Community Oriented Medical Education: The responsive model

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The overall goal of medical education is to prepare graduates who will contribute towards the improvement of health (quality of life) of the individuals and the communities they will be serving. Traditionally, a physician receives sophisticated training which focuses on bio-medical sciences, skills in diagnosis, therapeutics and clinical management. However the exposure to relevant social sciences that may prepare him/her to address the social, economic and political forces affecting health lacks in this traditional mode of education.

Inspite of the growing knowledge and availability of technology little headway has been made in the achievement of better health outcomes in most of the developing countries. Is it the content or the context of the education program that is amiss?

The Government of Pakistan is committed to review the existing health care system and medical education and make it responsive to the national needs[1]. For this purpose workshops and seminars have been organized for the medical professionals. The first of these was a workshop on "Augmenting component of Community Oriented Medical Education in Pakistan" conducted in Karachi in June 1994. The workshop recommended to direct the Pakistan Medical and Dental Council (PMDC) to review the undergraduate curriculum and explore the possibilities of international funding for setting up Community Based Medical and Nursing Education in Pakistan.

In November 1994, a National Committee on Medical Education was constituted. This committee recommended strategies for implementation and sent them to PMDC. In October,1995 a two year project was finalized and approved from the Government and WHO on Community Oriented Medical Education (COME).

The government of Pakistan with the support of WHO planned to introduce COME in four existing Medical Colleges of Pakistan, one in each province. This project was launched in 1996. The four medical colleges are Ayub Medical College (NWFP), Bolan Medical College (Baluchistan),Dow Medical College (Sindh) and King Edward Medical College (Punjab). This allows the medical colleges to participate and contribute to the education of physicians and improvement of health services. Each of these medical colleges is in the process of developing a curriculum responsive to the needs of the community.

What is Community Oriented Medical education ?COME is an approach to medical education. It is an education that focuses both on populations groups and individual persons which takes into account of the

Table 1. The differences between the traditional and responsible model

Traditional Model	Responsive Model (COME)
Responsibility to somatogenic illness of the sick individual, diagnosis and cure	Prevention and health maintenance, promotion given equal emphasis to cure
Pre-clinical comprehensive mastery of basic sciences, objective: bank of memorized knowledge.	Selective substantive mastery of foundation knowledge, Objective: understanding of principles of human bio-psycho-social behavior
Teacher directed and dominated, subject centered, student passive and dependent	Student centered: Student-Faculty partnership in learning
Didactic lectures prevailing with detailed syllabus of existing knowledge.	Problem based small group learning Objective: To prepare for self learning of constantly changing knowledge.
Discipline-oriented, step block teaching by autonomous departments.	Integrated, interdisciplinary: Horizontal across disciplines, vertical connecting basic, clinical, community and behavioral sciences.
Clinical application taught after basic science knowledge foundation	Clinical and community health relevance by exposure starting beginning of year one.
Patient seen as passive objective	Patient seen as partner in health transaction
Community health, population and behavioral science poorly represented	Community health, clinical epidemiology, research methodology, behavioral and school sciences adequately represented
Setting for teaching and learning: lecture halls, laboratories and tertiary care hospitals	Small group sessions, community based settings mix of primary, secondary and tertiary care settings
Student assessment: largely measures memorization of factual knowledge	Assessment: A priori of application of knowledge to solve problems, creativity, critical appraisal, clinical reasoning, mastery of clinical skills and professional attitudes.

community concerned[2]. In general terms COME can be defined as relevant medical education, as it aims at producing doctors who are willing and able to serve their communities at primary, secondary and tertiary level.

COME is not a new name for the subject of comunnity medicine. It does not aim to produce community medicine specialists but physicians who are responsive to the health needs of the populations and individuals. It is expected that whatever these doctors choose to practice as specialists or researcher or both, they will adopt a community oriented approach. They will initiate activities and address the problems at their source rather than only treating the cases when the problem has already arisen.

The differences between the traditional model and the responsive (COME) model described by Prof. Zohair Nooman founding dean of the Suez Canal University,Egypt, are given in table 1 [3].

There is a general fear that teaching and training using the COME approach will produce 'barefoot' doctors. It has been shown that the quality of learning, teaching, service and research are not compromised.

Table 2. Strategies for COME in the community, in the academic centre and
in the teaching hospitals.

1. IN THE COMMUNITY
- Visits to community centers
- Internship, clerking, apprenticeship
- Family assignment with home visits
- Living in the community for a period
- Team meetings & feedback conferences
- Working with an independent practitioner
- Epidemiological research, field project
- Elective placement
2. IN THE ACADEMIC CENTRE
- Work and seminars
- Introductory courses on behavior etc.
- Community problem solving in the classroom
- Small group discussions on community health issues
3. IN THE TEACHING HOSPITAL
- Early patient contact & follow-up
- Clinico-pathological conferences highlighting epidemiological principles
- Medical ward rounds emphasizing preventive and promotive aspects
- Ambulatory (out-patient) care clerkships

The performance of graduates of the schools which use the innovative approach (COME) was found to be comparable to graduates of the traditional schools[4]. None of the inter-school comparison indicated that the innovative schools performed worse than the traditional school in national examinations or clinical skills in residencies, but suggest that these graduates are better at problem solving. Schmidt et al in their review of 15 studies found out that a significantly larger proportion of graduates from COME programs sought careers in primary care[5] and Friedman et al have shown interpersonal skills, continuing learning and professional satisfaction to be the distinctive outcomes of COME[6]

The advocates of the traditional schools also feel concerned that COME will neglect the bed side training in the hospital. In community oriented medical schools, educational activities for clinical teaching are based in the hospital at the bed side and also in the ambulatory and out-patient departments[7] The community settings are chosen for clinical teaching because although hospitals are a part of the community, but the admitted sick do not represent the total sick population of the community. Therefore when clinical teaching is limited to the hospitals only, the doctors do not get an opportunity to experience the actual state of affairs, as it is well known that only 10% of the sick people report to the hospitals and out of these only 1% get admitted[2]. For a competent doctor it is therefore vital to be trained at all levels of health care i.e. tertiary, secondary and primary levels health care..

The Community Oriented Medical Education is therefore a health oriented physician education (HOPE) rather than a disease oriented physician education (DOPE) [(8)]. This will enable the future doctor to face the health challenges of the future due to poverty, high cost of health care, inequitable availability of health care, lack of community involvement and imbalance between curative, preventive and promotive services.

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