

How to Apply Community-Oriented Medical Education (COME)

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Abstract

Community-Oriented Medical Education (COME) is considered one of the new trends in medical education in recent years. It can meet the health needs of the community and prioritize the health problems in the community. Moreover, it is a comprehensive approach in medicine that includes health promotion, prevention, and rehabilitation. However, Community-Oriented Medical Education is not a curative approach only but it formulates the concept of health for all that means a better productive life socially and economically. Furthermore, the graduate of Community-Oriented Medical Education acquires and applies many competencies such as leadership skills, problem-solving skills, and decision-making skills, clinical and managerial skills besides the ability to work in a team and interact with his community. Therefore, Community-Oriented Medical Education can graduate a community-oriented physician who has the ability to serve his surrounding community via dealing with health problems successfully at three different health care levels (primary, secondary, and tertiary).

Key Words: community; trend; medical education.

Introduction

In recent years, Community-Oriented Medical Education (COME) was applied by some medical schools in the world as one of the new medical education approaches. It is considered health-oriented physician education wherein it respects and depends on the health needs of population groups (community) [1]. The scope of Community-Oriented Medical Education (COME) is to graduate the community-oriented physician who has the ability to serve his surrounding community via dealing with the health problems successfully at three different health care levels (primary, secondary, and tertiary). Furthermore, the educational activities of Community-Oriented Medical Education (COME) are determined by the prioritization of the health problems and the needs of the community. It is also considered a comprehensive medical approach wherein it includes health promotion, prevention, and rehabilitation. However, it is not a curative approach only but it formulates the concept of health for all wherein the level of social and economic productive life of the community is usually a reflection of the health level of people [2].

Therefore, the high percentage of the total training program of Community-Oriented Medical Education (COME) is based on the large community (families) and primary health care units more than dependence on the highly equipped hospitals. However, there is a balance in the training program to include equal time for three various levels of health care. Besides, there is an integration between the educational program with the health system, the related health institutions, and the relevant community during the planning and implementation stages [3]. So, it can use the available resources and suitable technology in the community for the training of medical students in real-life situations. Thus, the medical graduates of the educational program of Community-Oriented Medical Education (COME) have the ability to serve their community and participate in community development activities [4].

In addition, Community-Oriented Medical Education (COME) depends on small groups for teaching and learning to meet the learning needs of students. Moreover, Community-



Oriented Medical Education (COME) can improve the health system via resolving the health priority problems and help to equalization of the health services delivery. In addition, the physician has better performance because he learns in an environment that resembles typically his later professional life besides he can also understand the process and retrieve information more efficiently. However, there are many controversial opinions about the cost-effectiveness of this innovation system. Some medical educators found no cost difference between the traditional system and innovative system while others confirm the reverse [5].

Community-Based Education (CBE)

Community-Based Education is considered one of the implementation fields of a community-oriented educational program. So, the main components of Community-Based Education are learning objectives based on the needs of the community, the members of the community, and the representatives of other community sectors that are shared by educational experiences. Therefore, Community-Based Education and Community-Oriented Medical Education have the ability to graduate the social and preventive physician rather than a curative physician [6].

In this context, we should mention that there is a difference between Community-Oriented and Community-Based Education. Community orientation medical school indicates the relevance of the objectives of this medical school to the community health needs and then the content of its curriculum reflects these objectives. On the other hand, Community-Based Education means learning activities in particular community settings [7]. In the same context, we should also mention that Community-Based Education has many related societal perspectives. Ethical perspectives represent autonomy, beneficence, non-maleficence, and justice while the social and cultural perspectives determine behavior and attitude towards health services. Moreover, political perspectives that represent good cooperation between government, university, and community while the educational perspectives show the relevance of education to the community health needs [8].

Noteworthy, the learning activities of Community-Based Education include many aspects. Firstly, community work in urban, suburban, and rural areas that establish the relationships among the health sectors of the community for its development. Secondly, a comprehensive and prolonged family health care program that covers social and economic views. Thirdly, community-oriented programs participation such as community survey, health education for child care, nutrition, and immunization [9].

Why it should apply Community-Based Education?

Community-Based Education means excellence and relevance. Excellence represents clinical and communication skills, teamwork skills, knowledge for endemic diseases, and the socio-cultural factors that are related to health helping interaction with the patient. Relevance represents the community impact via increasing the health services number and sharing in the national discussions for finding the best solutions for common health

problems in the surrounding community [10].

The concept of Community-Based Medical Education (CBME) is based on the majority of patients are being found outside the hospitals wherein those hospitals represent a part of the community not the whole of the community. Furthermore, it is considered an evidence-based medical education. It has a more scientific base in comparison with the traditional system of medical education wherein it applies relevant and effective educational sciences. In addition, it is an integrated system because it combines the community-oriented program with the problem-solving. Moreover, students can learn basic sciences with relevance to the clinical practice throughout the whole years of study. This program graduates a competent physician because he receives a balanced training at all three levels of the health care with a psychosocial experience for dealing with the community and its components such as the patient and his family [11].

Moreover, the stakeholders of Community-Based Education have enthusiasm for the adoption of this new approach in medical education because the implementation of Community-Based Education has many benefits for students, staff members, educational institutions, health services, and society. Firstly, students can work as a team in the real-life situation in the community that motivates them for continuous learning. Furthermore, they acquire more communication skills that enable them to deal with the different members of the community besides developing a sense of responsibility. Worthwhile, the student of Community-Based Education can also acquire and apply various competencies such as the ability to interact with his community, the ability to work in a team, problem-solving and decision-making skills, clinical and managerial skills besides the leadership skills [12].

Secondly, staff members acquire teaching and research experiences that are related to their community and share in the community development of their countries. In addition, Community-Based Education gives the community scientific experience for the educational institution to plan its education, research program, and the health intervention activity. Furthermore, the society helps in the development via awareness of its facilities and capabilities in the health field [13].

Thirdly, Community-Based Education can also improve the program assessment besides the student competencies. Moreover, the educational academic organization is usually in contact with the community and the political leaders to give power to the medical school in many fields politically, financially, and morally wherein it has an important role for the local health policy development. The educational academic organization is also contacting international organizations such as the World Health Organization (WHO) for its local accreditation related to the community-oriented approach. In addition, Community-Based Education program can update and develop the curriculum according to the changing patterns of health and the community problems via a continuous assessment by the staff and students who are involved in the community wherein it has a role for the promotion of the health system and services in the community [14].

Worthwhile, there are global minimum essential requirements for



undergraduate medical programs according to the World Federation for Medical Education (WFME) and the Institute of International Medical Education (IIME). These essential requirements consist of seven main domains that include professional values, attitudes, behavior and ethics, scientific basic of medicine, clinical skills, communication skills, population health and health systems, management of information, critical thinking, and research. Therefore, it should mention that Community-Based Education fulfills these previous domains for medical students through the educational strategy that depends on the identification of tasks for students to improve inadequate conditions, and the identification of the required competencies for these tasks and eventually designing learning objectives to develop these competencies. Recently, a number of the evaluation studies were conducted to assess the graduate's performance of these novel medical schools in comparison with the graduates of other traditional schools. These studies concluded that the graduates of this modern school (Community-Based Education) are better than the graduates of traditional schools especially for clinical and communication skills [15].

How to Apply Community-Oriented Medical Education (COME)?

Noteworthy, the design of any successful medical educational program such as Community-Oriented Medical Education (COME) should meet the above mentioned seven main domains of essential requirements for undergraduate medical programs that are classified into competency categories such as medical knowledge, patient care, professionalism, communication skills, system-based practice, and system-based learning. Thus, it should determine specific learning objectives (specific competencies) to measure the knowledge, skills, and behavior of students under the umbrella of these competency categories [16].

At the first, it should identify the overall objectives of this program that the student will be able to achieve by the end of this program. These learning objectives should include the ability of the medical student to describe the community health problems and its priorities, use the medical knowledge for community health problems diagnosis, and identify the prevention methods of these diseases and health care delivery services, and primary health care besides attitude, behavior, beliefs, and the culture of the community. Moreover, the student should also able to develop the plan for the community health problems diagnosis and intervention, with developing psychomotor, problem-solving, and research methodology skills for the community health promotion [17].

Secondly, it should identify the specific learning objectives of the above-mentioned competency categories. Therefore, it should determine specific learning objectives of medical knowledge via identifying the knowledge related to the clinical problem by consultation, texts, and literature besides the biological, behavioral, and the social mechanism of patient problem, recognizing the ability to enlist the differential diagnosis for specific chief complaint and patient characters, demonstrating the problem-solving skills (generate hypotheses, test hypotheses, test differential diagnoses, and analyze conflicting data) besides the ability to rank differential diagnoses via using history taking and physical examination information [18].

Thirdly, it should determine specific learning objectives of the patient care wherein the student should have the ability to obtain complete and focused history taking, perform complete and focused physical examination besides utilizing and interpreting the laboratory data for diagnostic approach procedures with demonstrating the mastery of medical information management and record [19].

Fourthly, it should determine specific learning objectives of professionalism wherein the student should have the ability to demonstrate patient confidentiality and respect it in oral and written communication besides the personal responsibility for the patient care. Moreover, the student should also have the ability to demonstrate the personal beliefs and limitations, truthfulness, and honesty with the health care team members besides recognizing the mastery of caring attitude for the patients and families [20].

Fifthly, it should determine specific learning objectives of communication skills wherein the student should have the ability to identify knowledge of family and the support system, ethical and cultural issues, psychological, social, and economic factors related to health care delivery assessing the expectations and assumptions of the patient for the health care system besides utilizing the verbal communication for effective engagement of the patient and family [21].

In the same context, it should determine specific learning objectives of system-based practice wherein the student should have the ability to manage the health care via demonstrating the medical knowledge and its use in the health care delivery besides identifying the impact of socioeconomic factors on the health care delivery and recognizing the clinical and cost-effective approach for diagnosis and treatment. Furthermore, the student should have the ability to identify the health care funding and its application for the best patient care, evidence-based medicine and its application for the best patient management, and recognizing the roles of the health care providers besides utilizing the management care system for creating the plan for the patient treatment and health care with demonstrating the ability to work in a team with the other health care professionals in the health care delivery [22].

Finally, it should determine specific learning objectives of practice-based learning wherein the student should have the ability to identify the quality of medical literature and the medical research areas in the future utilizing the new knowledge and communications in the health care delivery besides utilizing the positive and motivated attitude for active participation in the educational process and its activities [23].

Conclusion

Community-Oriented Medical Education (COME) is considered health-oriented physician education respecting the health needs of the community. Therefore, the graduate of Community-Oriented Medical Education has the ability to serve his surrounding community via dealing with the health problems at three different health care levels. Furthermore, Community-based education is considered one of the implementation fields of a Community-Oriented Educational Program wherein the learning activities are



held in particular community settings. Thus, the implementation of community-based education can achieve many major benefits for the students, staff members, educational institutions, health services, and society because it is characterized by excellence and relevance.

Declaration of conflicting interests

The author declares that there is no conflict of interest.

References

- Hays R. (2007). Community-oriented medical education. *Teaching Teach Educ*; 23: 286-293.
- Worley P, Esterman A, Prideaux D. (2004). Cohort study of examination performance of undergraduate medical students learning in community settings. *British Medical Journal*; 328:207-209.
- Habbick BF, Leeder SR. (2009). Orienting medical education to community need: a review. *Med Educ*; 30:163-71.
- Ali A. (2012). Community-Oriented Medical Education and Clinical Training: Comparison by Medical Students in Hospitals. *Journal of the College of Physicians and Surgeons Pakistan*; 22 (10): 622-626.
- Elshama SS. How to Develop Medical Education (Implementation View). 1st ed. Scholars' Press Germany, 2016
- Talaat W, Khamis N, Abdel Aziz A. (2011). Ten Frequently Asked Questions on Community- Oriented/Based Medical Education. *Med. J. Cairo Univ*; 79 (2): 55-60.
- Khan I, Fareed A. (2003). Perceptions of students and faculty about conventional learning and community-oriented medical education. *J Coll Physicians Surg Pak*; 13:82-5.
- Hamad B. (2006). Evaluating the community-oriented medical education in two medical schools in Sudan. *East Mediterr Health J*; 12:249-51.
- Azizi F. (2003). Evaluation of the community-oriented medical education in two medical schools in Sudan. *East Mediterr Health J*; 9: 191-200.
- Ayesha A, Kazi A, Jahangeer A, Fatmi Z. (2006). Knowledge and skills in community oriented medical education (COME) self-ratings of medical undergraduates in Karachi. *J Pak Med Assoc*; 7:313-7.
- Kristina TN, Majoor GD, van der Vleuten CPM. (2006). A survey validation of generic objectives for community-based education in undergraduate medical training. *Education in Health (Abingdon)*; 19(2): 189-206.
- Kaye DK, Muhwezi WW, Kasozi AN, Kijjambu S, Mbalinda SN, Okullo I, Nabirye RC, Oria H, Atuyambe L, Groves S, Burnham G, Mwanika A. (2011). Lessons learnt from comprehensive evaluation of community-based education in Uganda: a proposal for an ideal model community-based education for health professional training institutions. *BMC Med Educ*; 11:7.
- Daniels ZM, Vanleit BJ, Skipper BJ, Sanders ML, Rhyne RL: (2007). Factors in recruiting and retaining health professionals for rural practice. *Journal of Rural Health*; 23(1):62-71.
- Kaye DK, Mwanika A, Sekimpi P, Tugumisirize J, Sewankambo NK: (2010). Perceptions of newly admitted undergraduate medical students on experiential training on community placements and working in rural areas of Uganda. *BMC Medical Education*; 10(1):47.
- Karle H. (2010). World Federation for Medical Education perspectives on person-centered medicine. *Int J Integr Care*; 10: 007.
- Boon V, Ridd M, Blythe A. Medical undergraduate primary care teaching across the UK: what is being taught? *Educ Primary Care* 2017; 28(1):23-8.
- Lam TP, Lam YYB. (2009). Medical education reform: the Asian experience. *Acad Med*; 84:1313-7.
- Shankar PR, Piryani RM. (2009). Medical education and medical educators in South Asia - a set of challenges. *J Coll Phys Surg Pakistan*; 19:52-5.
- Widyandana D, Majoor G, Scherpbier A. (2011). Effects of partial substitution of preclinical skills training by attachment to primary health care centers: an experiment study. *Med Teach*; 33(6):313-7.
- Richards RW. (2001). Best practice in community oriented health profession education: international exemplars. *Educ Health.*; 14(3):357-65.
- Fauziah N, Claramita M, Rahayu GR. (2018). The effect of context, input, and process in achieving interprofessional communication and teamwork competences. *Ind J Med Educ*; 7(1):24-35.
- Claramita, Setiawati EP, Kristina TN, Emilia O, Vleuten C. (2019). Community-based educational design for undergraduate medical education: a grounded theory study. *BMC Med Educ*; 19:258.
- Koponen J, Pyorala E, Isotalus P. (2012). Comparing three experiential learning methods and their effect on medical students' attitude to learning communication skills. *Med Teach*; 34: 198 -207.