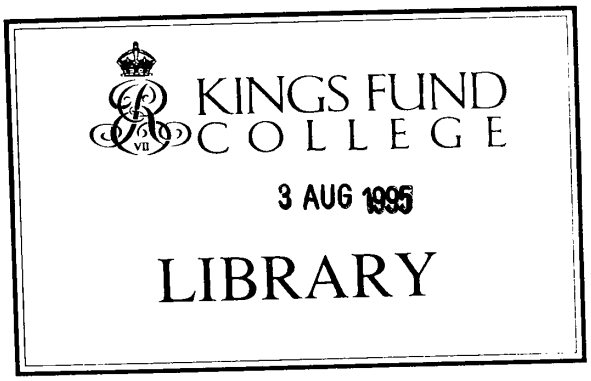
SHARING IDEAS 1

Community-based teaching

change in MEDICAL EDUCATION

Edited by Angela Towle



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Edited by Angela Towle

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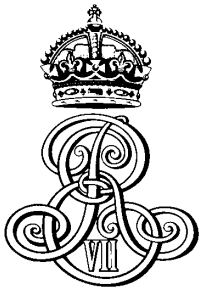

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I would also like to thank various colleagues who have helped me to think through the issues raised in this report, although they should not be held responsible for the final analysis. In particular, I thank the Enterprise Team at CELC and Nigel Oswald at Cambridge.

Executive summary

There is an unprecedented interest in community-based teaching among medical schools in the UK at this present time, and the last couple of years have seen the development of many community-oriented initiatives within the undergraduate curriculum. Although there has been a gradually increasing role for academic departments of general practice over the last 30 years, the present debate goes well beyond just expanding the role of academic general practice to encompass community orientation in all areas of the curriculum.

In many instances, recent community-based teaching initiatives have arisen as a pragmatic solution to local problems, particularly in providing students with sufficient clinical experience. These difficulties have arisen as a result of changes in the patterns of health and disease, in medical practice and in health care delivery leading, for example, to an expansion in the role of primary care in diagnosis and patient management. The impact of these changes has been most noticeable in London, but provincial medical schools are now experiencing similar problems, and it is certain that these trends are set to continue and possibly accelerate into the next century.

There is a danger that some community-based initiatives are merely a rapid response to external pressure and not part of any overall curriculum philosophy or plan within the medical school. They are often more a change in the location of teaching rather than a re-orientation of the curriculum. There is as yet no coherent philosophy of community-oriented medical education in the UK in relation to the need to produce doctors for the future who are responsive to the health needs of the communities they serve and the health services which employ them. There is a convincing case to be made that a community-oriented curriculum (which does not exclude some hospital-based teaching) is an approach which can deliver the kind of undergraduate medical education envisaged by the General Medical Council, and which accords with what is known and can be inferred about the future trends in twenty-first century health care and the likely roles and responsibilities of doctors.

Community-oriented medical education is conceptually challenging. Part of the problem stems from a lack of understanding about the meaning of community-based and community-oriented medical education, but also because it raises difficult questions: what sort of doctor are we trying to produce? what does a community-oriented curriculum look like in the UK? how would it work in practice? At present no-one is taking a lead in answering these questions which need to be addressed by a wider consituency than just the medical schools. Indeed one of the important features of a truly community-oriented curriculum is the partnership between the medical school and the community it serves.

Unless there is a coherent philosophy which underpins the various community-based initiatives which are currently being tried there is a danger that they will remain marginal to mainstream curriculum development and will not be sustained. In particular, they need to be included in the assessment system if they are to be taken seriously by students (and staff). On the other hand, they have the potential for being powerful forces for change in their own right if developed as part of an overall plan for curriculum change.

It might be helpful to set up a working group to help people to visualise what a community-oriented curriculum might look like, without prescribing any single model. The tasks of such a group might include: definition of the competencies required for a future doctor; development of rigorous aims and objectives and methods of assessment; identification of learning resources; identification of appropriate settings for learning and the mapping of resources; mechanisms for involving the community in curriculum development; relationship with postgraduate and continuing education.

Hospital-based medical teachers are not currently engaged in the debate about community-based teaching to any great extent. It is important not to perpetuate the divide between hospital and primary care/community. Community-oriented medical education is not just the preserve of departments of general practice. The community, general practice and hospitals each have a place within the undergraduate curriculum and the different roles and strengths of each must be defined in relation to the overall curriculum. Ways must be sought to involve hospital teachers in the debate at both national and local levels.

There is an urgent need to make available funding for educational research and development, and curriculum evaluation. The next few years look set to witness experimentation on a large scale and the pressure will be on to devise quick solutions as a response to rapid changes in the health services. If quality is to be maintained, and solutions are to be more than 'quick fix' measures, money will be needed for pump priming and evaluation.

Moving more teaching into the community is not a cut-price option. It will require some reallocation of resources from the hospital. At present there are no secure long-term funding arrangements in place which allow confident planning for the future on the scale which is required. No proper costings are yet available, but the kinds of things for which funding will be required are: remuneration of teachers (GPs and other community-based teachers, including patients themselves); adminstration and coordination; contributions towards student travel expenses; staff development.

In order to ensure that the quality of the education is maintained when students are dispersed over different sites and a wider range of teachers than before, it will be important to introduce staff development and training programmes. These should be for all those who are involved in teaching students.

If the academic staff of medical schools are to devote time to curriculum development they must be rewarded appropriately. This is true whether it is a community-oriented curriculum or not. It is a promising time to consider the introduction of a career track which allows those who are interested in medical education to concentrate on curriculum development and to pursue educational rather than scientific research.

Over the next few years of change and experimentation it is to be hoped that there will be a continued willingness to share ideas and experiences, and to work together to find solutions to common problems.

Chapter 1: Introduction

This report arises out of a conference held at the King's Fund Centre on 10 July 1992 on community-based teaching. The conference was the first in a series entitled 'Sharing good practice' which is designed to highlight key issues through the presentation and discussion of selected case studies, to identify new areas for development, and to identify constraints and problems and propose solutions. It was decided to focus the first conference on community-based teaching in view of the central importance of this topic in the current debates on the future of undergraduate medical education.

Various pressures are focusing attention on the place of community-based and community-oriented medical education in the UK in a way that has not been experienced before. Although there has been a gradually increasing role for academic general practice in the undergraduate curriculum over the past 30 years (Fraser & Preston-Whyte, 1988), encouraged in particular by the Todd Report (Royal Commission on Medical Education, 1968), the present debate goes well beyond just expanding the role of academic general practice to encompass community orientation in all areas of the curriculum. The reasons for this are discussed in Chapter 2.

The move towards more community-based teaching raises a number of issues which this report attempts to highlight, drawing largely on the experience of participants at the conference. It is not designed to be a comprehensive record of community-based initiatives in the UK, but does present some different approaches which have been tried or are being planned. The intention is not to define correct or preferred methods, but to provide a source of ideas and inspiration, as well as indicate possible pitfalls, at a time when great experimentation is underway and many medical educators are under pressure to develop in a short space of time new ways of teaching which are more in line with present and future health service delivery and which meet the latest guidelines on the undergraduate curriculum issued by the General Medical Council (GMC).

The illustrations of community-based initiatives in this report (Chapter 3) are of two kinds: case studies which were presented at the conference by teams from three medical schools and which describe quite different models of community-based teaching; and short examples of work in progress or planned, selected from those provided by conference participants. These studies illustrate a variety of local solutions to local problems. To what extent the models are generalisable elsewhere is for the reader to determine for him/herself. Some of the approaches are being tried in medical schools other than the ones represented here and it should not be inferred that these are the only medical schools in which innovations of this nature are taking place. Indeed, it is likely that the next few years will see the development of many different kinds of initiatives and that what looks progressive now may soon be superseded.

Referring to the case studies and examples, the report also attempts to highlight problems, constraints and possible solutions (Chapter 4) in order to make a series of suggestions for future research, development and decision making.

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Chapter 2: Why community-based teaching?

The purposes of this chapter are 1) to clarify what is meant by community-based teaching and community-oriented medical education; 2) to examine the pragmatic reasons which are driving the move towards community-based teaching; 3) to consider the philosophical arguments for community-oriented medical education.

1. Definitions

There is currently some confusion about what is meant by community-based teaching and community-oriented medical education. In the UK it is frequently equated with teaching in general practice or primary care, with the result that the focus is more on where students are located (general practice as opposed to hospital) than on broader considerations of the aims and objectives of the undergraduate curriculum. The most useful set of definitions is contained in the report by a World Health Organisation (WHO) Study Group: 'Community based education of health personnel' (1987). The paper by Hamad (1991) also gives a clear summary of what community-oriented medical education is and is not.

Community

The WHO report gives a wide variety of definitions for the term 'community'. The one recommended by Hamad is 'A group of individuals and families living together in a defined geographical area, usually comprising a village, town or city'.

Community-oriented education

An education that focuses on both population groups and individual persons, which takes into account the health needs of the community concerned (definition from the first meeting of the Network of Community-oriented Educational Institutions for Health Sciences, 1979). In general terms, it can be defined as relevant medical education which takes into consideration in all aspects of its operations the priority health problems of the country in which it is conveyed. Its aim is to produce community-oriented doctors who are willing and able to serve their communities and deal effectively with health problems at primary, secondary and tertiary level, through the delivery of health-oriented rather than disease-oriented physician education. The aim is not to produce community medicine specialists or a new category of health personnel.

Community-based education

A means of achieving educational relevance to community needs and, consequently, of implementing a community-oriented educational programme.

Community-based learning activity

An activity which takes place within a community or in any of a variety of health service settings at the primary or secondary care level. Community-based learning activities include:

- Assignment to a family whose health care is observed over a period of time.
- Work in an urban, suburban or rural community designed to enable the student to gain an understanding of the relationship of the health sector to other sectors engaged in community development, and of the social system.
- Participation in a community survey or community diagnosis and action plan, or in a community-oriented programme, such as immunisation, health education of the public or child care.
- Supervised work at a primary care facility, such as a health centre.

Learning activities conducted in large-scale, specialised medical care facilities, such as hospitals providing tertiary care, cannot be considered as community-based activities.

BOX 1: EDUCATIONAL PRINCIPLES OF COMMUNITY-BASED EDUCATION

- *Responds to priority health needs, concentrating on the health problems prevalent in the community.*
- *Relates to all the needs of the individual.*
- *Promotes health education of the public to a high degree with the aim of fostering community self-reliance in the protection and promotion of health.*
- *Has as a basis an explicit statement of the professional competence expected to be achieved through the tasks to be performed, from which to derive learning objectives.*
- *Fosters problem-solving abilities.*
- *Promotes the idea of 'learning how to learn' both during and after basic education, and an ability to confront uncertainty, which will lead to educational self-reliance.*
- *Is community oriented throughout its duration.*
- *Takes into account the individual needs of the students.*
- *Includes instruments for the assessment of each student's competence in the skills that should have been acquired.*
- *Encourages the health team approach.*

Source: WHO, 1987

Community-based curriculum
A curriculum in which community-based learning activities are distributed throughout the duration of the curriculum. The principal features are given in Box 1.

2. Pragmatic reasons for community-based teaching

The current interest in community-based teaching in the UK has arisen primarily through necessity rather than for ideological reasons. It is, by and large, a forced response to changes in medical practice and the health services, and a growing realisation of the limitations of traditional ward-based clinical teaching in a tertiary referral hospital (see for example Case Study 2). Until recently community-based teaching was equated with general practice attachments, perhaps supplemented with patient/family attachments in the preclinical course. Now, the mainstream clinical specialties (medicine, surgery, paediatrics, etc) are finding that they are unable to teach students solely in the teaching hospitals.

The trends and directions in health care which are currently acting as a force for change in undergraduate medical education and which will have to be addressed in the future development of clinical teaching have been outlined in reports commissioned by the King's Fund London Initiative (Stocking, 1992; Towle, 1992). Over the past 50 years there have been major changes in demography, in patterns of illness, in medical technology and in the work of acute hospitals. As a consequence many illnesses previously treated in hospitals are not now seen on the wards or even in outpatient clinics, and the reduced length of stay in hospital reduces the opportunities for undergraduates to get to know patients and study their progress over time. The recent NHS reforms had the potential for profoundly affecting undergraduate medical education through the impact of capitation funding and cross-boundary flow on teaching hospitals. These effects are now beginning to be felt, not only in London with its oversupply of inner city teaching hospitals, but increasingly in the provincial medical schools. The longer-term impact of the reforms, for example, the conferment of Trust status, is still uncertain.

The pressures for change are likely to increase rather than stabilise when account is taken of future trends and directions likely to affect health care into the next century. The trends outlined in Box 2 are both long term and international, and it is a sobering thought that changes in health services occur far more rapidly than in medical education.

BOX 2: TWENTY-FIRST CENTURY HEALTH CARE

TRENDS AND DIRECTIONS

- *Chronic degenerative diseases and cancers have replaced acute infectious diseases as the primary causes of disease and death in Britain. For many conditions the management of disability has become as relevant as treatment.*
- *Greatly increased possibilities for short-stay, day case and ambulatory care have been created by the rapid development of minimally invasive methods of diagnosis and treatment and less toxic anaesthesia. Developments in pharmaceuticals have shifted the management of certain conditions (e.g. peptic ulcer) from surgery into primary care, and look set to do so for others.*
- *Technological changes promise to make greatly enhanced diagnosis and monitoring capabilities available in primary care settings. Related developments in information technology and telecommunications could make expert opinions available in primary care settings, or directly to patients.*
- *As a result of these changes acute hospitals are likely to become smaller, and more specialised and to focus on the care of people receiving complex, rare and/or expensive technologies and/or those suffering from trauma and multiple pathologies.*
- *A reasonable proportion of the diagnostic and investigative work that currently takes place in outpatient and other acute hospital settings could be moved to primary and community care, or to patients' own homes. Certain specialties (e.g. psychiatry, dermatology and the clinical care of elderly people) may become almost entirely primary and community-based.*
- *The social and economic context in which health care takes place is changing: improvements in education, the increased information available on health care, and the changing position of women in society all mean that people are beginning to request improvements in the information they receive about their health and involvement in choices made about their care.*
- *A new emphasis on the rights and preferences of health service users means that waiting times for operations and for expert opinions – and the overall quality of care – are subject to new scrutiny.*

Source: King's Fund Commission on London

The net result of the pressure and trends outlined above is an increased need to locate students outside the main teaching hospitals, which usually means in general practice, as well as to make use of community-based services, for example in paediatrics and psychiatry. However, the redistribution of students is frequently not accompanied by any fundamental changes in the aims and objectives of the course: students are expected to learn more or less the same things but in a different setting. Sometimes community-based teaching has arisen to fill in a gap in the curriculum rather than as part of any overall plan: initiatives are frequently local and opportunistic. Some teaching is community-oriented only to the extent that the wards have been shifted to another location for teaching purposes, while others have taken more account of community values and provision of health services to populations.

Although individual community-based learning activities may have aims and objectives appropriate, and even specific, to the community rather than the hospital setting, there is as yet no coherent and well developed philosophy of community orientation throughout the curriculum, such as that put forward by the WHO Study Group (1987), although recent documents on the future of the undergraduate curriculum, such as those produced by the GMC and King's Fund (1991), give a framework for such development.

BOX 3: SIX REASONS IN FAVOUR OF COMMUNITY-BASED EDUCATION

Participation in community-based education activities:

1. Gives the students a sense of social responsibility by enabling them to obtain a clear understanding of the needs of a local community and the problems it and the country as a whole are facing. They also come to understand how health and other factors that contribute to community development are interrelated.

2. Enables the students to relate theoretical knowledge to practical training and makes them better prepared for life and their future integration into the working environment, while improving their productivity. Opportunities for employment on graduation and career prospects are enhanced. They are better able to manage their careers and, at the same time, to recognise and resolve the types of problem that require a multiprofessional approach.

3. Helps to break down barriers between trained professionals and the lay public and to establish closer communication between educational institutions and the communities they serve. It allows the students to become more closely integrated in the life of the community and actively involved in its development.

4. Helps to keep the educational process up to date by continuously confronting the students with reality, a very important factor in development. It also helps in clarifying and finding solutions to problems. In this way education contributes to development.

5. Helps the students to acquire competency in areas relevant to community health needs, while utilising only the health service facilities that are available. For example, in some communities there is no university hospital and in others the services provided by the ministry of health may be insufficient to provide an adequate quality of care. Experience has shown, however, that students educated under such conditions can still become efficient health workers.

6. Is a powerful means of improving the quality of the community health services. Evidence exists showing that the use of health service facilities, particularly rural and urban health units, for educational purposes, leads to their improvement.

Source: WHO, 1987

3. Philosophical arguments for community-based teaching

Frequently, community-based education as promoted by the WHO has been viewed as providing third-rate education to produce 'barefoot doctors' for developing countries. Its relevance to industrialised countries has not been fully appreciated in the UK, although there are community-oriented medical schools in North America, Australia and Europe which have high reputations. This is partly due to misunderstandings about what community-oriented medical education is and what it is not. Hamad (1991) puts forward convincing arguments to refute the most frequent misconceptions, which are that community-oriented medical education: is third-grade medical education producing third-grade graduates; produces community-health doctors/specialists; is not scientifically based (based only on 'soft' sciences and neglecting basic sciences); produces graduates not competent in dealing with patients as they spend most of their time in the community; neglects hospital-based teaching; is expensive and requires more resources than traditional approaches.

The reasons in favour of community-based education given by the WHO Study Group in their report (Box 3) are as applicable to improving the quality of undergraduate medical education (and also of the health services) in the UK as anywhere in the world, especially in designing curricula for the twenty-first century.

Even if medical schools in the UK are unwilling to embrace the full concept of a community-oriented curriculum as defined by WHO, there is a need to articulate a philosophy of undergraduate medical education which ensures that future doctors are responsive to the health needs of the people and of the health services which ultimately employ them. The need for change in the undergraduate curriculum is widely, though not universally accepted, but there is a wide gap between general aims (for example as stated by the GMC) and the day-to-day practicalities of providing students with largely opportunistic clinical experience. This gap was pointed out by Oswald (1989) in a paper which presented the reasons for basing clinical education in general practice: after outlining how such a scheme might work in practice, he highlighted the need for a detailed curriculum from which would be derived a comprehensive list of experiences and teaching that would be completed during the course.

Those in the country who are attempting to articulate philosophical reasons for community-oriented medical education, generally do so in relation to the aims of the undergraduate curriculum set out by the GMC. Even back in 1984 it was concluded that 16 of the 20 GMC recommendations of 1980 could not be achieved at any reasonable level without using the educational resources of general practice (Association of University Teachers of General Practice, 1984). In a recent paper, Iliffe (1992) argued that learning medicine in general practice offers the student important educational opportunities that cannot be found easily in the present hospital-based system. The move of students into the community should be seized as an opportunity to redefine the curriculum for the twenty-first century and as a strategy for bringing about change. For example, it is an opportunity to broaden the experience of undergraduates outside the hospital setting, to achieve a balance between curative and preventive medicine, and to address the wider aspects of health care and interprofessional collaboration. It is even more appropriate in relation to preparing students for professional practice in the next century, when all the signs are that more patient care will occur in the community and primary care, that doctors will be functioning to an even greater extent as members of multiprofessional teams and that patients themselves will be required, and indeed demand, to play a greater role in decision making about the management of health problems.

The trend towards greater patient autonomy, coupled with the inevitable need to contain costs, argue for a greater role for the medical school in working in partnership with the community it serves to ensure effective and efficient health care which meets the needs of the population as well as individuals. This partnership has several possible dimensions: the medical school's mission towards its population; the contribution of individual members of the community to the education of future doctors; and the incorporation into the curriculum planning process of the views of the community about the kind of doctors and health care they would like. The need to develop strategies for expanding the medical school's mission to embrace the population perspective, in addition to the usual biomedical and individual patient-physician perspectives, was discussed at a recent conference attended by participants from the USA, Canada, Australia and the UK (White & Connelly, 1992). They identified three levels at which the medical school's commitment to improving the population's health should be addressed and made five recommendations, including the establishment of a health intelligence unit within a school or group of schools to monitor community health and collect data on priority health problems in order to inform curriculum planning. Initiatives to involve patients in the teaching and assessing of medical students, and giving them proper recognition as teachers, are beginning to attract interest in the UK, although other countries are much further advanced, for example in the use of simulated patients. As yet the idea of community involvement in curriculum development has not been addressed here, although Case Study 1 shows how one particular curriculum innovation arose out of community dialogue with the medical school.

Not only does a change of setting allow a change in the orientation of the curriculum, but the kinds of initiatives in community-based teaching currently underway allow experimentation, innovation and change. Bringing about change in traditional medical schools is notoriously difficult and one of the most effective ways has proved to be through the establishment of an experimental or parallel track curriculum. Community-based parallel tracks have been initiated in medical schools in several countries, including the USA (Kantrowitz, *et al.* 1987), in order to introduce new methods of educating physicians for the future. Example 6 is one of the first proposals of this kind in the UK and aims to explore the possibility that the

fundamental teaching resource for basic medical education could be in the community of patients registered with a teaching group general practice. A further advantage of a community-based curriculum is that it helps to keep the educational process up-to-date and responsive to change, an important consideration given the fact that health services can change so much more rapidly than medical curricula.

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Chapter 3: Examples of community-based teaching

This chapter comprises the three case studies which were presented at the conference, plus 16 examples of different approaches to community-based teaching selected from those submitted by conference participants. They have been grouped into three broad categories.

a) Learning in the community gives three approaches to community-based learning in which students are directly involved with community health care providers (formal and informal) other than general practice. Students are thus presented with an alternative to the medical model of illness.

b) General-practice based learning. These include a variety of initiatives led by academic departments of general practice at different stages in the curriculum. There may be some joint teaching with other specialties and moves towards a more integrated approach in some cases.

c) Integrated approaches. These include a range of community-based initiatives which are originating from outside academic general practice, although there may be general practitioner involvement in the teaching. They include teaching by specialties which are doing an increasing amount of their clinical work outside the hospital, and are finding it difficult to teach their subject solely on hospital patients.

a) LEARNING IN THE COMMUNITY

CASE STUDY 1

THE COMMUNITY MODULE AND BEYOND

GEOFF WYKURZ, CITY AND EAST LONDON CONFEDERATION

The new alliance between St Bartholomew's Hospital Medical College, the London Hospital Medical College (including the Dental School) and Queen Mary & Westfield College, known as the City and East London Confederation for Medicine and Dentistry (CELC) has provided the opportunity to introduce a community-oriented approach within the pre-clinical course. The Community Module provides students with an opportunity to develop an understanding of the needs and circumstances of people living in three districts in East London (City & Hackney, Tower Hamlets and Newham).

Background

The motivation for introducing a community-based scheme into the medical course came from people within the medical colleges and community organisations in East London in the late 1980s. There was a concern that students had no programmed involvement with 'the community' during their pre-clinical years and very little in their clinical years. This was considered to be a major deficiency in their medical education. It was also recognised that the majority of students began their education highly motivated to meet people in the area and this enthusiasm was not being tapped and channelled.

It was therefore decided to establish a scheme whereby students would take part in a supervised community activity that would be an assessed element of their training. The initiative was originally intended to promote greater contact between students and people in the community in which they would be working and studying. It was also hoped that the experience would challenge students' attitudes and stereotypes.

Initially information on community-based courses was gathered from other colleges, which involved visits to the universities of Newcastle upon Tyne, Southampton and several in Australia. A series of consultative meetings with representatives of community organisations, health service departments and the medical colleges preceded the introduction of the module. During these meetings the details of the design, implementation and financing of the initiative were discussed. The collaborative nature of the relationship between the medical colleges and community organisations has been the cornerstone of the module's success to date.

In order to facilitate the management of the scheme it was considered essential to secure the funds to appoint a full-time coordinator. Financial support from the King's Fund and the Department of Employment's Enterprise in Higher Education programme have funded this appointment and the remuneration of tutors.

The process adopted to design and subsequently modify the Community Module reflects the World Health Organisation's underlying principles for a community-based educational programme which emphasises the importance of involving the community in the development of the curriculum to ensure that it reflects local health issues. These guidelines have proved a valuable reference point to underpin the purpose and development of the module.

Aims

The Community Module has two elements: the first takes place during the second term of the students' first year (Term 2) and the second in the first term of the students' second year (Term 4).

The Community Module has been designed to create an opportunity for students to learn about: the local community; local social issues; inequality in relation to race, class, gender, sexuality, age and disability; the delivery of services and access to health care. It is also intended to encourage students to develop a sensitive and empathic response to the needs and circumstances of people in the community. Students are therefore given the opportunity to place their medical and dental education in an appropriate social, cultural and environmental context. To complement this awareness, students are expected to develop skills in observation and reflection, communication and teamwork. During the second element of the module students undertake a project that includes some basic issues of information-gathering in a community context.

Term 2
Structure and process

The Community Module is allocated 12 sessions of three hours duration, spread over ten weeks. The students work in groups of four within 'clusters' of 12 to learn about a local community (i.e. a specific neighbourhood or minority ethnic group in East London). Each cluster is supported by two tutors who are responsible for planning the programme for their group of students. The tutors are recruited from the medical colleges and dental school, departments of public health and community organisations. By bringing together people from these different organisations, complementary experience and expertise generate creative programmes for the students.

Each programme gives students the opportunity of contacting people working in health and local government agencies, visiting community organisations, meeting with local people and undertaking other activities that are designed to encourage analysis and reflection of some of the issues of concern to the community.

Before students begin working in their clusters they receive an 'information pack' which includes a variety of information sheets giving background reading material and guidelines on aspects of the module with maps and details of the area in which they will be working. Each student is given a 'diary' to encourage them to record their observations, reflections and notes of questions prompted by their experience.

Tutors are given the freedom to interpret the module's aims in the most appropriate way for their community. They devise programmes for each sub-group that centre on a particular 'theme' to provide a focus for the students' local study. Themes have included: the elderly, parents and children, the Jewish community, housing, the family, mobility and transport, leisure and exercise, crime and health, isolation and loneliness, women, drug users, mental health, education and employment, HIV/AIDS, homelessness, young people, learning difficulties, homeworking, single-parent families.

Assessment

At the end of Term 2 each student has to submit an essay and participate in the planning and presentation of their sub-group. This work has to be illustrated with examples from their experience. Assessment criteria with guidance on 'writing an essay' are given to students which are complemented by notes to tutors on 'marking an essay'. Briefing sessions are arranged for tutors to discuss the process and responsibilities of assessment. In the presentations to the tutors and fellow students in their cluster, each sub-group has to summarise the significant features of the community studied in relation to their specific theme. In 1992 in a few clusters students negotiated their own assessment criteria for the 'style' component of the sub-group presentations and participated in a peer assessment of this element.

For many students and tutors the presentations have been the high point of the module, when both parties discovered how much had been learned in a short space of time. The quality of the presentations has been generally high with some imaginative approaches. All have had to include a poster, but overhead transparencies, photographs, slides, video and role play have also been used. Many posters have demonstrated creative talent, conveying clear messages and images of the communities and themes in an imaginative and informative style.

The experiences of a student and two tutors involved in one cluster are described in Boxes 4 and 5.

BOX 4: 'GETTING INTO THEIR SHOES'

SALIMA BEG DESCRIBES THE INSIGHTS PROMPTED BY HER EXPERIENCE

'It seems rather inadequate to pick up a textbook and read it to get an impression of the issues facing a local community and its people. In order to get a real understanding you have to get into their shoes and walk around, and this is in essence what we did in the Community Module. I visited a very run-down and crumbling estate in Tower Hamlets which is awaiting demolition.

The Codrington Estate is a dark, grim place: filth lies strewn everywhere and together with the cramped, damp living conditions it endows its inhabitants, the Bengalis, with an aura of despair, isolation and frustration. These are people drifting without hope in a sea of desolation. Part of their problem stems from a lack of communication between the present residents of Tower Hamlets and the health care professionals.

To the Bengalis it appears that the NHS neither cares about them nor recognises communication as an issue, yet this is the very key to providing appropriate, available and accessible health care for the non-English speaking population. The inability to communicate in English is widely perceived as the fault of the patient.

The National Association of Health Authorities and Trusts in its report 'Action not Words' suggested that language differences should not be perceived to be the patients' problem but an issue to be overcome by the providers of the health service. Now this seems to me to be a feasible target, especially in the short term. Why is it then that it should be left to voluntary community-based organisations backed by dwindling resources to provide at the best of times a skeleton service to the community? Rather, the health service should aim to employ more health advocates who are not just translators or interpreters, but rather troubleshooters in the hospital environment.

So, having walked around in their shoes and seen things with their eyes I find that I am more aware of the issues and socio-economic conditions faced by the present population of Tower Hamlets. It has given me the opportunity to meet the patients I will be treating in my clinical years and it has made me see that a patient is not just a case of asthma or a case of bronchitis, but rather that his condition has been brought on or aggravated because of the damp, and the squalour and the poor ventilation in which he lives; because he sleeps five to a room; because he must face the stress and financial strain of losing a whole day's pay just to visit outpatients; because he must take his seven-year-old son from school to accompany him to hospital to act as an interpreter.

Finally this Community Module has served to emphasise the declaration of Alma Ata from the International Conference on Primary Health Care in 1978 which defines health as a 'state of complete physical, mental and social well being and not merely the absence of disease or infirmity.'

BOX 5: 'THAT'S WHAT YOU CALL COMMUNITY-BASED EDUCATION'

MYRA GARRETT AND JAHANARA LOQUEMAN, FROM THE TOWER HAMLETS HEALTH STRATEGY GROUP, GIVE THEIR PERSPECTIVE AS TUTORS

'The Tower Hamlets Health Strategy group is a voluntary organisation which has been involved in community development in health in the London Borough of Tower Hamlets for some years. Its first project was based on the Spitalfields Health Survey and identified a number of important needs in the Spitalfields area, one of which was to provide Bengali-speaking health advocates for women. Funding from a charitable trust enabled the project to employ a Bengali advocate in the area.

The health advocate works specifically with health visitors and other health professionals of Spitalfields, providing advice and helping people to help themselves. The community experience a variety of illnesses, eg. asthma, depression, eczema, mental illness, tooth decay. Many people would miss out on important services without the link between local residents and the services provided by the health advocate. In such a poor environment, with gross overcrowding, unsafe estates and very high unemployment, primary care services are extremely important, so ensuring access must be a high priority.

I really admire the Community Module – that's what you call community-based education – students can go out there, they can see the community and will be able to look after people when they become doctors in the future. They are the people who should know why an illness is not the fault of people and why a lady comes with all sorts of aches and pains. Too many health professionals do not know the sort of living conditions people are in. If the community module helps them to know the community it is a very good project and should continue.'

Term 4
Structure and process

In September 1991 medical and dental students embarked upon the second element of the Community Module which involved undertaking a short community project on a specific issue within a module of 12 three-hour sessions, spread over eight weeks. The projects were intended to reflect the module's core aims, building upon the students' experience in Term 2, but introducing them to some of the principles and issues of information gathering in a community context. This includes a knowledge of sources of information; listening skills; the ability to describe accurately what they see and hear; an awareness of the values and perspectives they bring to their study; reflective skills; an awareness of their responsibilities to the community within which the study takes place; report writing skills.

Individuals from the medical colleges, dental school, NHS departments and community organisations are invited to propose projects. Criteria for the projects encourage proposals that provide a 'community perspective' on an issue (i.e. eliciting views and opinions of people in the community) and generate information that could be of value to the sponsoring agency. This approach encourages a high commitment from tutors and students alike. Although the projects have varied in the number of students involved, each project has to provide sufficient tutors to maintain a ratio of 1:6.

Following an introductory lecture, students are given summaries of the projects with brief details of where the project is located. Each student is invited to rank their five preferred projects on a selection sheet and is allocated accordingly.

The following two sessions are used by tutors to prepare the students in their project for their tasks. This involves briefing about the issue and area, followed by activities on listening skills, interviewing and questionnaire design appropriate to the specific study. Tutors are offered exercises and materials to assist

them during these sessions. Time spent on 'fieldwork' is limited to three days because of the need to allocate sessions for the discussion and analysis of project findings and preparation of the final report.

In 1991 projects varied in size from six to 36 students and one, working with Hasidic Jewish mothers, specified that all the students had to be women. Project topics have included: Priority setting in the health service – consumer values; Health attitudes and beliefs in Hackney; Needs of the elderly mentally frail; Assessing a course for GPs on ethnic health issues; A consumer survey on patient satisfaction at an accident and emergency department; Healthy eating for older people – attitudes and food availability; Attitudes to smacking and children's rights; Use of medicine – assessing the quality of advice given to patients and their understanding; Refugees – their health and rights.

Assessment

In 1991 each student had to participate in the preparation of a group report and write an individual report on a related subject. Students were expected to provide evidence of their understanding of the circumstances and views of the people they had met. In addition, each project had to prepare a poster illustrating their work that could be displayed in a local venue so that the project's findings could be shared with the community within which the study took place.

The experiences of a student and a tutor involved in one Term 4 Project are described in Boxes 6 and 7.

Evaluation

Evaluation is considered an essential element of the module. Questionnaires are distributed to students by the Joint Academic Unit for Medical and Dental Education and by the Community Module Coordinator, who also arranges meetings with tutors to discuss the module. The Term 2 element has taken place twice; Term 4 once only. A number of issues have arisen through the evaluation of the Community Module over this period.

Student Learning – The students' experience of the module was generally positive: they enjoyed working in the community, meeting people, visiting community projects, spending time out of the 'academic environment' and working in small groups. Students found it interesting to learn about people, their living conditions, the ethnic and cultural diversity of the area, local issues and information on the services provided by the statutory and voluntary services.

Most of the students considered that their experience during the module would positively influence how they worked with people/patients in their future careers. For many, they stated it had raised their awareness of people's needs, cultural differences and the causes and effects of health problems. Some also felt that their communication skills had improved and that the experience had made them more sympathetic: for example, one student commented that s/he would 'view people as individuals, not as sick specimens' in the future. A small minority considered that the experience would not influence their future work.

In some of the Term 4 projects students felt they were being used as 'research assistants' and not given enough opportunity to develop their own approach to an issue. This seemed to relate to two factors: the limited time allocated to the module demanded substantial preparation by tutors before the project began – involving the design and printing of questionnaires and the negotiation of interviews which limited the students' autonomy. The fact that the projects were intended to be 'real work' meant that many tutors had a direct interest in the outcome and therefore the design of some projects limited any modification by students.

Tutors enjoyed working with the students and observing their developing enthusiasm, seeing perceptions change, pre-conceived ideas questioned and insights develop.

BOX 6: 'A VERY REAL PIECE OF WORK'

ARIF GHAZI, WRITING ABOUT HIS TERM 4 PROJECT

'I was involved in a study of local chiropody services. The initial expectation of our group was that chiropody was a fringe subject, not very important to medicine. We later realised the important role it has to play in the lives of the elderly patients who require the service and that immobility can be very restrictive.

The emergency chiropody clinic is open between the hours of 9.00 and 9.30 a.m, but pensioners cannot use their bus passes until after this time. The chiropody services have the reputation for having long waiting lists and often there are cases where the notes go missing once patients have been transferred. There is a general poor level of awareness of the community services available and this certainly needs to be increased, especially in ethnic groups such as the Chinese and Asian communities. They are often supported by members within their extended family networks. Foot care only becomes a problem for patients who have no immediate family to tend to them, so they quickly become isolated.

Access to services can be poor. In one case an elderly woman had been transferred from her local clinic to the central clinic which required her to take two buses; she also had to walk up two flights of stairs because she had a phobia of lifts. Another gentleman required his toenails cut every month: his condition was not serious enough for him to use the ambulance, so he had to walk one and a half miles to the hospital. Ironically, there was a local clinic 50 yards from his house, but it was overrun with work so they could not take him on.

Through this project I have certainly become aware of the need for more locally-based services (e.g. toenail cutting). Although an ambulance service is available, it appears poorly organised. Patients are often picked up early in the morning, but are not returned home until at least late afternoon. This wastes their whole day. It seems unreasonable to expect patients to wait so long.

Our initial expectations of the project were that it would be quite boring. But it was certainly an eye-opener and once we were told that the outcomes were to be used by the Community Health Council in their recommendations to the District Health Authority, we quickly became aware that what we were doing was a very real piece of work, not just something for academic purposes.

I feel the project was relevant to our medical education in a number of ways: it enabled us to meet local people in the community where we will be working; the survey we conducted was a good exercise in learning interviewing techniques; we learnt to build a rapport with patients and develop our communication skills. The group work also involved peer communication and organisation skills. However, I do feel that it would have been more relevant if the module had been timetabled alongside sociology and psychology. We also needed more time for our projects.'

Group size – The experience of Term 2 has demonstrated the importance of working in small groups. The allocation of 12 students to a cluster enabled the tutors to plan programmes for students to work in fours, pairs or individually. The ratio of one tutor to six students also proved effective, especially for the Term 4 projects; however, even when this ratio was maintained, larger projects did not work as effectively as the smaller ones. Projects with more than 12 students seemed to lack coherence. Tutors and students found it difficult to meet sufficiently regularly during the module to coordinate their efforts and students appeared to work less effectively.

Contact with people – Some students expressed frustration that more opportunities could have been created to enable them to meet more local people and exercise more choice in the theme studied in their cluster in Term 2. The time involved in arranging meetings with local residents for 12 students is very

BOX 7: 'A WONDERFUL PIECE OF COLLABORATIVE WORK'

JANET RICHARDSON, CITY & HACKNEY COMMUNITY HEALTH COUNCIL

'From the tutors' point of view, this project was very interesting. We involved two of our Community Health Council members, one is Afro-Caribbean and works with black elders in Hackney; the other is herself elderly and uses the chiropody services. So at the very beginning we introduced the students to people who had a very strong interest in the subject.

We provided background information on the chiropody service (with help from the District Chiropodist) and on the work undertaken by the CHC to improve the service. The CHC had been unsuccessful in its endeavours, so we welcomed the opportunity not only to work with the medical students but to get enough people who could do some work for which we had not got the resources.

To begin with we felt some resistance from the students: what was this all about? what were we doing here? But as the project developed the enthusiasm really built up. When the students went out to the clinics and the community centres and met elderly people who told them what some of their problems were, the whole thing shifted.

The group report was a wonderful piece of collaborative work, done at breakneck speed, because the students were in the midst of exams with a huge amount of pressure on them. The students' project produced some very clear findings and recommendations which were formally put to the District Health Authority by the CHC in its role as the statutory health watchdog. Subsequently there have been meetings with the District Chiropodist and other senior managers to see how they will take forward these recommendations.

Our CHC has long been saying that medical education needs to move out into the community, because doctors do not seem to understand people: they just look on them as slabs in beds. The CHC said to the Colleges that there was another way: bring your students out and we will do something about it. We talked to the Colleges who listened, and after a lot of pressure and discussion the Community Module arrived.'

time consuming and was made more difficult by the inflexibility of the timetable, which restricted the timing of visits.

Translation and interpreting – Facilitating student access to members of minority ethnic groups whose preferred language is not English has required the payment for translation and interpreting services for some projects. This is an essential cost if there is to be a serious commitment to enable students to learn the views and concerns of people from the variety of communities living in East London. The involvment of health advocates in this process encourages the students to develop a respect for their talents and skills and the importance of their role in the health service.

Time allocation and timetabling – Each element of the module had to be self-contained: none of the other modules within the basic medical sciences course provided students with knowledge or skills that would assist them in their community-based tasks. Many of the sessions allocated to the module in each term were therefore taken up with preparing the students for their fieldwork and with assessment. This reduced the time available for 'fieldwork' to the equivalent of three days in each term.

In 1991 students and tutors felt that the timetabling of the sessions marginalised the module. Most of the sessions were on Fridays, others took place after examinations, at the end of Rag week and on the first and last day of term. Sessions were later timetabled more sympathetically, providing some day-long periods and avoiding Fridays to enable more Jewish and Muslim tutors to be involved and to create learning opportunities for students to visit religious organisations.

Following the first run of the module, opinion was divided on whether sessions should be one session a week or five day-long sessions. Some suggested a combination, so a mix of half-day and full-day sessions was planned for subsequent elements.

Tutor involvement – The desire to place students in the community at the earliest opportunity and teach them in small groups placed a major responsibility on the tutors to plan and facilitate the students' learning. This involved substantial preparation in planning programmes and arranging visits before the beginning of Term 2 and the design of the questionnaires and negotiating interviews before Term 4. Although the majority of the tutors enjoyed working with the students, many have felt that the time and effort involved was more than anticipated and would influence any future participation.

Resourcing tutors – During each element of the Community Module 50 tutors were recruited to establish an effective ratio for a community-based activity. Their support required a substantial commitment of time from the coordinator and other staff from the Enterprise Team at CELC, who organised briefing sessions and produced teaching materials for the tutors to use in their sessions. The process of recruitment and assistance in the design of programmes or projects required visits to the majority of tutors.

Improved networks – By bringing together people from a variety of statutory and voluntary agencies to become tutors, many positive working relationships have developed beyond the work associated with the Community Module. For example, staff of the Public Health Department in Newham have improved their communications with local voluntary organisations, enabling them to work more effectively in the district.

Overload – Sustaining the commitment of tutors at a time of increasing pressure on public health departments and cuts in grants to voluntary organisations (that in many cases threaten their existence) has major implications for the long-term viability of the Community Module. Some tutors also expressed difficulties in arranging meetings and visits with other community organisations who were unable to commit time due to increasing demands on their services.

Communication with students between sessions – Tutors expressed the need for an effective method of communicating information (change of arrangements, etc.) with students between sessions. Secretarial help with arranging visits to projects and back-up when local arrangements fell through was also requested. Messages are usually conveyed by using a noticeboard prominently displayed in the foyer of the main building with notes in pigeon holes. A more effective method has yet to be found to enable tutors to contact students.

Assessment – In Term 2 tutors generally favoured the presentation as a form of assessment in combination with an essay or record of student experience. Some tutors suggested that the diary should be compulsory and that attendance should be included in the assessment. Although many students designed very effective posters in both terms, this was not a popular form of assessment among students.

Several tutors considered that there was too great an emphasis on assessment in Term 2, with students preoccupied in gathering material for their presentations and tutors devoting a disproportionate amount of time to assessment rather than helping students learn about the community. Many students felt 'over assessed' in Term 4, particularly as it coincided with other demanding modules.

The diversity of work undertaken by the students made moderation between clusters in Term 2 and projects in Term 4 difficult. During the first cycle moderation was carried out by an external assessor. This involved reading a large number of scripts and has led to the decision to involve more external assessors in the future.

Status – Following the first Term 2 element some students and tutors considered that the module appeared to be marginalised within the course and its status should be improved. Although the timetabling has substantially improved, the module is not welcomed by all the staff teaching the basic sciences. For some it is seen as something imposed on the curriculum that threatens the teaching time of other subjects and departmental teaching budgets.

Student travel expenses – Many students incurred significant travel expenses during the module, especially those working in Newham. This raised the issue of how funds could be secured to cover this expense and arrangements made to administer claims.

Finance – The sum originally budgeted for the remuneration of the tutors was considered insufficient to cover their responsibilities with regard to preparation, planning, supervision and assessment. In addition to course materials, funding has had to be secured to cover the cost of hiring rooms in community centres for some students and to pay for translation and interpreting services.

The introduction of the Community Module into the medical and dental curriculum has been dependent upon external grants. The pump-priming of this investment has enabled the colleges to plan ahead to replace this grant aid with core funding from their own budgets. The process has not been a smooth transition. It has required early consultation, continual negotiation and persistence at a time of severe constraints on the budgets of the colleges. The commitment of funds from the colleges to maintaining the Community Module demonstrates their recognition of the value of this community-oriented initiative and their commitment to maintaining such activities as a core component of the curriculum.

Community benefit – Many community organisations valued the work undertaken by the students during the Term 4 projects. For example: information gathered by one group of students is likely to lead to the establishment of day-care services for elderly Jewish people in Stepney; another project has critically examined chiropody services in City & Hackney, generating recommendations that the local Community Health Council wish to take up; students investigating community services for diabetics were asked to make a presentation to GPs in Newham; information from an occupational health audit in GP surgeries in Tower Hamlets will be used by a local voluntary organisation; students working with a mental health project have prepared a 'Survivor's Guide for Users of Mental Health Services in Tower Hamlets'.

In Box 8, a doctor who has been involved in the development of the Community Module from the outset gives a medical perspective.

The Future

The critical success of the module has encouraged consideration of other community-oriented initiatives within other phases of the curriculum.

Phase II projects

The new curriculum designed by CELC has introduced projects of 35 days duration spread over two terms at the end of the second year and beginning of the third year (Terms 6 and 7). This has provided an opportunity to introduce a community-based project in which students are investigating changes in childbirth in East London during the last 100 years. The project involves a study of medical intervention, women's experience, women's collective action to improve services and an analysis of the socio-economic and political context. Students have undertaken recorded interviews with local older people and health professionals (working and retired).

A student's view of the relevance of this project to her training and career is described in Box 9.

Patients as partners

To continue and develop the community-based theme into the clinical phase of the curriculum, CELC wishes to explore the introduction of patient/family attachments. The intention is to establish a pilot study involving two small groups of students in an optional 'module'; one group during the first two years of the curriculum with a second group pursuing the initiative during their final two years. It is a significant feature of the programme that the patients are involved in the assessment of the students and therefore have the status of 'teacher'.

BOX 8: 'SOMETHING THAT WILL STICK IN THEIR MINDS FOR THE REST OF THEIR LIVES'

JANE LEAVER, ST BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE

'When considering applicants for medical courses, motivation and ability to communicate are important aptitudes and yet, at St Bartholomew's, we did not let them see a person for two years. We stuck them in lecture theatres and had them dissecting dead bodies with no contact with the community. It just did not make sense.

Our students live and study in the East End of London where there is a rich diversity of cultures and communities. There are people living in the area with so much to teach our students. It would be a missed opportunity if we did not create activities that introduced them to the community before they met patients at the bedside. With the support of local tutors who know the area students have gained experience that has broadened their horizons. It is important that medical students recognise the limitations of 'medicine' and the effect of housing conditions and the local environment on health. The Community Module provides students with an opportunity to learn through experience, to actually see something that will stick in their minds for the rest of their lives and contribute to their understanding of the circumstances and needs of their future patients.

Many medical students have complained in the past that they have not felt useful during their training, and they would like to contribute in some way to the local community. The Community Module is an example of how students have made a practical contribution to the community through a number of projects and learnt a great deal through the process. It is important that community-based activities take place during the pre-clinical phase to enable students to put their future learning within an appropriate context.'

Joint initiatives between CELC and the Community

CELC not only wishes to establish a partnership with community organisations in the education of medical and dental students, it also wishes to explore other practical and effective initiatives that draw upon the experience and expertise of the Colleges and the community to address issues of mutual concern. As an example of this collaboration, funding has been secured for a project to develop a model for establishing effective partnerships between GP practices and carers that will improve the quality of life for patients and encourage more sensitive and responsive support to carers. This initiative will involve not only carers and voluntary organisations who support them, but also representatives from the local authorities in Hackney and Newham in the management and implementation of the scheme.

The Community Module

The long-term future of the Community Module is unclear. Funding constraints and the pressures on community organisations in East London suggest that the module may need to be radically revised to create a community-based element in the basic sciences curriculum that community organisations can support in the long term.

Reference

1. World Health Organisation (1987) *Community-based education of health personnel.* Report of a WHO Study Group. WHO Technical Report Series No. 746.

BOX 9: 'I VIEW PEOPLE OF THAT GENERATION DIFFERENTLY NOW'

TAMMY ANGEL REFLECTS ON HER COMMUNITY-BASED STUDY

'The aim of our study was to investigate the changes in childbirth that have occurred over the last century with respect to who delivered the babies (the swing from midwives to obstetricians); who attended the births; where the births took place and the intervention used. There were four students in our group: I personally decided on this study because it is a field of medicine that I wish to pursue in the future.

A large proportion of the information generated has been through interviewing women who have had children in the local area. We have interviewed about 20 women who we contacted through day centres and clubs in the local vicinity. We asked if anyone would like to be interviewed, which often involved visiting them at home. I must say that this was very enjoyable as well as informative. We were all very surprised at how responsive these ladies were and how willing to share some very private experiences with us. Some have told us amusing tales of their innocence.

Some experiences have been very sad: in one interview I conducted the lady showed me a photograph of the male members of her family, including her husband, all of whom have since died. This really brought home to me the devastating loneliness this lady felt then at losing her husband and still feels today, some 20 years later. It made me realise that it is very important to consider the potential isolation when talking to the little old lady who presents at your GP clinic. I was also struck by the effect of World War II and its consequences of fracturing many families and communities.

My first year Community Module involved a study of the Orthodox Jewish community and their practices and customs, so it is interesting that this project brought me into contact with several elderly Jewish ladies, which has given me an insight into their past lifestyles. Our project was very appropriate in giving us a background to the Sociology course where we studied changes in maternal mortality and stillbirth rates as well as the evolution of the medical profession and the so-called 'medicalisation' of childbirth.

The quality of experiences of the project as well as the first year Community Module depends heavily on the tutors and the resources allocated to the project, and we have been fortunate in both. I see the major value of this project as having given me some experience in the technique of interviewing and really listening to people, both essential skills for any doctor. I also feel that I view people of that generation differently now as I have a better grasp of the experiences they are likely to have endured. The variety of experiences I have been privileged enough to hear have also impressed upon me that the natural tendency to class all older people into one 'category' should be actively discouraged.

In conclusion, I think it is important to understand how people's past experiences will influence their trust and involvement of the medical profession in the future.'

EXAMPLE 1: ELECTIVES AT A SICK BAY FOR THE HOMELESS

DAVID EL KABIR, WYTHAM HALL

The GMC report observed that the pressures on the community and the needs of society are focused on the needs of the most disadvantaged of individuals. This is not yet reflected in medical education where a highly unsatisfactory definition of what constitutes ill health is left to the medical profession, not the needs of the patient and the community.

These thoughts have been provoked by my experiences setting up and running a medical service for the homeless, one of the most disadvantaged and marginalised groups in our society, as Fellow and Tutor in Medicine at St Peter's College Oxford, and as a general practitioner recipient of many disillusioned medical students.

To set up a meaningful medical service for the homeless we had to be creative, to get away from preconceptions and to adapt the service pragmatically to needs as they became apparent to us. It was obvious that the medical model, with its rituals and hierarchies, had to be discarded, as it was an all too familiar experience for our patients to be shepherded around, if not patronised. Clearly, the eyes that perceived the patient had to adapt in turn to the way in which they were being perceived. If one was to encourage trust and hence a continuity of relationship, which was surely to be one's aim, one had to be aware of oneself and sensitive to nuances of hope, expectation and rejection. Doctors need therefore to have acquired some maturity of outlook about suffering, decay and death in a society which is ill-equipped to deal with the more painful reality of existence. The consultation thus became a unique dialogue, a jointly creative act, infinitely variable, predictable only in that the doctor has professional skills which are being sought. It was not a routine learnt at medical school with superimposed cosmetics derived from communication skills workshops nor techniques of problem solving.

It soon became apparent that a great many of the illnesses suffered by the homeless were not effectively treated in hospitals, largely because the patients were not treated with any understanding. Hospitals are perceived to be unsympathetic and at best too rigidly regimented to be tolerated by the majority of our patients. The need for a sick bay where we could extend the work of Great Chapel Street became increasingly obvious.

At the same time it became increasingly clear to me that medical students were singularly ill-equipped throughout their medical training for seeing their patients as a whole or understanding their lifestyle. The average medical student had considerably less insight into the human condition than the reader of good literature. It seemed increasingly absurd to be competent at treating disease while having an increasingly restricted view of what constitutes ill health and its effects on a particular person. This schizoid view of human suffering could not meet the needs of the individual, or of our society.

The idea of a sick bay, staffed by medical students or doctors during their clinical training in London, was thus allowed to germinate and eventually, after much persuasion of statutory bodies and charitable institutions, a large house in central London became available. Wytham Hall thus became a reality, and admitted its first patients over eight years ago. It is now a community of some 14 doctors, medical students and administrators who live 'above the shop'. The atmosphere is informal and there is a natural warmth about the place which is a product of our curiosity about our patients and an awareness of the uniqueness of every human encounter, and that uniqueness extends to the medical consultation and its outcome. The dynamics of these encounters are explored in our weekly ward rounds, which are seen as a dialogue between doctors and patients, and where treatment and future plans are elaborated by collaboration and achieved by consensus. These dynamics are further probed by 'Balint Groups'.

Our approach has attracted the attention of a number of overseas medical schools and a charitable foundation provides scholarships for medical students to spend one month electives living with us. Students have come from Harvard, Yale, New York and Middlebury College, from Israel and lately Prague and Budapest. Many of them have felt that their whole approach to medicine has been changed by the time they have spent with us.

EXAMPLE 2: A COMMUNITY HEALTH SERVICES OPTION

PHYLLIS MORTIMER, CROYDON COMMUNITY HEALTH TRUST

Background

Clinical studies are still, at present, acute hospital-based and with a large percentage of the patients having more rarefied medical conditions, since such patients naturally gravitate to the centres of expertise. This leads to the students gaining unbalanced practical experience, with less emphasis on the conditions they will encounter once they have qualified. Also, since many clinical options are taking place in hospitals other than the teaching hospitals and the students are now having less structured teaching, there is a wide disparity of experience among the students.

An option of Community Health experience would lead to a greater sense of the reality of current medical practice, and the patient can be seen in the context of his or her own whole family unit; or as more often happens, as someone who does not have a family to support him or her once they leave hospital.

Medical students do experience general practice as part of their current clinical options. However, this is still presenting the medical model as the most important aspect of medical care, whereas the reality is that more care is needed by the elderly, confused and handicapped in their own homes, and only a multidisciplinary approach of doctors, nurses, therapists and social workers can provide this adequately by working as a team. The Community Health setting is the ideal one in which this vital aspect of health care can be provided.

Description of the proposed option

A pilot project is proposed for students about to begin their clinical course. The option will include:

- Experience of Community Health Services by attachment to the Locality Manager and Senior Medical Officer. Most time will be spent observing all community-based staff at work across the range of service provision in a variety of settings.
- Experience of working closely with the Local Authority and with voluntary agencies by attending day nurseries, special centres, working with Crossroads and other voluntary provision.
- Experience of management and administration by shadowing operational and specialist managers, including gaining insight into the collection of activity data and its use.
- Each student will undertake a special project to address the social and environmental factors which influence health and well being. This will be agreed individually with each student and could include: a family with special needs; the role of carers; highly dependent people in a community setting, e.g. frail elderly or people with physical disability; links between community and acute services.

The project would be managed by a Project coordinator, probably from an administrative background, with clinical coordination by the Director of Medical Liaison and Consultant Community Paediatrician.

Benefits of the project

A formal evaluation will be carried out at the end of the project and will include considerable input from the students themselves, e.g. comparing their view of the role of Community Services at the beginning and the end of the placement.

It is anticipated that students will gain experience of clinical teaching, medical practice and health service delivery outside a hospital setting.

Constraints/barriers

It might be difficult for some students to find a Community Health Service near to where they live or study in order to be able to chose this option. Obviously Croydon is very well situated with good public service access from many directions. Some project money has been secured for a pilot project to finance student bursaries, as this is the last long vacation in which they can earn money. A continuing small resource would be needed to finance the extra time of the staff who would be working with the students.

b) GENERAL PRACTICE-BASED LEARNING

CASE STUDY 2

TEACHING GENERAL MEDICINE IN GENERAL PRACTICE

PAUL BOOTON, KING'S COLLEGE HOSPITAL MEDICAL SCHOOL, LONDON

An innovative scheme is underway at King's to teach general medicine from a general practice base. This was launched at the beginning of 1992 as a pilot scheme as part of the King's 2000 plan to develop a community-based teaching hospital.

Problems with hospital-based teaching of general medicine

Changes in hospital practice, and especially teaching hospital practice over recent years have resulted in a number of important changes for students. Medical thinking dictates a policy of shorter stays, and economic and political policies dictate fewer beds. This results in sicker patients in those beds and an increase in outpatient and community care. Even higher medical knowledge and technology has resulted in a splintering of general medicine into superspecialised units. Research has now taken over from teaching as the high status activity of teaching hospitals and the latter now occupies a rather lowly position in the academic hierarchy.

For students shorter stays and fewer beds mean a loss of potential patient contact. Sicker patients decrease not only the quantity but because of the 'greatly reduced opportunity for students to participate in patient care' decrease the quality of the experience too. Students based in hospital are increasingly seeing patients in just one phase of their illness, usually at their most ill when they are least able to help students. Increases in community care have no relevance to students still based in hospitals. Higher technology and superspecialisation leads to factual overload: 'We are in danger of floating off into society the human equivalent of floppy discs!'. The factual overload with its inherent lists and rote learning dulls the spirit of enquiry and leads to acquisitive rather than inquisitive patterns of learning.

Superspecialisation leads to a fractured and often biased experience. The emphasis on research has been at the expense of teaching; a lack of interest reflected in unclear or non-existent course objectives and unfair or arbitrary assessment. Students who used to complain of being humiliated at the bedside are perhaps now more likely to complain of being ignored. It is therefore not surprising to find so much dissatisfaction and disillusion amongst students, especially in the context of present worries over future careers.

The situation at King's

At King's we were faced with a similar changing pattern of health care. The response to this was the King's 2000 plan which aims to take care out of the community as far as possible, using the hospital only for things which cannot be done elsewhere, and to promote integration of that care across the community. This forms a creative response to the changes that affect all hospitals at present. It was made possible through the strong base that the hospital has in the surrounding local community.

However, these deliberate changes accentuate and accelerate the changes in hospitals discussed above. Therefore, at the same time the Department of General Practice set about developing a strategy for community teaching which would work alongside and integrate with the hospital development. The

King's Department of General Practice comprises a federal structure of linked practices and so has an ideal structure for this kind of programme. The general practitioner tutors have worked together to develop a high degree of teaching skill.

Advantages of a community base for teaching general medicine

General practitioners have been involved in a number of ways with undergraduates in different schools, but in the main this has been in showing them their work as GPs. We felt that potentially they could offer far more than this:

- They have large numbers of patients who are drawn from the same pool as the hospital. The patients discharged early from the hospital are being looked after by general practitioners based in the community. Newly convalescent patients are at an ideal stage for students to make contact.
- They are generalists who see a spread of disease of all types and at all stages. They see an appropriate balance of common and rare illnesses. They are experts in managing common and in spotting rare diseases.
- They have an increasing interest in medical problems.
- Teaching is a respected skill which elicits widespread interest within general practice, an interest demonstrated by the relative sophistication of vocational training in general practice compared to other vocational schemes.

Our ambitions for the scheme

In launching the scheme we set out our educational ambitions:

- To teach general medicine not general practice.
- To provide a safe, supportive and honest learning environment. In the context of this environment we felt we could encourage our students to be honest with us about their learning difficulties and problems (and we could be honest about our own strengths and weaknesses).
- To teach skills and to encourage self-directed learning. With the limited amount of teaching time available it seemed most appropriate to ask the tutors to teach skills and to help the students to be responsible for their own learning.
- To encourage an inquisitive rather than acquisitive approach to learning. To help develop a scientific attitude and enquiring approach to learning and go some way to combating superficial patterns of knowledge acquisition.
- To teach diagnosis and management of common diseases.
- To teach whole person medicine. This is usually thought of as a 'general practice' approach, which indeed it is, but it is one which would greatly enhance the practice of all specialties.
- To teach whole team medicine. To show how different disciplines work together to produce patient care.

These educational aims were developed into a series of specific objectives.

How the scheme works

Students join the eight-week firm (Firm C) as part of their first year rotation as they would to any other firm (the firm has taken over from one of the existing medical firms). Each firm takes four or five students. Each student is introduced to their general practice tutor who in turn introduces them to the practice. Larger practices may have two students, smaller practices have one student but work in pairs together so that their students share some teaching sessions during the week in order to avoid any sense of isolation and to encourage learning together. In the event this has been as important for the practices as for the students in giving tutors mutual support, and practical assistance with the teaching.

The students spend six sessions a week in the care of the practice and two in complementary hospital sessions. The remaining two sessions comprise their games afternoon and pathology lecture block. Of the practice sessions, four are spent with their tutor, one is left for self-directed learning in or out of the practice and the other is spent in a skills workshop with the whole student group together. We have found that the tutors need to protect approximately two sessions of their week for the exclusive use of their student.

In teaching general practice, the student and tutor usually spend much of the time working together in ordinary surgery sessions. For the purpose of teaching general medicine this would expose the student to a large amount of unsorted and inappropriate material. Therefore the activities that we encourage for the students are planned encounters between the student and patients in the surgery or in the patients' homes. The nature of the activities and their timetabling is negotiated with each practice to allow them to take advantage of any special facilities (such as diabetic clinics) and to give as much flexibility to the practices as possible in coping with the teaching burden.

To promote coordination across the firm, a major system is selected each week (such as CVS, neurology, etc.) and our teaching is coordinated around that. This was put in for logistical reasons but has proved very popular with the students as it gives them a framework around which to base their study. It is not intended to prevent opportunistic teaching.

In addition to the acute problems the students see in the practices, they are attached to a hospital medical firm once a week, presenting their findings at a teaching round later in the week. We have just begun a scheme to take our students into casualty where they meet unsorted acute admissions. This gives them a very practical and challenging opportunity to consider issues of diagnosis and management in patients who may not yet have seen a doctor.

The case presentation and the skills workshops

At the end of the firm each student is expected to make a case presentation based on a patient they have studied. They are expected to explore one aspect of their patient's problems in depth, going back to primary sources and presenting this to their colleagues and tutors in both oral and written form (the latter using a word processor). At the outset of the firm they spend time identifying skills they will require to carry out the various tasks involved. The skills they identify are each made the subject of a weekly workshop. Typical topics would include:

- Learning methods and learning resources.
- Case presentation methods.
- Communication skills.
- Using a word processor and information technology.
- Clinical decision making.
- Evaluating clinical research.

Assessment

We have built in several levels of assessment. Our students receive an end of firm assessment from their tutor based on the objectives we have set and which are shared with the students at the outset of the firm. They also take part in a short OSCE.

The tutor takes time at the beginning of the firm to review semi-formally with the student their current learning and skills, and carries out a further review about half-way through the firm in order to focus teaching in the latter part of the firm on any weak areas.

Perhaps of most importance is the continuous feedback they receive from their tutors in the context of a supportive and friendly environment. Honest self-appraisal is encouraged and constructive support offered to hone student skills.

Response from the students and tutors

The students were distinctly guarded in their response before the launch of the first firm. They were displeased at being allocated to the firm and would not have chosen it if they were given the option. Literally within three days attitudes had been transformed. Pessimism gave way to considerable enthusiasm. Points they made included: the careful planning of the course; the value of individual tuition; the sensitivity to student needs; the emphasis on practical skills; the weekly systems teaching. There is now much enthusiasm for the scheme across the whole student body. Negative points were: worrying that they might miss out on the social aspects of hospital life; working too hard!

The tutors shared the students' apprehensions in the period before the firm started. There was much free floating anxiety mainly centred around whether they would know enough medicine and whether they would find enough patients. Like those of the students these apprehensions were quickly quieted. There were no difficulties recruiting enough patients and the personal revelation of their competence in teaching medical skills was an empowering experience.

As the tutors became established in the work they continued to feel very positive about it. They particularly mentioned: satisfaction because of the depth of involvement with the students; developing medical and teaching skills; realising own strengths; developing links with other practices. The main problems encountered were those of time and organisation. The increase in workload was thought to be between 10 and 20 per cent ('and emotionally 100 per cent' said one tutor). (These opinions were canvassed in the very early days in the firm when the difficulties were likely to have been maximal.) The smaller practices all used locum cover for up to two sessions a week to allow them time to teach, the larger ones tended to cope with existing staff. The use of locums meant that the financial rewards of the firm were minimal. This did not put off any of our tutors but upset some of their less supportive and money conscious partners. Organising the teaching and sorting out and inviting suitable patients was hard work and time consuming. The current perspectives of two GP tutors are given in Boxes 10 and 11.

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BOX 10: IMPLICATIONS OF PERSONAL TUTORING ON THE COMMUNITY-BASED MEDICAL FIRM

BRIAN FINE, GP TUTOR

One of the aspects of the teaching on Firm C that has been in part responsible for the overall success of the project has been the large amount of teaching at a one-to-one level or in very small groups. This high level of personal teaching has offered opportunities for the development of new teaching styles based on a closer working relationship between tutor and student. The development of this relationship has powerful implications, but can also present some problems for both teacher and student.

BENEFITS OF EXTENSIVE ONE-TO-ONE TEACHING

1. Identification and solutions of problems. The development of a relationship between student and tutor based on mutual respect and trust, allows for the rapid identification of problems related to the learning needs of the student. This often results in a resolution of the problem, or in being easily able to think of ways of adjusting teaching and learning methods to encourage a more successful outcome. In addition to problems related to educational needs, other problems may also emerge which might hamper the progress and development of the student. These problems may be practical or personal in nature and though solutions are not always quick and easy, it is usually beneficial to think about the difficulties in an open way with the student.

2. Parallels with a patient-centred approach to medicine. The model of a personal, student-centred approach to teaching can act as a common model for that of a patient-centred approach to medicine.

3. Encouragement of positive self-criticism and self assessment. Through having a lot of personal contact with the tutor and developing a positive, mutually respectful relationship, the student may learn that it is both possible and indeed beneficial to examine problems in relation to the learning and start to evaluate progress for him- or herself.

4. It fits in well with the structured self-learning programme. Through a positive learning relationship with the tutor the student can be encouraged to take more responsibility for learning, and feeding back needs to the tutor.

PROBLEMS THAT CAN ARISE OUT OF EXTENSIVE ONE-TO-ONE LEARNING

1. Dealing with problems that may emerge. Difficulties may arise for the tutor in responding appropriately to problems that the student may wish to share, particularly if these problems are of a personal nature.

2. Providing adequate training and support for the tutor. The tutor needs to be able to think through possible problems that may emerge and be clear as to how these might be approached. The tutor may not have a lot of experience and will need appropriate support and training.

3. Time. This approach involves a lot of tutor time in terms of planning as well as the teaching itself. Some tutors have found this to be a major diffficulty.

4. Modelling by the student. Because the one-to-one teaching relationship can be so powerful it is likely that there may be some modelling by the student on the tutor. This may be undesirable a) because the model might be inappropriate, and b) because it is probably more helpful to encourage the student to develop a style of his or her own.

5. Unmet expectations of the student and tutor. The student may hold an image of learning connected with the model of a junior doctor, working in a hospital, dealing with dramatic events, working in a team with other students. The tutor may feel frustrated at the problems in achieving the potential that this style of teaching offers.

Despite these problems, the experience of the community-based medical firm so far has confirmed the power of the large amount of one-to-one teaching in motivating students and achieving successful learning.

BOX 11: DEVELOPING SELF LEARNING IN THE COMMUNITY-BASED MEDICAL FIRM

HELEN GRAHAM, GP TUTOR

PROBLEMS WITH COMMUNITY TEACHING

Despite the benefits of one-to one teaching, GP tutors report that the dual demands of primary care and student supervision for eight weeks is too intense. Tutors feel they are expected to provide a constant flow of clinical experiences. This is an unrealistic situation and results in stress for both tutors and students. It is not a teaching model used in hospitals, where tutorials are interspersed with free periods for the clerking of patients.

TIME MANAGEMENT AND LEARNING STYLES IN COMMUNITY TEACHING

Many students complain of too much time 'wasted' on the wards. GP tutors fear the same may be true of general practice attachments. What students are really saying is that they have not learnt to use time for their own learning needs. The problem is one of time management: time to identify deficiencies in their knowledge, to learn at an independent pace, and to learn to use resources appropriately. They need time for self-directed learning in the hope that the didactic learning model of the pre-clinical years will develop into the adult learning model in which gaps in knowledge are self-corrected.

RESOURCES IN GENERAL PRACTICE

General practice does not have ever-present patient resources on the premises. When the last patient leaves, the waiting room is empty. Developing self-learning projects will need to use alternative resources within primary care. Clinical decisions in general practice are based on information from a wide range of sources which include pathology, X-rays, simple equipment such as peak flow meters, urine dipstix, assessments by nurses in screening clinics, and functional assessments in patients' homes. Teaching practices have libraries and journals. All these provide a potential basis for self-directed learning.

AIMS AND OBJECTIVES

With the limited teaching time available, we aim that tutors should teach skills, and that students should be responsible for their own learning. However, students need to be guided through self-learning if it is to be effective. Structured self-learning projects could complement the weekly topic, and could be adapted to the needs of an individual tutor and practice. The student would be encouraged to develop an inquisitive rather than an acquisitive approach to learning, through the application of observation and deductive reasoning to clinical problems. Examples have included case studies with attached blood results and a worksheet designed to guide the student through the diagnostic process; and an 'instant disability exercise' to sharpen the students' awareness of the impact of disability on daily life, and the importance of functional assessments. Follow-up of these topics can be done during a tutorial session.

THE FUTURE

We intend to develop structured self-learning approaches in the community firm, and to validate their effectiveness as a learning method. We hope that it will provide a suitable model for use on other firms.

EXAMPLE 3: THE FIRST FIVE YEARS
AN INCREMENTAL APPROACH

CHRIS DRINKWATER, NEWCASTLE

The family study: Year 1, Term 1

Mixed sex pairs of students are introduced to a pregnant woman due to deliver in approximately three months, and make regular visits during pregnancy and after delivery. The objectives are:

- To observe and understand in its context the background of the family, e.g. housing, family activities, relationships and finance.
- To understand the history of the pregnancy, labour and delivery.
- To observe and understand the development of the new-born baby and the effect it has on the family.
- To observe and understand the family's use of health and other relevant services.
- To observe and understand the family's interaction with the wider society, e.g. in work and in the community.

The key issue is observation and understanding and this is supported by linked lectures and seminars. The students are given two other tasks: to write a report of not more than four thousand words; with the cooperation of the family, to complete a questionnaire which forms the database for collated information about all of the families which is used in subsequent teaching.

The learning outcomes are: an abilty to establish rapport and communicate effectively; an appreciation of users' views of health services; an understanding of how survey data is collected and used; an ability to integrate theory and practice in the presentation of data.

The main assessment tool is the students' individually written report which is marked and contributes ten per cent of their total marks for the whole year. There are also problem-based assessments at the end of each year.

The patient study: Year 2, Term 4

Mixed sex pairs of students visit a patient with a chronic disease or disability. The focus is again on observation and understanding, but the students are expected to appreciate how the patient's condition affects structure and function, its epidemiology and how medical services can intervene to prevent and ameliorate the condition.

The learning outcomes are similar to those expected of the family study. The increment is an increased depth of clinical understanding. There are also three linked tasks: observing one of their GP tutor's evening surgeries; taking part in two video role play exercises; writing a report of not more than four thousand words on their patient, and demonstrating critical reading skills by reviewing two scientific papers relating to this report.

Future plans: Year 3–5

The challenge is to build incrementally on this existing base so that students acquire skills, knowledge and understanding within a structure that emphasises development and continuity.

There are eight GP tutors for each of the first two years; instead of stopping at the end of Year 2 they should continue to have a role which would include coordination of community-based clinical teaching. The main resource implication of this is an increase in the number of tutors, with a parallel increase in tutor support services.

These tutorial groups should then be linked to a network of clinical specialists and the students' problem solving approach would be reinforced by looking at the following problems over a continuum:

- How does the problem present to the GP? (which could include issues about why the patient decides to present).
- What does the GP/student do? (examination, investigation, treatment, referral – general issues about the process of decision making).
- What does the specialist do? (as above).
- What are the long-term implications, need for follow-up?
- Epidemiological perspectives at various stages of this process.

The advantage of this approach is that it follows the normal process of care. It would, however, require considerable cooperation between GPs and specialists. This might take some time initially, but in the longer term at least some of this could be supported by resource packages.

An important advantage of this approach is that it would allow students an opportunity to explore the need for teamwork and would also give them the opportunity of learning to become a member of a team. This could be reinforced by:

- Patients as teachers – particularly members of self-help groups.
- Some deliberate multidisciplinary learning elements, e.g. care of the elderly with District Nurse and Social Work students.
- More teaching by other professional groups – dieticians, health visitors, physiotherapists, etc. All of this would require a skilled coordinator with time and resources.

EXAMPLE 4: CO-OPERATION WITH OTHER DISCIPLINES

CARL WHITEHOUSE, MANCHESTER

The Department of General Practice is, or has been, involved in three areas of community-based teaching. This summary concentrates on aspects where there has been cooperation with other disciplines rather than basic primary care teaching.

Community follow-up – first clinical year

From 1983-90 the Department of General Practice has been involved with a number of medical firms at the three teaching hospitals in organising follow-up of patients in the community after discharge from hospital. Students have identified patients, visited them at home and then discussed their findings in seminars jointly led by members of the Department of General Practice and physicians. The aims of the exercise were to learn more about the natural history of the disease, the influence of the disease on the patient and their family, and the influence of the family and the environment on the disease. Evaluation by student feedback was positive. This has been temporarily suspended because curricular reorganisation with shorter medical firms produced logistical difficulties. There is a proposal to reintroduce the scheme on a pilot basis from 1992.

The Medicine in the Community module – second clinical year

This eight-week module was introduced in 1986 by the Departments of Geriatrics, General Practice, Public Health, Occupational Health and Paediatrics, to enable students to learn different aspects of medicine in the community. The first four departments contributed their total curricular time and the Department of Paediatrics contributed one week to cover community paediatrics. It was envisaged that hospital aspects of geriatrics would also be covered, but the multidisciplinary approach would enable students to learn the interactions between hospital and community. Teaching was to be problem-based, each week looking at a theme (three concerned with the elderly, two with adult years and two with families with children) and beginning and ending with a multidisciplinary seminar. Students were to be attached to a general practitioner tutor, and to learn about public health and community provision in a single district. The departments agreed four themes which encompassed their separate departmental objectives for the module. These themes were: 'clinical realism' (which covers the field of a broad needs-based assessment, setting of achievable care objectives and acceptance of uncertainty); management options and resources; communication and teamwork; ethical issues.

The module has been consistently highly rated by students, but there has been no formal evaluation of the achievement of objectives. The module is the only one in the year which is not assessed as part of finals. There have been various modifications in the structure and achievement of effective multidisciplinary input has been variable. The geriatrics department has changed staff and become unhappy with the module as a way of achieving their objectives, and intend from January 1993 to move to two weeks of hospital geriatrics teaching, leaving the other departments to develop a six-week community module.

A community 'firm' – first clinical year

The reduction of beds in one teaching hospital led to a shortage of opportunities for students to obtain clinical teaching on the wards. Proposals were made that one 'medical firm' would be a community one with teaching from general practice. At the time these proposals proved logistically impossible and the eventual proposal was that one firm spent two out of their five clinical sessions a week receiving teaching from the Department of General Practice. This was done as group teaching. One session included patients with conditions that would exemplify the topic of the day. These patients (chosen in advance using practice disease registers) were invited to attend for the seminars; students did not see them in their home environment. The experience and teaching was highly rated by students, but administrative workload was high, and the teaching or clinical opportunities could not be achieved within normal medical activity – both patients and teachers had to make special arrangements, making this a high-cost approach. Changes in the curriculum since 1990 have led to the shelving of the experimental community firms.

Future plans

As stated above, there are likely to be further experiments in community follow-up, and a radical review of the Medicine in the Community module is currently taking place. A major curricular review is also underway with setting of basic objectives. It is anticipated that community teaching will contribute to the achievement of these objectives within a multidisciplinary approach. In the medium term there will be involvement through general practitioners teaching in association with medical firms (both in the teaching hospitals where students do medicine and surgery in the second clinical year), and offering opportunities for students to follow-up patients and learn within the community.

Achievement of the above requires resources for GP tutors to be away from practices and involved in multidisciplinary hospital teaching. Obtaining such resources would be facilitated by sharing of experience from other regions, especially if this includes evaluation of achievement of basic medical educational objectives.

EXAMPLE 5: THREE TYPES OF TEACHING IN GENERAL PRACTICE

P M REILLY, BELFAST

Essentially two types of teaching take place in Northern Ireland and we hope to develop a third type soon.

Early patient contact (started in 1989)

On arrival at medical school (five-year course, 150 students/year), pairs of students are attached to families or households throughout Belfast. This selection is made by 25 GPs who each provide three families and therefore relate to six students. Students are briefed initially and thereafter visit their family at least once per term. They also have a tutorial (two hours plus) from their GP each term. The GPs have been thoroughly briefed and all have a list of objectives, basic guidance handout, plus a short selected reading list. GPs attend a seminar annually. They are paid via NHS funds using rule in the Statement of Fees and Allowances (SFA). They therefore get £11 (approximate current figure) per student per session. Having six students means they get enough to buy in a locum if necessary, i.e. they get protected. The students are to write a commentary over the two years based around their visits, reading and guided by the objectives. Usually this is a joint effort between each pair of students. When students come to the brief but more formal sessions in psychology and sociology in the fifth and sixth terms they have done some experiential learning. They can be their own resource (in part) or at least any group of them can have been exposed to several issues – chronic illness, stigma, disability, unmet needs, etc. The course needs a more formal, probably interdisciplinary assessment which is part of the end of course assessment.

Student attachments

These more conventional attachments take place in the fourth (pre-final) and fifth years. They are two weeks in duration. They are preceded by multidisciplinary seminars (alcoholism, terminal care, bereavement, handicap, ethics, etc) and also have a specific week of orientation in the department with interview skills and primary care team exercises to the fore. Increasingly we are specifying what we want from the teaching practice, who are asked to make a programme out with the student who also has a checklist of activities which are supposed (indeed are) to be carried out. The students undergo end course assessments (clinical, modified essay questions, OSCEs, etc.) on return to the department.

Clinical teaching in the community

We shall soon begin these teaching sessions for senior medical students in local practices. In these sessions one practitioner, plus other primary care colleagues where relevant will take six students per half day. At least six patients with a common disease will be interviewed, examined and their management discussed. The focus of this exercise is competent clinical medicine, good examination technique, ability to relate to patients and team members, negotiated decision making, awareness of the patient's family, relationships and environment. GPs will again get payment through SFA rules. The level of payment for six students should protect them from the immediate demands of the practice. A locum could easily be paid for. Such teaching would really be assesssed in final professional exams.

Constraints and solutions

The main constraints are: organisational, financial, GP recruitment, training, protection; tertiary care attitudes in some places. Solutions will come from: better funding of departments of general practice; realisation by GMC, UFC, Department of Health and some medical schools that the range of patients with common illnesses plus trained and educated generalists are in the community with reasonable facilities. The development of Hospital Trusts and GP Fundholding could hasten this process, though not without the odd crisis.

EXAMPLE 6: AN EXPERIMENTAL PARALLEL MEDICINE COURSE

NIGEL OSWALD, CAMBRIDGE

A project is due to be initiated in Cambridge in October 1993 in which a small group of volunteer students (four per year in the initial experimental phase) will be based in a general practice continuously for 15 of the 27 months of the clinical course. The students will follow patients of the practice in their contacts with the teaching hospital and will thus receive teaching from specialists as well as from their general practitioner teachers. At the same time they will also be exposed to the context of health, illness and recovery and to the issues of disease prevention and irremediable illness. Thus, a more integrated education using present under-utilised resources will be achieved.

Objectives of the course

By the end of the placement in the parallel course the student will be able to demonstrate:

- An awareness of the principles of medicine appropriate to a student undergoing basic medical education.
- A high degree of skill in clinical method and in the early stages of clinical problem solving.
- A high degree of skill in communication with patients and other health professionals.
- An understanding of health, illness and rehabilitation as a continuum in which each episode is an event in the life history of an individual and family.
- An enquiring attitude to medicine, coupled with knowledge of how to formulate and pursue appropriate research questions.
- A capacity for self education and self motivation.
- Knowledge and practical experience of the interrelations between primary and secondary care.

Practical and educational arrangements

Learning will take place at the practice premises, in patients' homes both in and out of hours, in hospital outpatients, special departments, wards and operating theatres. Students will do substantial periods of on-call work and will be mobile and in continuous contact with their supervisor. Hospital experiences will be largely based on the illnesses of patients of the practice. This has been demonstrated to be a practical proposition.

A significant amount of teaching will continue to be led by hospital specialists. There will be opportunities to develop collaborative teaching with the initiation of clinical sessions by specialists in the practice. The value and implications of such sessions will be explored as part of the project.

The basis of learning will be through small group, one-to one, peer group and self-directed learning. Teachers will be experienced in small group and one-to-one methods. The most exciting developments may be in self-directed learning and in developing students' own strengths as teachers.

In order to achieve these aims, students will need to pay detailed attention to their own education. To make the course effective and to achieve the goals of the GMC, part of the experiment will involve the development of a 'core' curriculum which will specify knowledge and skills to be attained and attitudes to be addressed by students. The appropriateness and applicability of such a core will be assessed. Formative methods of assessment of students in this setting will be developed and will require specific educational guidance.

The project proposes to follow graduates through their professional training, seeking evidence whether the objectives achieved during basic training are converted into professional attitudes and competences appropriate for an evolving and responsive health service. This will in part involve the use of attitude inventories devised locally for other projects.

Evaluation

A research period of five and a half years is envisaged. This will allow for one year's preparation, and for 16 clinical students to have entered the parallel track, 12 of them having reached their qualifying examination. Evaluation of the project will demonstrate:

- Detailed knowledge of the experiences of the participating students.
- The specification of a carefully considered core course of knowledge, skills and attitudes appropriate to basic medical education.
- Research findings on the development of alternative teaching methods, including self-directed and peer-group learning.
- The development of formative and summative assessment methods appropriate to learning in the parallel course.
- Implementation of proposals to assess and follow the progress of doctors who have qualified through the parallel track.

Resource implications

The major costs of the project will be salaries. Two full time teachers will be required to run, evaluate, develop and report the experimental pilot study. Educational and secretarial support will be essential. Further expenses will be associated with the need to acquire and maintain temporary accomodation, equipment (including computer hard- and software), video recording facilities and communications with other students. Travelling and training, including training of other interested general practitioner academics will also be necessary.

While it is expected that the medical school will be able to provide medium to long term support, during the experimental period, external funding is being sought for the majority of expenses. Although the teaching input for this experimental period is substantial, it is anticipated that the ultimate costs of education in a parallel track will be no greater, and could be less than, those in conventional medical education.

EXAMPLE 7: A FIRST CLINICAL YEAR COURSE

M JOHNSON, A HAINES & M MODELL, UNIVERSITY COLLEGE , LONDON

Aims and objectives

- Acquisition of knowledge of epidemiology, natural history, presentation and management of common disorders.
- Acquisition of skills in history taking, physical examination, communication and problem solving.
- Appreciation of the importance of social and population factors in clinical medicine.

Methods

Two parallel tracks have been run over the current academic year: one in which four students spend six weeks in a practice and meet for teaching sessions in the Department of Primary Health Care, and a second in which pairs of students peel off from a six-week hospital-based medical firm to spend two weeks in a practice. Patients registered with selected GPs are the major resource, and students spend most of their time seeing cases in their own homes, in the surgery or other locations such as day centres. The course is structured to ensure that students see a wide range of common diseases, with weeks two to five of the six-week module each being allocated to particular areas of medicine. For example in the second week students will see cases of IHD, diabetes and stroke. At the end of each week students meet with one of the course tutors to pool experiences and knowledge gained in a plenary session. Students are encouraged to observe and take account of the social setting in which they see the patients, and the population aspects of medical care are reinforced by an epidemiologist whose teaching is closely linked to the clinical experience they gain in the community.

Evaluation

Evaluation of the course is conducted by the students themselves using anonymous questionnaires and has so far been encouraging. Students are assessed 'subjectively' by the GP tutor to whose practice they are attached and 'objectively' by an end-of-firm OSCE.

The Future

We will be taking eight students on each six-week cycle as well as continuing with the current two-week cycle in the coming academic year. We are continuing to develop links with departments as diverse as general medicine, oncology and public health to widen the scope of teaching provided and to integrate teaching across disciplines. We plan to create a more detailed process for evaluation, including investigation of any relationship between psychometric variables and the acquisition of particular skills.

Main constraints

There are two major obstacles. One is recruiting already overstretched GPs to take on what is quite a taxing educational commitment. We offer an inducement in the form of two clinical lecturer sessions to each GP tutor, but even then we face a difficult task.

The second problem is probably more important. It concerns the position of our innovative course within the context of a still largely traditional curriculum, a hospital specialist-oriented final examination, and a subsequent obligatory year as a houseman with working conditions and educational input still very far from acceptable. Students understandably regard the final examination and housemanship as the end-points of their undergraduate years, and if these remain largely unchanged then innovations such as ours may come to be seen as irrelevant to their needs.

EXAMPLE 8: A NEW CLINICAL FOUNDATION COURSE

JENNY FIELD, SOUTHAMPTON

As from September 1992, third-year students at Southampton will start their clinical course with a six-week Clinical Foundation course. During this time students will be attached in groups of three to a clinical tutor who will be responsible for helping the students to achieve the following aims.

- To orientate themselves in the hospital and the general practice settings.
- To develop simple communication skills.
- To assess patients' presenting problems.
- To assess psychological well being.
- To carry out a screening clinical assessment, i.e. history and examination.
- To record and present orally information about patients.

During this first year only one of these tutors (myself) will be working in the community; all the others will be hospital-based consultants and senior lecturers. We would like more community-based doctors to be involved in the future, as we feel these basic clinical skills should be able to be learned in a wide variety of clinical settings.

Main constraints

- This teaching will be time consuming. Consultants have junior staff and can delegate teaching, whereas GPs do not.
- Some hospital-based teachers do not believe that GPs can teach clinical skills.
- Some GPs do not have the confidence to teach clinical skills, as they believe their diagnostic method to be less valid than the hospital model.
- Students may feel upset to miss the 'hi-tech' hospital approach during this time if their peers are enjoying this.

Possible solutions

- Close liaison between a GP tutor and a consultant tutor may share the teaching time and benefit both sets of students as they see medicine in both contexts.
- Discussion of the teaching of clinical skills among the large group of clinical tutors may show differences in approach between the group of hospital teachers at least as great as the differences between hospital and general practice.

EXAMPLE 9: PRACTICE-BASED PROJECT WORK

PETER BUNDRED, LIVERPOOL

For the past five years, community-based project work has been part of the third year curriculum at the University of Liverpool Medical School. Initially the projects were epidemiological in nature, usually involving the students in gathering and procesing of information from population-based surveys. The projects have evolved over the years into small group research topics with individual general practitioners. The students have had some choice over the study topic and with whom they worked.

Since 1990 this project work has been directed at audit in general practice. Initially the students were attached to practices in the city in groups of four or five; more recently the students have been travelling further afield. Practices are asked to submit bids to the Department of General Practice some weeks before the audit week. Some eight to ten suitable projects are chosen by members of the department from the 30 to 40 usually received from interested GPs.

At the start of the week the students are given an introductory session and then they choose a topic from the list supplied. The groups which are self-selected then meet a departmental tutor who helps them to develop a protocol for the audit project. The students then disperse to the practices to discuss the protocol with the GP. There is usually some negotiation between students and practitioners about the scope of the project. Data gathering usually starts on the second day of the week and continues into the fourth day. The afternoon of the fourth day is set aside for the students to access the university computer laboratory for the analysis of their collected data and to write up the results of the project on the morning of the fifth day. Finally there is a seminar on the afternoon of the fifth day when the students present the results of their projects to the group and to the GPs who are always invited to attend. There is a prize for the best project which is donated by the Liverpool FHSA.

We have found the audit project to be an exciting community-based learning experience for the third year medical students. It is often their first experience of general practice which means that they are now exposed to the GP in their third year rather than in the fourth year which previously was the case. They are made aware of the importance of audit early in their clinical course. They learn the importance of the development of protocols in their project and lastly they get experience of the use of computers in the analysis of data and report writing.

Although students and staff find the week to be rather hectic, it is enjoyed by all. The students often comment that they enjoy the independent learning that this project gives them.

EXAMPLE 10: A GP TUTOR'S PERSPECTIVE

S RATNESWAREN, ELTHAM

I work in a two-partner practice in an urban setting (Eltham/Chislehurst) and we look after just over five thousand patients. I have been involved in student teaching since 1989. We have students from the United Medical and Dental Schools of Guy's and St Thomas's Hospitals. We take one student at a time and they spend four weeks with us. On average we receive about six medical students in a year. GP tutors meet the Department of General Practice at UMDS at least once a year for about half a day.

Every week the student is expected to spend five sessions in the surgery. During their attachment we as GP tutors are expected to cover four main areas: minor illnesses, psychological disorder; chronic diseases and ethics. Students are also given an opportunity to spend time with the district nurse, health visitor, practice nurse, social worker and the local pharmacist.

Constraints and barriers

Teaching is a very enjoyable hobby but I feel the link between the Department of General Practice and the GP tutors in the periphery seems to be very weak. The present once a year meeting is inadequate and does not help us to evaluate our own teaching skills. At the end of the clerkship each student submits an evaluation of his/her GP tutor and I am not sure whether they give a true and frank opinion. At present I do not see any plan by the Department to help the GP tutors to improve their teaching skills. During the four-week attachment, medical students return to the medical school each Friday for seminars. I would like to take part in the seminars, and obviously I could take my own initiative and attend, but taking time off from work is not easy. I have to find a locum to cover my work and locum pay has become expensive.

Student assessment

Another difficulty I have is in making an objective assessment at the end of the attachment. We are supposed to grade the students in knowledge, clinical skills, and application and attitudes. Since the students who come to us are at different stages in their clinical course, their knowledge, skills and attitudes vary and grading becomes difficult.

c) INTEGRATED APPROACHES

CASE STUDY 3

AN INTEGRATED SOCIAL MEDICINE COURSE

MICHAEL JOFFE, ANITA BERLIN & CHRISTINE VIZE, ST MARY'S, LONDON

Need for course/approach and getting commitment/agreement

The general curriculum review process at St Mary's is committed to implementing the GMC recommendations for greater integration of teaching in the areas of general practice, community medicine (now called public health) and behavioural sciences. Structures are in place to put this commitment into practice and a Curriculum Review Group has been set up to look at the curriculum which will ultimately aim also to introduce vertical integration into the undergraduate medical curriculum once the present constraints of examination regulations are removed. There is strong medical school support for this process and the Social Medicine course is seen as a pilot project for a major part of the wider curriculum review. A steering group meets monthly and detailed planning is underway.

The departments of General Practice, Public Health, Psychiatry, Medicine of Old Age and Palliative Medicine have been planning this course for a number of years. Students have been consulted throughout. A considerable degree of detail has already been finalised, a part-time administrator has been employed, funded by the Clinical Division of the Medical School and a start date for the course of 1 February 1993 agreed. Furthermore, a lecturer in General Practice with appropriate experience and a specific remit for this course has been employed.

This is a very ambitious project which takes half a year of students (fifty to sixty) as one group and no opportunity will be available to pilot the scheme, so the course's success or failure will only be known once the course has started next year.

The plan is to develop a predominantly community-focused course aiming to provide students with knowledge, skills and attitudes in primary and secondary care from an individual, social, psychological and population perspective. To achieve this we are devising a six-month, horizontally integrated 'Social Medicine' course for medical students in their first clinical year. This will combine the teaching of general practice, public health, psychiatry, medicine of old age, palliative medicine, oncology, ENT, dermatology and ophthalmology. It will also permit the integration of communication skills, health promotion and health services management and group projects throughout the course and across the subject areas.

Description of the planned course

The design of the course is based on the following guiding principles:

- To encourage the interaction between individual, family, social and community factors to be studied.
- To allow sufficient continuity for the 'natural history' of specific complaints to be observed both within hospital and the community.
- To expand on and integrate the inter-personal skills teaching already available.
- To link a health promotion and health policy approach with a diagnostic and treatment model of care.

- To encourage a critical and evaluative method of enquiry, taking into account ethical and legal issues.
- To encourage interdisciplinary teaching and teamwork.
- To allow for a synthesis of factual information through regular small group tutorials.
- To foster attitudes appropriate to caring professionals regarding race, sexuality and disability; the course will actively seek to challenge prejudice and broaden concepts of normality.
- To help prepare medical students for a life-long education which is reflective and adaptable.

The timetabling of the course will concentrate on integrating the clinical hospital-based teaching and GP-based teaching with one and a half days a week of seminar teaching (including tutorial time). This will allow the general practice attachment to be spread over the whole six-month course which has advantages in terms of continuity. The teaching time will be allocated in the following way:
Monday: Clinical time
Tuesday: GP clinical time
Wednesday: Seminar time (morning only)
Thursday: Seminar time (including two hours tutorial time)
Friday: Clinical time

Communication skills will be taught as a specific topic and from several specialties' perspectives early on in the course and topped up throughout the course at appropriate intervals to monitor students' progress and pick up on any areas that require attention. This will enable students to put their newly acquired skills into practice in their subsequent clinical experiences and have opportunities to raise any issues that might arise in real situations at specific times throughout the course.

The clinical time, other than the GP day, will include attending outpatient clinics and ward rounds and time spent with health care teams in the hospital and at community sites. Due to the complexity of timetabling specialties with fixed clinic times, the specialties involved will be slotted in as appropriate, aiming to strike a balance between providing sufficient continuity within specialties and useful integration between them.

The two sessions per week allocated to a GP practice will not only allow the students to gain experience of general practice but also give them opportunities to follow up some of their learning in other related specialties through case studies, projects etc. It is envisaged that this method will enable students to follow patients along the primary and secondary health care routes as well as giving them an insight into the workings of a local health authority. There will also be one complete week where students will go to a rural practice to gain a different and specific general practice experience.

The seminar time will be predominantly arranged as interactive seminar teaching time with groups of about 14 to 15 students. A variety of teaching methods, including self-learning modules will be used. The seminars for the more clinical specialties will obviously come before the subsequent clinical teaching.

A regular tutorial slot once a week, with groups of seven or eight students, will help ensure that integration of the curriculum occurs and enable the students to reflect on what has been learned. It will also enable the tutors to assess their students' progress and help to spot any difficulties along the way and offer opportunities for formative evaluation. Part of the tutorial time can also be given over to areas not officially covered by the specialties but relevant to them all, e.g. ethics teaching, and for this outside expertise can be brought in as appropriate.

A major part of this learning will be through the allocation of cases to students to follow up both from the community and hospital perspectives and individual and epidemiological angles. This reflects the genuine shift in practice from hospital to community (particularly with regards to the mentally ill and elderly patients) and a need to focus education on the change in demography.

Evaluation

Evaluation is planned to:

- Ensure that students attain an appropriate level of skills, knowledge and attitudes. (It will be mandatory to pass the course in order to sit University of London finals.) A mechanism will be built in for students who fail the course.
- Provide information to improve the course as it progresses.
- Measure the outcome of the course in terms of students' views, teachers' views and resources.

The current project to evaluate the existing outpatient clinical teaching funded partly by the King's Fund will complement the Social Medicine course by providing useful information which we can incorporate into our evaluation structure.

Positives

Support – The course now has the support of the Dean, the Clinical Studies Committee, the Timetabling Committee and the students themselves, and the start date of 1 February 1993 has been fixed.

Link with curriculum review – The course is now seen as something of a pilot for the curriculum review process in St Mary's and incorporates a number of the recommendations of the GMC with respect to the development of interdisciplinary learning, self-directed learning and a community focus.

Learning – It is hoped that the new learning methods will help facilitate acquisition of the knowledge, skills and attitudes that are required by medical students. Learning will be task and problem based to encourage integration of overlapping topic areas. The course workbook will provide a means of formative assessment as well as providing guidance, detailed objectives and giving cohesion to the course. The tutorial system will encourage small group learning and will help students with an educational approach with which they may not be familiar.

Teaching – We have received a grant towards the costs of staff development from the King's Fund for the first two years of the course. The participating GPs will be given a priming session in the early autumn and follow-up training workshops before the course starts, together with further sessions once the course is up and running. Other staff will be given training as a rolling programme running parallel to the course.

Management – It is a big advantage to the course to have central administration and management, and money has been given by the Clinical Division to fund a coordinator for two years. This is seen as essential for the smooth running of such a complicated course, which now has subgroups dealing with course content, timetabling and staff development, and to which representatives of all involved specialties are invited.

Problems

Strategy – There is a lack of coherent strategy in the existing courses, which has made the task of developing an overall strategy for the new course very difficult. Due to the time constraints and number of people involved, it is being done in rather a piecemeal fashion. We need a shared vision for the course to succeed fully.

Time – This is a hugely ambitious project and there has not been enough time so far to devote to detailed planning by the steering group. There is no chance to pilot the course and no opportunity for parallel tracking. (The teaching commitment will be increased as teachers will be teaching smaller groups but more often).

Flexibility – A great deal of flexibility and compromise is required both within and between departments with respect to the content of the teaching, methods of teaching and timetabling. There needs to be a shared vision of what the course is about for its integrative nature to be achieved.

Skills – New administrative and teaching skills need to be acquired. For some departments there will be a very sudden switch from traditional teaching methods. Staff skills and confidence to teach some of the specialties needs to be addressed.

Finance – GPs will need to be funded for half day locum per week as teaching will be more active than at present. There will be more work for practice administrators in compiling patient lists for case studies. Some practices may need structural alterations. The Tasked money which has been obtained will help with GP payments. There is the question of payments for other teachers who do not get SIFTR money for their departments at present – those in community-based specialties such as palliative care and those in hospitals outside St Mary's itself. The cost of student travel also needs to be considered.

Other resources – More suitable accomodation needs to be found for the increased amount of seminar teaching. More video equipment is also necessary as well as additional books at all sites to enable students to pursue self-directed learning.

Timetabling – This is a very complex task. It will be necessary to integrate timetables from all departments, with arrangements to cover holidays and sickness. Some specialties can only teach at St Mary's so careful planning is required to avoid excess travelling for the students who are doing their principal attachments elsewhere. Clinic times are generally fixed due to the shortage of consultation rooms, and this will also present difficulties.

Future plans

- Immediate aim is to meet start date of 1 February 1993.
- Methods of evaluation and means of modifying the course if necessary need to be worked out and agreed upon. A way of ensuring that the students meet the objectives set out for them at the start of the course needs to be reached.
- Staff development programme as parallel rolling programme and possibly extended to include broader staff development for curriculum changes.
- Possibility in due course of a one-year Family Medicine course to include Obstetrics and Gynaecology and Paediatrics.

Postscript

Following the presentation at the King's Fund, planning of the course continued while efforts were made to find solutions to outstanding difficulties. By mid-September, with the new academic year about to begin, these had not been resolved; the timetable was unworkable as the 'ologies' would not release students for core teaching and Tasked money, needed to compensate GP tutors for additional teaching, was not forthcoming.

The Steering Group decided with much regret not to implement the course in February 1993 as planned, but to continue to work together in order to provide the planned staff development programme and to develop pilot projects in integrated learning with a view to introducing a modified course in 1993–4.

As the dust begins to settle it becomes clear that if the course is to succeed now there is a need to establish and maintain a shared vision and clarify what is meant by 'integration'. There needs to be more explicit institutional support and consideration of financial factors affecting non-SIFTR teachers.

All parties involved with the course felt they had gained through the need to review their current departmental teaching and develop clear learning objectives, while establishing very useful interdepartmental links.

EXAMPLE 11: PROPOSAL FOR COMMUNITY-BASED GP/CONSULTANT FIRMS

NICK PARRY JONES, UMDS, LONDON

Background

The rationale for basing undergraduate teaching in the community has been well rehearsed. An important defect of the existing hospital-based system, and of the recent proposals for undergraduate education to be carried out largely by GPs, is that both perpetuate the GP/hospital divide: the inequitable split between time spent with specialists and time spent with GPs would simply be reversed. It is questionable, too, whether GPs could accommodate the workload beyond the pilot stage.

Proposal

Undergraduate medical education should be based in the community where consultants and GPs combine to form joint teaching firms as follows:

- The GPs and consultants on the firm would jointly define the educational objectives of the firm, devise a programme and timetable for the students on their firm, and share the teaching workload between them.
- Consultant teaching would be based on midday outpatients held in the practices of participating GP teachers. These would have both academic and service functions. Students would both sit in with the consultants and clerk some of the referrals for immediate presentation to the consultant or accompanying junior staff.
- GP teaching would be based on students sitting in on the GP surgery, on consultations or clerkings done by students and presented to the GP, and on accompanying the GP on home visits.
- Students would follow-up on patients they had seen either in community outpatients or in the surgery.
- Students would regularly present patients they were following at joint multidisciplinary teaching rounds held in the teaching practices and in the hospital (to discuss inpatient management).
- It is envisaged that the joint firms would be particularly suitable for the teaching of general medicine and surgery. For junior students the focus of teaching would be on the acquisition and practice of basic skills (on communication, interviewing and examining patients, for which there would be designated teaching sessions). For senior students the focus could be on interpretation, use of knowledge and decision making.
- The consultants on each firm could each have a different specialty in terms of the service expertise they brought out into the community; their teaching brief would be to teach general medicine or surgery to undergraduate level.
- The firms would be based each on a different geographical patch within the reach of the medical school. This school would provide each firm with an administrative assistant. The participating GPs within each patch would be on a contract with the medical school to provide teaching services, as would the consultants on the firm. Periodically the consultants could rotate (individually or en bloc) around the geographical patches, to provide fresh interaction at a postgraduate level.

Possible benefits

- Students would experience primary and secondary care simultaneously (following patients between the two phases) and they would receive teaching aiming at integration. There would be no need for a general practice firm as such: final year students could conduct one or more of their 'shadow house officer' placements in general practice as a 'mini-trainee'.
- Seeing them actively cooperating in both the care of patients and in teaching, students could come to enjoy and value the differing skills and knowledge of both consultants and GPs, experiencing them as complementary to each other, rather than alternatives.
- In combining into firms to teach undergraduates, consultants and GPs would learn directly and indirectly from each other. This two-way postgraduate exchange of knowledge, expertise and viewpoint could enrich both service and academic relationships.

A pilot study

Four existing teaching hospital firms (two medical and two surgical) could link up with interested GPs. Each firm would operate for six months as a community-based firm, sharing the teaching with GPs, and for six months as it currently operates, as a hospital-based firm. A study group of 32 students (4 x 8) rotate through the four firms when they are in 'hospital mode'. The study group and the control group are assessed at the beginning and at the end of the year against agreed criteria, and staff and students contribute to the evaluation.

EXAMPLE 12: THE DEVELOPMENT OF COMMUNITY PSYCHIATRY

CLARE ADAMS, BELFAST

Background

The development of community psychiatry in Northern Ireland with sectorised services has been evolving over the past five years and is now almost complete. However, the teaching of undergraduate medical students has remained confined to the inpatient treatment units in the large mental and district general hospitals.

The university staff responsible for undergraduate teaching have had a number of recent meetings to consider the GMC document on the proposed 'core plus options' curriculum. This has resulted in:

- More time being made available in the 4th-year clerkship of four weeks for clinical attachments (19 sessions). In addition, students spend four weeks in their final year attached to a psychiatric hospital.
- A greater emphasis being paid to skills training.
- A wider range of hospitals being used for the training.

Future developments

Despite the changes already mentioned, no definite plans have been developed to ensure that students are involved in the increasing number of community facilities. In the past students have tended to be exposed to an increasingly limited number of patients with severe psychiatric illness and to a restrictive view of treatments for the mentally ill within the psychiatric hospitals.

The Department of Mental Health would hope that, with the development in community services and the increasing opportunity of contact with patients who are less severely ill, it will be possible to begin to involve students more directly in outpatient and community work, which would help to redress some of the difficulties already mentioned and would be more appropriate training for undergraduates, the majority of whom will not in the future be working in the psychiatric field.

Assessment methods

A number of assessment procedures already in use would lend themselves to the monitoring of training in a community setting.

- The OSCE examination at the completion of the fourth-year clerkship.
- A 'feedback session' with the students at the end of their attachment.
- A short dissertation on an aspect of their experience during their attachment.
- A final year log book.

Anticipated difficulties

As the training of medical students is heavily dependent on the goodwill of NHS colleagues, there may well be difficulties in arranging clinical attachment programmes in a community setting which would need to be well organised with regard to timetables, supervision, etc. Also, the quality of attachments may be variable, depending on the state of development of particular services.

EXAMPLE 13: INTEGRATION OF PAEDIATRIC TEACHING

SEAN DEVANE, KING'S COLLEGE, LONDON

King's College School of Medicine and Dentistry admits approximately one hundred undergraduate medical students each year. In a non-integrated curriculum, clinical teaching is conducted in the last two and a half years of the medical curriculum. During this time students spend eight weeks attached to the Child Health Department in groups of 16 students.

King's is among the few medical schools which have both a Department of Child Health and a Department of Community Paediatrics. These departments are headed respectively by a Professor in Child Health and a Professor of Community Paediatrics. The former is assisted by a Lecturer in Child Health. The latter is assisted by a Lecturer in Community Paediatrics, although this post is funded by the NHS and not the UFC. The school is fortunate in having both departments established alongside an integrated Child Health Care Group, a Care Group which exists within King's Healthcare Trust, in itself an integrated hospital and community shadow trust. The close integration of community and hospital-based services for children within the Camberwell Health Authority area provides a strong clinical base for paediatric teaching within and without hospital.

The eight-week course is organised to provide each student with experience of acute hospital-based general paediatrics and community-based paediatrics. Close association with district general hospitals in Brighton, Exeter and Cheltenham allows the hospital-based paediatric experience to be shared between a London-based teaching hospital with tertiary referral services and provincial district general hospitals providing a good standard of general paediatric care. The presence of an academic Department of Community Paediatrics allows the integration of undergraduate medical students into the community paediatric services. This allows exposure to the many medical and paramedical services provided in the community.

Pro-active timetabling associated with the inclusion in the student schedule handbook of the addresses and telephone numbers of all community venues, allows students to observe, on a first-hand basis, the provision of services to children in a deprived community in an inner city setting. The timetabling is possible because of the presence within the Community Paediatric services of a lecturer with specific responsibility for undergraduate teaching. Since the introduction of this post in 1991, the satisfaction rating expressed by the undergraduate medical students for extramural paediatric teaching has increased dramatically.

The on-going development of the undergraduate course in paediatrics will lead to an increase in the percentage of the time spent on the firm outside the walls of the hospital. Within a year, it is envisaged that the amount of time spent in the community paediatric setting will equal that spent within King's College Hospital.

EXAMPLE 14: COMMUNITY-BASED TEACHING IN PAEDIATRICS

KIA MENG TANG, ST BARTHOLOMEW'S, LONDON

Present situation

At present in Hackney, medical students from St Bartholomew's Hospital Medical College spend on average only one half day during their eight-week paediatric attachment in the community. This time is usually spent attending one of the district's child health clinics. I have, with some more students, been able to arrange visits to schools and day nurseries. Students also receive lectures on community paediatrics and immunisation. Assessment of this part of the teaching programme is extremely difficult: students are usually asked a 'community' question in their written examination after the course, but this usually assesses book knowledge. In end-of-course evaluation questionnaires many students have said they enjoyed coming into the community and wanted more time as the half day was not enough. The present teaching is clearly insufficient, especially now when there is so much emphasis on community care.

Future plans

In the coming year, with the combination of the clinical teaching of students from the medical schools of St Bartholomew's and the Royal London hospitals, medical students will be spending a week in the community. My plans include home visits with health visitors, time in day nurseries to observe and interact with toddlers, learning and performing developmental checks competently, and time in schools discussing health issues with adolescents. Clearly this will need careful planning, coordination and discussion among health professionals in more than one health district (students will be sent to areas in three health districts in East London).

I feel the main constraint to more community-based teaching, at least in paediatrics, is the lack of professional organisation. The students have expressed the desire for more sessions outside the hospital confines and it is up to us not to dampen their enthusiasm.

EXAMPLE 15: A PILOT PROJECT IN COMMUNITY GYNAECOLOGY

ANGELA TOWLE, ST BARTHOLOMEW'S, LONDON

In order to study the feasibility of extending the clinical teaching of medical students from the hospital (St Bartholomew's) into the community, a one-year pilot project was set up in which one gynaecology firm was linked with one general practice.

The Medical College supported the project in view of the difficulties being experienced in the teaching of particular hospital specialties as a result of bed cuts. The consultant on the gynaecology firm had identified three particular areas of need for students which were not being met by hospital teaching and which would be amenable to teaching in general practice. These were: sexual problems, family planning and the menopause. He also believed such teaching should help improve students' interpersonal relationships in a sensitive problem area, should give male students more confidence in talking to women about sexual problems and provide more opportunities for students to gain practical experience (e.g. in taking smears).

The practice partners and nurses organised two teaching ssessions on a Friday afternoon for one student: from 2-4 p.m. students joined the nurses for a well-woman clinic, and from 4-5.30 (or until the end of surgery if the student wished) students joined one of the GPs who endeavoured to concentrate her gynaecology patients during this session. The pilot project was carefully evaluated through student questionnaires and regular monitoring meetings with the practice staff.

Students were very enthusiastic about the experience: it was rated highly for usefulness and interest. They appreciated the effort put in by the practice staff and their main criticism was that so few of them had had an opportunity to attend one of the sessions. The most successful sessions were those when the student had chosen to stay for the entire surgery as they saw a greater number of gynaecological patients then.

The students' enthusiasm motivated the practice staff to persist with the pilot project despite some considerable organisational problems. The main problem was the reluctance of women to come to a clinic on a Friday afternoon, partly because this was not an attractive time (women preferred morning or evening appointments) and partly because, unlike many practices, this one does not have a 'clinic ethos' (patients know that they can be seen during ordinary surgery hours whatever their problem and are not used to the concept of special clinics). The lack of patients caused great stress to the practice, especially the nurses, who had the responsibility of providing the students with a useful educational experience for two hours in the absence of patients, and at the end of a full week's work.

A second problem was that many women were reluctant to have a student sitting in: they went to the clinic because they wanted to be seen by a (female) nurse in privacy. About half the patients refused to have a male student and about a quarter refused a female. During the second half of the experiment most of the students attending the practice sessions were female, which defeated one of the aims of the project – to make male students more comfortable in dealing with gynaecological problems.

The evaluation showed that although the model of gynaecology teaching tried in the pilot project was unsuccessful, students, practice staff and the hospital consultants all felt that the experience was extremely valuable and that ways should be sought to continue community gynaecology teaching, even though bed closures were no longer jeopardising hospital teaching. It is planned to re-start the experiment using a model in which all the gynaecology students on the firm will attend a teaching session by a GP about interpersonal skills in the context of gynaecology, using a series of videoed consultations and then sit in with the nurses for a normal surgery and see the mainly gynaecological problems which present.

EXAMPLE 16: IDEAS FOR THE COMMUNITY-BASED TEACHING OF SURGERY

CELIA INGHAM CLARK, LONDON

Increasing numbers of day cases and short stay admissions have reduced student/patient contact. The intention was to increase opportunities for consultant and teacher to see patients together.
Methods: GP with four or five patients needing surgical opinion sets up a mini-clinic in his surgery. Consultant plus two students visits surgery and sees patients. Approximately 30 minutes per consultation.
Evaluation: positives – reasonable amount of time to teach; improved GP/consultant liaison; GP gets prompt consultant opinion on his patients; reduces number of patients visiting hospital outpatient clinic. Negatives – organisation and execution are time consuming; takes up valuable surgery time in the practice.

Future plans/ideas

- Students to spend one day of the firm attached to each nurse specialist whose work bridges the hospital/community divide. These may include stoma therapist, breast care nurse, Macmillan nurse.
- Students accompany the consultant on domiciliary visits (the number of these varies with specialty – for example, high in geriatric medicine).
- Surgeon visits GP surgery to do minor operations (local anaesthesia). GP gains surgical skills, students accompanying surgeon sees the pathology and the techniques.
- Home visits with patients from hospital with physiotherapist and occupational therapist for home assessment prior to discharge, e.g. for amputees, recent joint replacement.
- Pre-operative visit to see patient before surgery for, e.g. cataracts, joint replacement or patients with chronic disease, e.g. COAD, arthritis, to assess efffect of disease on activities of daily living.
- Post-operative visits to follow up patients whom they have seen in hospital. Home visits with midwives.

Constraints/barriers

- Student security. Not always safe for them to visit alone. Therefore try to link their visits with those of district nurse, GP, health visitor, midwife, etc.
- Direct input from hospital teachers is lacking – most hospital teachers have no direct contact with community.
- Cost – who pays students' travel expenses?
- Time – students' curriculum already full – how much time should be given over to such projects?
- Patient consent. Who obtains this and how? Some patients may not want students to visit them.
- Capacity – many nurses and paramedical students already visit the community with district nurses, midwives, etc. How much capacity is there in the system for medical students too? How much responsibility should nursing professionals be expected to take for medical students?

Solutions

- Increase the amount of teacher time (recognise dedicated teaching time in job descriptions). This will cost money – who will pay?
- Improve liaison between hospital and GPs. This has many other spin-offs.
- Ensure adequate funding.
- Find out capacity of the home visiting system and determine what proportion is available and what is suitable for medical students.

Chapter 4: Problems and solutions

This chapter summarises the major problems and constraints which have already been identified in relation to community-based teaching in its widest sense in the UK and, where possible, suggests ways in which they may be addressed. It does not address the general difficulties of bringing about change in medical schools, which are to some extent independent of the type of curriculum change to be introduced. It is, however, clear that institutional commitment is a *sine qua non* if community-based teaching is to succeed and the problems are to be solved. The problems have been grouped into three broad categories: conceptual, attitudinal and practical. Reference is made to the Case Studies and Examples described in Chapter 3 which illustrate the general points made below; in addition some of the studies illustrate specific problems associated with particular approaches.

1. Conceptual problems

Community-based medical education is conceptually challenging. There is no general agreement that this is the right way to teach. Current community-based teaching, such as the examples described in this report, are largely isolated developments within a curriculum, tied into mainstream teaching and examinations to a greater or lesser extent. If innovative courses are not ultimately linked into mainstream curriculum development and the examination system they will be perceived as marginal or irrelevant and will sooner or later wither away (see Examples 4 and 7). There has been almost no attempt to relate these individual experiences to the aims and objectives of the curriculum as a whole (where these actually exist). There is as yet no clear view of what a community-oriented curriculum might look like in the UK. Neither has there been any attempt to visualise how community-based teaching might be coordinated throughout the curriculum in order to provide a coherent educational experience when, of necessity, students would be learning in a much wider variety of settings than hitherto. The lack of clarity about the concept leads to inconsistencies of approach, mixed messages and weakness in the face of opposition.

Part of the difficulty stems from a lack of clarity about what sort of doctor we are trying to produce. In the discussion at the conference, the questions which recurred were 'what is the end product?' 'what sort of doctor will be needed in five, 20 or 50 years time?' No-one has identified what competencies will be required for the practice of medicine in the UK in the twenty-first century and what the relationship will be between doctors and other health professionals. This uncertainty has a parallel in the current debates among health service providers about the expanding role of primary care, the shifting boundaries between primary and secondary care and the continual redefinition of the roles and responsibilities between the different health professions and between specialties within medicine. The question 'what is it that the most highly educated and expensively trained members of the health profession should be doing?' has not yet been satisfactorily answered, nor is it clear who will take a lead in thinking this through. There obviously needs to be a match between the output of the medical schools and the needs of the services which are the ultimate employers, yet there are worryingly few bridges between the two parties which allow effective communication. Nor can undergraduate education be divorced from postgraduate training and in particular the pre-registration house officer year, which may need to be reconsidered in the light of a move towards community-oriented curricula. University and professional regulations may compound the conceptual problems.

A helpful start might be to develop a model which people can study as a concrete example. One possible approach might be for a group of creative and committed people, of varying expertise and perspectives, to work out the aims and objectives of a community-based curriculum and visualise how it might be implemented, taking into account concurrent health service developments. This working group might have a variety of related tasks. Their first task might be to define the competencies required for the future practice of medicine, and to develop rigorous objectives and matching assessment (possibly requiring a redesign of final examinations which, if unchanged, could undermine any competency-based and community-oriented curriculum). They might also identify learning resources and guidelines, including

problem-based learning methods. They could identify appropriate settings to provide worthwhile learning experiences to meet the objectives, which in turn might mean describing ways of mapping community and hospital resources. Lastly they might consider mechanisms for involving the community in curriculum development so that the medical schools and community can work in partnership for the benefit of both.

In addition to this approach, there needs to be a real commitment to funding research and development and evaluation. In the USA there are three Foundation initiatives (the Pew Charitable Trusts, W K Kellogg Foundation and Robert Wood Johnson Foundation) specifically devoted to changing medical education. The Kellogg initiative alone has committed $47.5 million to a new national effort known as Community Partnerships, aimed at developing seven new community-based, non-hospital teaching centres that stress primary health care education and research from a multidisciplinary approach. In the UK the King's Fund has supported a number of community-oriented medical education projects in London, but few other sources of funding are available for development work on a national scale. One suggestion that has been made is that one per cent of the national medical education budget could be top-sliced to fund curriculum development and evaluation.

2. Attitudes

Community-based medical education raises different sorts of issues for the different constituency groups involved in undergraduate medical education. At a very basic level there are concerns over whether this is the right way to teach undergraduates (unresolvable until it is clearer what sort of doctor we are trying to produce – see above), given the lack of hard evaluation data. Some of the arguments advanced against community-based education are the same as those put forward to counter any curriculum change: they should be recognised as natural reactions to any proposed change and dealt with by the normal strategies used to overcome resistance.

Attitudes of hospital-based teachers

Many hospital-based clinical teachers have negative attitudes towards teaching students in the community. Even the words 'community medicine', 'general practice' or 'primary care' may raise antibodies. Some see community-based teaching as a threat to their traditional well-established power bases (especially if there is a potential reduction in funding), as unnecessary, unworkable or as a retrograde step leading to a lowering of academic standards and an abandonment of scientific medicine. Some of these arguments are refuted in the paper by Hamad (1991); paying attention to the maintenance of quality (see below) is vital. Even if not openly hostile they may undermine community-oriented initiatives, for example by the messages (overt or covert) that they give to students. They will probably ask for evidence that it 'works' or is better than the existing system. One possible solution is to set up an experimental parallel track and compare the traditional and innovative track (see Example 6), although this depends on some money being made available for evaluation.

It is important that moves towards community-based teaching do not alienate hospital-based clinicians. Perpetuating the divide and professional rivalries between primary/secondary/tertiary care is unhelpful, especially at a time when the boundaries between them in service terms are blurring. It is unfortunate that hospital teachers are hardly engaged in the current debate about community-based teaching. Rather than perpetuate the divide, it is more constructive to define what each has to offer in the spectrum of clinical experience required by undergraduates. Hospital teachers should be invited to observe or monitor/evaluate what is happening so that they become involved. Joint teaching initiatives, for example where specialists and GPs teach on the same course, should be encouraged. Example 11 provides a possible model of how an integrated approach might work in practice, and there are several other models among the examples in Chapter 3. Other possible ways of bridging the divide are to base hospital teaching in district general hospitals where relationships with GPs and the community are generally closer. Outreach programmes in which hospital consultants run specialist clinics in general practice provide excellent educational opportunities both for undergraduates and at postgraduate level. Integration of hospital and community

services will allow students to follow patients through the spectrum of care. Students might be based in general practice and follow patients through the hospital system (as in Example 6).

Equally dangerous is the attitude that community-based teaching is the answer to all the problems experienced by hospital-based clinical teachers in providing the right, or indeed sufficient, clinical experience for students. If general practice, for example, is expected to cope with large numbers of students who cannot be accommodated in hospitals, without adequate resourcing and support, they may be unable to 'deliver the goods', resulting in an inevitable backlash against community-based initiatives.

Attitudes of general practitioners

A survey in 1985 (Fraser & Preston-Whyte, 1988) showed that 'undergraduate teaching is seen as having the highest priority by most academic departments of general practice both currently and in the future. Furthermore the approach to teaching adopted by virtually all departments is consistently professional'. This analysis still seems true, although there are some indications that the new fundholding practices are beginning to question whether medical education is a priority given the new opportunities for generating income and providing services, and the new responsibilities they are being asked to take on, for example in relation to the management of chronic conditions such as diabetes and asthma. The enthusiasm of many GPs, especially those associated with academic departments, for taking a higher profile in the undergraduate curriculum, is evident (Iliffe, 1992). Indeed most of the interest and ideas in medical education are currently coming from those departments. However, it is often the same enthusiastic GPs who are also leading in postgraduate and continuing education as well as research and service development, and there is a limit to what they can be expected to do if their motivation and level of activity is to be sustained. It is clear that priorities will have to be set. Some are already daunted by the educational tasks they have been asked to do and the expectations placed upon them by the medical schools, particularly in the absence of a reallocation of resources. Some worry about the impact that more teaching might have on doctor-patient relationships in primary care. GPs who have been comfortable with teaching students the principles of their specialty naturally feel diffident, and may think they lack sufficient knowledge and skills, if they are asked to take on a larger role in the mainstream of the curriculum and will require training and support (see Case Study 2). Links between GP tutors and academic departments are not always strong and GPs may wish for more support and direction, even for their current teaching tasks (see Example 10).

Attitudes of students

Students are in general conservative in their attitudes and not enthusiastic about the notion of community-based teaching. Many perceive it as 'not proper medicine'. Most come into medical school with a layman's view (reinforced by media images) that being a doctor is about putting on a white coat in a hospital. Mature students seem somewhat better able to recognise the value of community experiences, and are more highly motivated, but it is likely to be the school leavers who have a more limited experience of life and how different communities live, and who are in need of community-based learning activities in order to broaden their attitudes and horizons. There is also a slight danger that students may become angry and frustrated when confronted by health problems in the community. While this may help them to get into perspective the role of medicine and of the doctor in influencing people's health, and to face the political and economic dimensions of health and disease, there may be a risk that some will become disenchanted with the medical profession and the NHS.

There are two obvious ways of motivating students to recognise the importance of community-based learning. Students are more likely to be enthusiastic if they are engaged in real pieces of work (Case Study 1) and there should in theory be plenty of opportunities for these in a community-based curriculum. There may even be the possibility of employing students in the health care system in the latter part of their training, with the dual intention of increasing their commitment and easing financial difficulties. Secondly, students are driven by examinations and in order to demonstrate the importance of any community-based teaching truly, it must be assessed in the examinations which matter (see Example 7 for the difficulties which emerge if students get mixed messages through the assessment system).

Attitudes of the community and individual patients

Patients are accustomed to the idea of seeing medical students when they attend a university teaching hospital. In a general practice setting, in their own homes or in other community settings, they may not be so willing to tolerate even the mere presence of one or more student, especially if they are seeking medical opinion for the first time for a perceived embarrassing problem or one that might be construed as trivial (see Example 15). Patients are generally more assertive in community than in hospital settings and if they feel that they are being exploited or intruded upon, they will be more likely to say so and refuse a student's presence, either active or passive. It is in this area that particular efforts must be made to establish a partnership between the medical school and the community so that the latter can understand the benefits of community-based teaching, and individuals and groups are motivated to contribute to the education of future doctors. Some examples of the benefits which the community might expect are an improvement in the quality of primary care if practices are also developed for a teaching role, and an improvement in services if the results of students' projects are fed back to the community and local policy planners (see Case Study 1). Patients would be able to voice their concerns within their own environment where they feel less intimidated and more in control.

3. Practical Issues

Resources

One of the major constraints to the development of effective community-based medical education is the failure to address resource implications. Although the cost implications have not been worked out, this kind of teaching is not cheap and should not be seen as a cut-price option. If the balance of clinical experience is to shift from the hospital to the community, resources must be reallocated accordingly, and a core budget set up to fund community-oriented activities. Currently the main teaching hospitals receive large amounts of money through SIFTR to cover the excess costs incurred through teaching and research activities. In practice it is unclear how this money is spent specifically in relation to undergraduate clinical teaching, and it is not available for use in supporting community-based initiatives in general practice. The Department of Health have provided some Tasked money for academic general practice to support teaching and research in 1992, but the allocation of that money by Region to individual departments has been problematic in some cases. Future funding arrangements are unknown and a secure and efficient mechanism is urgently needed if academic departments are to plan ahead effectively to meet the new challenges. They must feel confident that they have sufficient long-term funding to recruit and pay for the extra GPs they require and provide sufficient incentives for existing teachers to take on a higher teaching workload.

Neither does this address the question of how to finance community teaching which is not based in general practice. Patients and voluntary organisations should not be expected to give their services free of charge, especially if they are to be given an official role in teaching and assessing students. Voluntary community organisations are already under financial pressure with grants being witheld (See Case Study 1). There is increasing concern about the under resourcing of community care and that the development of an expanded role for primary care will not be accompanied by adequate funding. If these services are not adequately resourced it is unrealistic to expect to add medical education free of charge.

The cost implications are difficult to estimate until more work has been done to visualise what a community-oriented curriculum might look like in practice. At present, most of the initiatives have arisen as local solutions to local problems. They have not been costed out and it is not known how generalisable these models are to other situations. The kinds of things that funding is required for are:

- The creation and support of a sophisticated administrative infrastructure to organise decentralised educational experiences for large numbers of students. This may require a coordinator and appropriate information technology.
- Remuneration of teachers (GPs and other community tutors, including patients).
- Assistance with student travel expenses.
- Upgrading of premises for teaching. For example, practices may require additional teaching facilities such as libraries, seminar rooms and extra consulting rooms.

Recruitment

Already some medical schools are finding it difficult to recruit new teaching practices and some have lost old ones because of the introduction of fundholding. There is a particular problem in inner city areas where there may be a high proportion of single-handed practices, or in the case of London, several medical schools 'fishing in the same pond'. More work is required into the attitudes of GPs towards teaching, especially those not currently involved, to clarify the incentives, training and support (practical and moral) required. A start on this has been made at King's College, London with a project arising out of the developments reported in Case Study 2.

It is not just additional general practitioners who are required as teachers in new community-based initiatives. One of the aims of community-oriented medical education is to widen the range of teachers to other health professionals, representatives of community organisations, patient self-help groups and individual patients. The role of such tutors needs clarification before criteria for selection can be developed and appropriate appointments made.

Maintaining quality

One of the arguments heard against community-based teaching is that it will result in a lowering of academic standards and that the quality of teaching will decline. In reality, general practitioners are usually one of the few groups of teachers in any medical school who have ever had any training in teaching or who have a grounding in educational theory and practice. Many departments of academic general practice give training for their GP tutors and general practice is singular in having a vocational training scheme which is educationally sophisticated. However, there will be a need for continued and enhanced staff development if the GPs are to do a different kind of teaching and if more GPs need to be recruited as teachers. Similarly, teachers who are recruited from other, less conventional sources (see above) must also receive appropriate training if they, the students and academic staff are to feel comfortable and confident with their new responsibilities. Coming at a time when academic audit is being introduced into higher education, the demand for staff training programmes is likely to increase considerably. The questions of who is going to organise and run such programmes, and who will pay for them, have hardly been raised, let alone answered.

Logistics

One of the advantages of a hospital setting is that patients are concentrated into a small area and it forms a convenient base for students to meet. If students are taught in community settings of whatever kind they will be dispersed, either singly or in very small groups. This raises problems of organisation and timetabling (who will coordinate attachments and visits, ensure that both 'teachers' and students know what is happening, organise recruitment and payments?) and of the 'commuting student'. There are several issues here: students may have to travel long distances (for example if there is no great concentration of general practices surrounding the medical school) and may encounter transport problems, especially if they have to rely on public transport; there may be problems with the weather (in winter) and of personal safety; there may be a sense of not belonging anywhere unless some 'home bases' can be created in addition to or instead of the hospitals/university.

Recognition for teaching

If the academic staff of medical schools are to devote time to curriculum planning, the development of learning resources, staff development and other important educational activities, they must be rewarded appropriately. The reality is that, at present, medical teachers have no incentives to spend time on curriculum development, and indeed may be penalised in career terms for doing so. At a time when it is clear that undergraduate teaching has to change, the stark choice is between continuing with the present situation where education is a largely spare time activity for a few committed enthusiasts who run the risk of exhaustion and despondency, or the development of a proper reward and recognition system for those who choose to make a career in education, and possibly educational research, rather than in scientific research. The time is certainly right for much valuable and exciting educational research to be undertaken.

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SHARING IDEAS 1

Community-based teaching

Community-based teaching is of central importance in current debates on the future of undergraduate medical education as changes in health care and service delivery are forcing medical schools to adopt new ways of clinical teaching.

This report arises out of a conference held at the King's Fund Centre in July 1992 to highlight key issues in community-based teaching through the presentation and discussion of case studies and the sharing of ideas and experiences.

The report outlines the pragmatic and philosophical reasons for a community orientation in the undergraduate curriculum; presents examples of community-based initiatives from different UK medical schools (involving general practitioners, hospital specialists, and a range of groups and individuals in the community); and highlights problems, constraints and possible solutions in order to make a series of suggestions for future research, development and decision making.

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