



COMMUNITY-RELATED ISSUES

The Role of the Community in Educating Medical Students: Initial Impressions from a New Program

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ABSTRACT Purpose: *The Keeping Families Healthy (KFH) program at the University of Florida College of Medicine is a new community-based course designed to improve physician–patient relationships. This paper describes the experience of the first-year medical students’ home visits, which were developed to foster health promotion and disease prevention.*

Approach: *This two-semester course offers first-year medical students the opportunity to integrate prevention, service, and humanism into the established educational curriculum. During the course the learners have opportunities to interact with families who have volunteered to serve in partnership with the College of Medicine faculty as community lay teachers. The program provides a valuable service to the participating families by helping them identify useful community resources, and by formulating healthy care plans for prevention of illness and stabilization of chronic illness.*

Conclusions: *Community-based learning and home visits expose students to personal travails (e.g. lack of financial resources) in a way that cannot be addressed in traditional settings. This exposure may involve students in community-building strategies that can assist not only individual patients, but also communities. Additionally, home visits provide an opportunity for pre-clinical students to have an active rather than passive role in their education.*

Frances Wald Peabody (1881–1927): “One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.” (Reynolds & Stone, 1995)

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Introduction

The first-year medical student enters the world of academic medicine armed with a bright mind, a sincere desire to learn, and a keen interest in science and technology. These are the right tools for completing medical studies in this age of science, specialization, and technology. For those who can access care, Western medicine provides the sophisticated clinical care needed for helping patients who are suffering from acute and chronic illnesses. Technological advances and medical treatments can sustain life and cure most diseases, but they may minimize the intimacy and communication skills demonstrated by traditional doctors of the past. Young doctors face the challenge of integrating the best of traditional and modern medical practice. We feel that early medical training offers an opportunity to demonstrate that physicians need to care as much about their patients' lives, feelings, and experiences as about clinical diagnosis and technological treatments.

The Keeping Families Healthy (KFH) program at the University of Florida College of Medicine is a new course designed with grant funding from the Health Professions Schools in Service to the Nation (HPSISN) program, with continued support from the University of Florida Area Health Education Centers. This two-semester medical course offers first-year medical students the opportunity to integrate prevention, service, and humanism into the established educational curriculum. During the course the learners interact with families that have volunteered to serve in partnership with the College of Medicine faculty as community lay teachers. The goal of this interaction is to allow the medical students a time to focus on their reasons for choosing medicine as a vocation while learning invaluable lessons about families, cultures, economics, health care beliefs and nutrition. The desired goal of this program is a more effective and attentive physician. The program also provides a valuable service to the participating families by helping them identify useful community resources, and by formulating healthy care plans for prevention of illness and stabilization of chronic illness.

The integration of service learning into health professions education is an increasingly important issue as health services delivery shifts to community-based settings, ambulatory services, and managed care models. These new policies, practices and settings are changing both health career paths and the knowledge base required for work in these varied settings (Pew Health Commission, 1995). To meet the health needs of communities today, health professionals need to be trained in working with persons from various cultural backgrounds, practicing disease prevention and health promotion in community-based settings, and working in teams with other professionals (Sternas *et al.*, 1999). At the University of Florida College of Medicine, support for these educational ideals were recognized, and collaborative efforts resulted in the KFH program.

Service learning is an educational method that may have the potential to

reform health professions curricula in ways that reflect the changing environment and potentially improve community health (Seifer *et al.*, 1996). Institutions such as the University of Rhode Island have combined the educational and clinical training expertise of an interdisciplinary geriatric service learning team approach. The multiple, chronic health problems of the elderly favor an interdisciplinary team approach from service providers, and this concept is important for improving the future delivery of health care services to the elderly in the United States. Georgetown University Medical Center is part of a network of innovative programs utilizing service learning to train future health care professionals and give them the knowledge and skills needed to improve the nation's health. Students who participate in service learning have opportunities to apply classroom knowledge to communities, and, in doing so, to build patient education and advocacy skills and learn the community competencies needed to practice in a changing health care environment (Georgetown University HPSISN Program Office, 1997).

The Model Physician–Patient Relationship

Medicine is positioned to impact on the daily life of both individual patients and society as a whole. Goodfield remarked in 1977 that no other profession has more to lose than medicine by the present state of affairs; none has more at stake in promoting mutual understanding. Medicine cannot be practiced without a bond between doctors and their patients; between scientists and practitioners; between society and the medical profession. While physicians of the past had intimate communication with their patients, frequently that communication was unbalanced.

The communication approach between physician and patient in the traditional medical relationship was often authoritarian. This paternalistic model, which is decreasing as a practice style, frequently reflected the physician's values and assumed those were to be shared by the patient. Today's patients are more actively participating in their health care decisions and taking overall responsibility for their health (Bentsen, 1998). New models of communication have been employed to promote mutual understanding between patients and physicians. The information model involves the physician sharing facts and data regarding treatment options, but leaves the final treatment decisions up to the patient. The interpretive model occurs when the physician both provides facts and explores the patient's values to select a treatment decision based on the patient's desires. Additionally, in the deliberative model, often seen as an "altruistic approach," physicians encourage patients to consider some higher purpose and values. For example, the physician might propose that the patient participate in a clinical research study to help test the efficacy of a new treatment (Bensten, 1998).

Many health care consumers of today have access to information through internet websites, self-help groups and mass media, and as a result are much

more educated about their health care issues. The patient-driven approach to physician–patient relationships challenges the traditional communication models of yesterday, and many curricula acknowledge the need to involve students in the patient-centered approach in their first year of medical training. A new level of communication is necessitated by societal changes as a result of the information explosion, and medical training needs to keep pace.

Patients face many problems that are beyond the medical doctor’s healing power or technological wizardry. The vicious circle of poverty, ignorance, and disease are some of the global health problems encountered in medical practice today. Societal concerns, which in the past were not the clinician’s focus of treatment, may be clearly relevant to the successful diagnosis and treatment of illnesses. Physicians must be aware of the societal complexities that exist for their patients, and incorporate a team approach (social work, nursing, psychology, etc.) to care for them optimally. As has been noted, “The non-somatic components of human life, defined out of existence by the medical model, stubbornly remain crucial to illness and recovery” (Schwartz & Wiggins, 1985). The reintroduction of humanism in medical teaching and practice becomes the first of the specific challenges for medical students. This requires physicians who can communicate well with their patients and understand patients in the context of their communities. This allows the development of a true physician–patient partnership with shared responsibility for care and well being of the patient.

The Keeping Families Healthy Program

The KFH program is a course closely integrated with courses in communication skills, physical assessment, and ethics. The program places 85 medical students in direct partnership with volunteer families from the community. In 1998 our medical students conducted 455 home visits with 65 families in Gainesville, Florida. The two-semester course focuses on family assessment, using the complex genogram as a tool to help identify families with healthy relationships and coping skills, as well as families at risk. The families openly share their health care beliefs and practices with their assigned student(s). After each home visit, the students meet in groups of seven to eight and discuss their visits. A physician and a non-physician health care provider, such as a psychologist, nurse, social worker, or physician assistant, lead each small group. The course includes a review of basic nutrition with an emphasis on diet, exercise, and tobacco with regard to cardiovascular disease and cancer; an introduction of basic concepts of clinical epidemiology, preventive medicine, risk assessment, and relative risk; and discussions of behavior change and community health.

The final examination in the course utilizes standardized patients to measure competence in use of the genogram, communication skills, and knowledge of medical ethics. Additionally, the students are required to develop and implement a “wellness prescription” for one member of their assigned family, using

information from multiple sources: the library, the Internet, their patients, their colleagues, small group leaders, and other sources they may find appropriate. A major goal is to allow the students the opportunity to mimic future clinical interactions between their patients and themselves, as well as with colleagues and attending physicians. The course has been designed to offer an enriching educational experience for the students, as well as to serve the family members in a meaningful and serious way.

Family and Student Reactions to the KFH Program

The KFH family volunteers consist of individuals, couples, and extended families. Care is taken in assigning students to families to ensure that each small group of students gets a variety of family constellations, as well as a mixture of wellness and chronic illnesses to explore. Many of the volunteer families have been with the program since it began in 1994. A self-report, anonymous questionnaire was recently sent to the 65 participating families regarding their evaluation of the KFH program; 58% responded. Using a 5-point Likert-type scale that ranged from 1 = unacceptable to 5 = outstanding, families rated the overall KFH program performance. The evaluation asked questions regarding the home visit procedures, interviewing/communication skills, likes/dislikes of the KFH program, and suggestions for improvements. The results were overwhelmingly positive. The families reported that they felt comfortable sharing information with the students, and denied that any problems were encountered between student and family as a result of the visit. Almost all the families were willing to participate again, demonstrating that family home visits are feasible and have few adverse consequences in a well-supervised training program.

Of the 85 participating students, 52 (61%) responded to a course-evaluation questionnaire. On a 5-point Likert scale, with 5 being superior, their evaluations of the utility of the home visits averaged between 4 and 5. Percentages of the responding students who agreed or agreed strongly with the following statements were: "I enjoyed getting to know my family" (82%); "My family was receptive to my presence during home visits" (95%); "Quality health care frequently requires more services than physicians alone can provide" (92%); "My knowledge of prevention services has increased as a result of the course" (75%); "I am now more aware of community resources available for my patients" (72%). Two-thirds of the students felt they learned information by visiting in the home that they would not have known if they had seen the individual in a health care setting. Interestingly, only 50% of respondents felt that they had a significant impact on the health of their family after the implementation semester. Many students developed particularly close relationships with their families; one student commented during a course debriefing: "After having known my 'family' (a quadriplegic man) I will never look at a person in a wheelchair with the same eyes."

Both the students and faculty reported several challenges and concerns related to this service learning experiences. More time needed to be allotted for home visits and small group sessions, and for the development of educational presentations and completion of activities. Most importantly, to facilitate service learning experiences, students and faculty alike had to be flexible in arranging their schedules with respect to the community participants' availability.

The Home Visits/Community-based Learning

Community-based learning is distinctive from campus-based learning. It is a process in which colleges and communities work together for mutual benefit through direct student service linked to course work. Home visits to families in the community offer more than a mere act of shared learning; they provide services that meet actual individual and community needs and facilitate students and the college in becoming partners in problem solving. Through community-based learning, the resources in the college's programs can be more fully utilized by both the students and family participants.

Many positive results can derive from community-based students becoming resource connections between college and community. Families voice their appreciation for sharing in the educational development of future physicians, and the opportunity to learn from the student about newly developed medical treatments and procedures. The students benefit as well. Community-based learning provides opportunities for them to relate the concepts taught in class to real-life experiences and to test theories taught in the classroom. The students develop greater understandings of community and its impact on health. This helps the student to become a more self-confident, keenly aware, and actively involved adult. When students and families work together collaboratively, solutions are discovered for many different types of problems.

Another important purpose of the home visits is to help students adopt an ethic of service. We hope that our community-based learning will provide the students with lifelong habits of genuine caring and serving that will benefit them and their communities for many years. This type of learning, we feel, can help shift students from individualized medical care to participation in a broader arena, in which they are active citizen in the communities in which they live.

Discussion

Community-based service programs like the KFH program at the University of Florida have much to offer both the students and communities they serve. Because of the unique relationship developed between the students and the participating families, a long-term community partnership is expected to continue successfully. The benefits received from the program are extensive and

hopefully will be long lasting. KFH does require enormous creative energy and careful attention to details to successfully orchestrate the large number of faculty, staff, students, administrators, and family participants who are involved. Medical students represent a large, untapped pool of service providers for addressing human needs in community settings. The home visits provide a wonderful opportunity for students to have an active rather than passive role in their education.

As a result of the Keeping Families Healthy program experiences, students are challenged in new ways. Not all visits are successful, and the students are encouraged to expect changes and to respond with flexibility to unplanned experiences. Students are taught to look at the process as a learning experience from a “real world” perspective, and to focus on the reasons why outcomes may occur differently from their initial expectations. As the course has developed and grown, the feedback from students and faculty has varied over the five years of operating this program. Each semester has presented specific challenges that require revision of the course, and implementation of better ways to meet the identified issues and challenges of service learning in medical education.

Conclusions

This service learning experience has helped to promote positive patient–physician relationships between students and their assigned families, in an intimate setting that includes both the home and community. Students reflected through their written comments and their class evaluations that they valued their service learning experiences. The bonds developed between faculty, students, and community volunteers make learning rewarding and challenging for all involved in the process. Medical education requires new modes of learning that incorporates both didactic learning and service learning experiences to promote improved patient–physician relationships.

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