Perceptions, Reflections and Learnings of Medical Students about a three-year Experience of Community-Based Education

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ABSTRACT

Introduction: Community-Based Education (CBE) represents an educational strategy that brings medical training closer to real scenario practice and promotes medical care of greater acceptability that contemplates the social sphere of health/disease processes and that adequately addresses the real needs of the population.

To date, there are few publications at the regional level in which the students themselves reflect on this type of training experience.

Objectives: to identify and communicate the main lessons learned from a CBE experience by Medicinedegree students.

Methodology: the systematization of experiences made by the first cohort that completed this experience at the Instituto Universitario del Hospital Italiano de Buenos Aires was reviewed. We reflected on the main difficulties observed and the most significant lessons learned from this experience. Domains were established, and the texts of the systematization generated during the course were codified. Then, a concept map was generated from which this work was written.

Results: this experience had three well-defined moments for the students: an initial stage, characterized by uncertainty and discomfort; an intermediate one, with strategic learning and some transformation; and an advanced one, with deep and situated learning.

Conclusion: it is recommended that EBC experiences are assigned enough time in the planning and that they end with a reflection process promoted by the teaching team.

Key words: medical education, primary health care, social learning.

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INTRODUCTION

Community-Based Education (CBE) represents an educational strategy in which students learn by working with different social actors in the community that the university is part of, interacting with people where they live and with their everyday problems, rather than doing so within the health care system1. Such a strategy has a significant advantage over the social responsibility of institutions since it brings medical training closer to its actual practice and promotes better medical care that includes the social sphere of health/disease processes and adequately addresses the real needs of the population[2].

Since 2018, the Instituto Universitario del Hospital Italiano of Buenos Aires has had an integrated curriculum with a community-based education profile. For this purpose, students have a training space called Community-Oriented Primary Care (APOC), which covers the first three years of the career[3]. In this space, they are divided into six groups of approximately ten students each and undertake actions in different communities in the metropolitan area of Buenos Aires. To this end, they must make a diagnosis of prevalent problems and a participating assessment of priorities with their community during the first year, plan and implement an intervention that addresses these problems in the second year, and evaluate the results of the intervention and systematize the experience in the third year. In this way, trainees accomplish, over the first three years of their medical training, each of the actions necessary to complete the APOC cycle exactly as it is performed in real-world settings[4]. In addition, they are asked to perform interventions from a salutogenic perspective that empowers communities in their health management.

Although CBE is not new, to this day, there are few publications in the region in which students themselves reflect on this type of training experience. What follows are the perceptions, reflections, and learning from students of the first cohort that completed this experience.

OBJECTIVES

To identify and communicate the main lessons learned from a CBE experience by undergraduate medical students.

METHODOLOGY

During the three years of the experience, all students kept a record of the activities carried out in the community. In the last semester of the third year, they took these records as input and reflected on their progress following the systematization method proposed by O. Jara Holliday, i.e., finding out "what had happened" (descriptive stage of systematization) and then asking themselves "Why happened what happened" (reflective stage of systematization)[5]. Each committee made a summary of the main ideas and produced a report that was presented to other students and tutors*.

To produce this publication, we continued working with a group of students who were part of the first cohort and who felt motivated to carry it out (since the actual production of the publication is not part of the activities contemplated in their undergraduate curriculum). There were weekly meetings to deepen the reflection on the main difficulties observed and the most significant lessons learned from this experience. For this, we established domains and codified the texts of the systematizations generated during the course. A concept map was then drawn up from which the paper was written. The result of this process is presented as a narrative synthesis with a thematic summary of what we consider to be of great value for this communication.

RESULTS

The final papers presented by the students were analyzed, together with the individual and group interviews recorded throughout the process. From the resulting insights, it is clear that this experience had three well-defined moments for the students:

Initial stage

This first stage proved to be mainly characterized by uncertainty and discomfort. The reasons seem to be multiple. The most representative phrases identified in the repositories reviewed appear in italics.

- *What does this subject do in the medical career*?

When choosing Medicine, most students do so based on the constructs that fit into the dominant medical model[6]. This model gives hierarchies to physicians who work in highly complex hospitals, focus on the biological and the objectifiable, and fulfill a predominantly curative role, which conflicts with a training proposal to go out into the communities to look at and address social problems and to work with healthy people.

- *Why should we waste a year making health diagnoses and asking people to focus on them if we can already start taking their blood pressure (BP) or giving them a workshop?*

Another identifiable source of tension between the dominant medical model and what the APOC proposes is related to the role of health professionals. They considered it a waste of time to carry out a community diagnosis and a participatory prioritization of the identified problems because they believed they already knew what the population needed.

*The compilation of the systematizations made by the different student commissions of this cohort can be found at the following link: TROVARE

- In APOC they teach us to be good people, whereas I came here to learn how to be a good doctor.

Within the dominant medical model, positivist and biologicist in nature, the linking elements of the doctor-patient relationship and interpersonal skills are not hierarchical for the correct practice of the medical profession.

- The ones in the other group were lucky because they got to work in a poor neighborhood; that is where there is a lot to do.

In this initial stage, we identified multiple prejudices of the students towards the communities, which directly or indirectly influenced the quality of the interventions they could undertake in the future. Among them, the notion of a selective PHC (Primary Health Care), i.e., a PHC that only serves people with low socioeconomic resources, stood out.

-We don't want to do this and neither does the community.

One of the main challenges for students in the first years is to find a community player willing to work with them from a salutogenic approach. The prevailing medical model not only affects the health system but also permeates the communities' expectations of health professionals. In this sense, it was often the case that communities demanded biologicist and physician-centered interventions instead of salutogenic ones, with the communities themselves as protagonists of the processes.

-How can I work with the community if I do not have a defined community?

APOC's model aims to work with defined communities, usually, a portion of the population, that refer to a specific health center. In our case, this does not happen because our health centers are only visited by people with health insurance which allows them to be treated in that center[&]. Moreover, many health centers are organized as polyconsultancies, without a specific and open offer for the communities

- How am I going to use this in the future?

The students found it difficult to imagine how to apply what they had learned in their future practice since none planned to be community physicians, and they saw a limited field of action for those who wanted to approach health from this type of proposal.

Intermediate stage

The main characteristic of this stage was that students complied with the assignments out of obligation and with the sole objective of passing the evaluation instances. However, incipient changes in their attitudes begin to appear; this stage is crossed by strategic learning in which students detect what the teacher wants to hear/read in the evaluations and repeat them to pass, without any significant change in their way of thinking[7].

- Let's do it so we get it out of the way.

- Since we started working with them (people with some disability), I started looking around the squares to see if there were games for people with disabilities or if the doorbells at the entrance of buildings were wheelchair friendly.

- We thought we wouldn't have anyone to work with (being a middle/high-class neighborhood), and in the end, we found out we had many things to work on[#].

Advanced stage

At this stage, the students, upon reflection, could make sense of what they had done, identified the relevance of these learning experiences, and saw with greater clarity how they could apply them in their future practice. In this way, and unlike the previous stage, significant learning is observed[8].

- We could see firsthand that healthcare is not only done in hospitals but depends more on the people and the communities than on the system. We realized that many people in the communities do not even reach the health system, so if we remain in the hospitals, we will never see them.

- We used to think that the physician was someone who knew all the answers to the medical problems of the population and gave the necessary indications for treatment. We now believe the physician's objective is curing diseases and improving people's quality of life, whether healthy or sick.

Students had the chance to reflect on how this experience changed how they thought about what health meant, how to construct it, and the role of health professionals in the health/disease process.

- Before, we thought the wealthy had no health care problems, and PHC was only for the poor. Here we saw and addressed many issues of middle/upper-class people.

Another point identified as a change arising in them through this process has to do with a significant reduction of the prejudices they entered the career with.

If we had finished the experience without reflection, our learning would have been very different and less profitable.

In this instance, they began to emphasize the importance of applying the concepts learned theoretically, understanding that the fieldwork gave them more profound and complex knowledge. But they also emphasized the importance of the final reflection as an opportunity to understand the purpose of learning what they had learned and how they could use it in their future practice.

[&]The students work in medical centers of the Hospital Italiano de Buenos Aires, a private hospital, so only those covered by their health insurance are attended. They spread over three centers in Ciudad de Buenos Aires and another three in the Buenos Aires suburbs.

[#]This committee identified -as problems to work on- social isolation in older adults, childhood obesity, and infantilization of medical care for people with some disability.

DISCUSSION

Our paper has as its main findings that the CBE experience provokes a strong early resistance and that reflecting on the experience was the tool that helped students evolve from strategic learning to a deep and situational one.

We understand that the resistance they initially experience is natural and predictable. One should be aware that the student's experience is crossed by the hegemonic medical model's characteristics, even when choosing a career. As stated previously, this model prioritizes the objectifiable and biological over any social aspect so that the tasks regarded as relevant are not those associated with generating health from the communities but instead, those related to curing the sick in hospitals[6]. In this context, it has become normalized that medical training takes place in hospitals while the scarce experiences that undergraduate students have in the communities tend to be of short duration, with not very clear objectives[9], and from a perspective that perpetuates the asymmetry between the figure of the physician and the population: the physician, who is the one who knows what the community needs, brings activities to the community to help it, instead of working with the community to empower it. Thus, one might expect students' perspectives on the medical curriculum to conflict with what is offered at APOC, which is instead geared towards a holistic, salutogenic, and community-centered approach.

This initial resistance and uncertainty are possibly aggravated by the fact that the initial experiences with the community they have in APOC are generally not friendly to someone taking their first steps with this type of work. D. N. Perkins discusses the process required to learn something highly complex by comparing it to a person learning to play baseball from scratch until they can play "the whole game"[10]. Among the notions he describes, he states that trainees must have -in the initial stages- a "beginner's version" of the game that allows them to acquire the basic notions and gain confidence to overcome the early disorientation of being exposed for the first time to such a complex scenario. This is extremely important to maintain the learners' motivation, what the author calls "making the game worthwhile". In our case, we do not have a version for beginners: the students go out from the first day to work in real scenarios (with the complexity that this implies), so they find themselves in a community that often does not want to work with doctors and, when they do, they expect a biologist intervention (because that is what they are used to). In this scenario, we understand that the discomfort experienced by students at the beginning of the course is to be expected.

Another relevant variable identified in this training experience relates to the time allocated (three years). K. Bain argues that knowledge is not something that is obtained, but something that is constructed[7]. This construction takes place through the adaptation and updating of what he calls "mental models" which are the set of representations that attempt to explain the world based on previous experiences and beliefs. Learning occurs when the mental model fails when trying to explain something so that a question arises, and with the answer obtained, a new, updated mental model with a better explanatory power of reality is created. In the case of our students, the cognitive effort they must make to deconstruct a mental model centered on the hegemonic medical model and adapt it to a salutogenic and community-centered approach took time. For this reason, we consider it relevant for this to be considered when planning CBE activities to generate proposals that contemplate the need to allow the necessary time for the construction process involved in learning to develop[11].

Another element we identified to favor the evolution from strategic learning to deep and situated learning was the reflection at the end of the experience. P. Carlino and I. Pozo maintain that no one learns for once and forever but that whoever is learning must return to the same thing and review it repeatedly from other perspectives so that this learning becomes increasingly complex, situated, and deep[8,12]. Carlino also adds that this reflection should not simply be left to free evolution but should be guided and encouraged by the teaching team. Therefore, when our students state that "if we had finished the experience without reflection, our learning would have been very different, less profitable", this is probably related to what G. Salomón maintains when he says that reflection is the way to turn information into knowledge[13].

Finally, we feel it is essential that the students worked on identifying and dismantling the prejudices with which they entered medical school. Accessibility is one of the central aspects of health services, which has historically been analyzed in terms of geographical aspects and supply-demand issues. However, in recent years, the notion of acceptability of the care offered has gained importance within the accessibility construct, given that - no matter how close and available a resource is to a person - he/she is less likely to use it if, for example, he/she is mistreated at the health center[14]. Thus, CBE experiences and the dismantling of prejudices they foster represent an opportunity to encourage future health professionals to provide health care that is more acceptable to the population[15].

We can conclude, therefore, that the CBE experiences are of great relevance for educating future health professionals who can provide care of higher quality and acceptability to the populations; for this, they must be conducted from a salutogenic and community-centered perspective, that sufficient time be allocated for them in the curriculum planning and that they end up with a process of reflection fostered by the teaching team.

Conflict of interest: the authors declare no conflict of interest.

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