewart, M.A. (1984) What is a successful doctor-patient interview? A study of four interactions and outcomes, *Social Science and Medicine*, 19, pp. 167-175.

Stewart, M.A. (1995) Effective physician patient communication and health outcomes: a review, *Canadian Medical Association Journal*, 152, pp. 123-133.

Simpson, M., Buckman, R. & Stewart, M. (1991) Doctor-patient communication: The Toronto consensus statement, *British Medical Journal*, 303, pp. 1385-1387.

World Health Organization (1987) *Community-based education of health personnel*: report of a WHO Study Group, Geneva, World Health Organization, 1987 (Technical Report Series No. 746).

World Summit on Medical Education (1993) *Recommendation of the world summit on medical education* (WSME), Edinburgh, Scotland 8 -12 August 1993, pp. 142-149.