Community Oriented Medical Education (COME) and Its Application.

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For the last 100 years, the role of doctors and healthcare systems are widening and changing due to two factors. First due to new knowledge reaching us as a result of new technology and research, which in turn leading to better understanding of Medicine, individual and community. Second factor changing the role Is societal reorganization of resources and their delivery.

Considering these factors, 166 members assembled in 30th world Assembly in 1977, adopting the concept of "Health for All", and issuing following statement:

"Attainment of all citizens in the world by the year 2000 of a level of health that would enable them t lead a socially and economically productive life[1].

This was followed by Alma Ata conference in 1978 where WHO and UNICEF accepted that Health for All can be achieved by Primary Health Care. This was a revolutionary turnaround where it was argued that secondary and tertiary rare should support the primary care with redistribution of resources involving community participation and more stress on prevention than ever before. The global strategy was suggested in detail in 34th World Health Assembly in 1981.

The cost effectiveness was accepted as an important factor that must be given due importance in every model. As the health workforce in most health systems costs 70% of budget, it is necessary that their training should be appropriate and cost effective[2].

However, it was realized that ground realities were different. The Council of Health Ministers, meeting at the Maastricht Summit in November 1991 pointed to the differences in goals, priorities and thus allocation of resources, which did not facilitate the coordination of efforts. An agreement was made to encourage Cooperation among governments in health information and education and the prevention of illness (EEC Resolution 91k/304/05)[3].

Following were some of the important recommendations of European Meetings regarding

Medical Education:

- Medical education policies should reflect health policies (Lisbon, 1988)[4]
- Cooperation between medical education and healthcare services should be strengthened (Edinburgh 1988[5], Venice 1989[6], Edinburgh 1993[7])
- Links should be established between phases of medical education (Crete 1990[8], Edinburgh 1993[7])
- Curriculum contents should be oriented towards the community and PHC (Crete 1990[8], Venice 1989[6], Edinburgh 1993[7])
- Emphasis in medical learning should shift from passive to active learning (Crete 1990[8], Venice 1989[6], Edinburgh 1993[7]).
- There is need to improve communication skills (Edinburgh 1993[7])
- There should be shift from lectures to small- group and independent learning (Edinburgh 1988[5], Crete 1990[8]).
- Curriculum must include ethics (Edinburgh 1993[7])
- Learning must promote the acquisition of lifelong active learning habits (Crete 1990[8], Venice 1989[8], Edinburgh 1993[7]).
- Strategies must include problem-based learning (Crete 1990[8], Venice 1989[6], Edinburgh 1993[7]).
- Learning must include community setting (Crete 1990[8], Venice 1989[6], Edinburgh 1993[7])
- Performance of teachers must be evaluated (Crete 1990[8], Edinburgh 1993[7]).

Unfortunately, we do not see most institutions in Pakistan following these policies. Like all Medical College, Muhammad Medical College (MMC) has a responsibility of producing a multi-potential graduate who can decide in relation to the community needs where he can best serve at Primary, Secondary or tertiary level. It is believed that Medical Doctors are more likely to apply their knowledge effectively in a particular setting if they have learnt in that setting.

For this write up, a community is defined as a group of people that our students are likely to serve after graduating. Whereas orientation is defined as focusing in a particular direction while being constantly aware of different perspectives of the situational setting.

Some specific key features of community orientation include:

1. Health orientation
2. People orientation
3. Community basis
4. Natural history of disease model
5. Life cycle
6. Case study
7. Team work

In order to make a beginning towards implementing Community Oriented Medical Education at Muhammad Medical College, and producing graduates who can discharge their duties successfully in the community, I would recommend that a student should spend 2 months in the community, hereby identified as "XYZ Village" harbouring about 100 families with 600 people. Hence

Community: XYZ Village (100 families, 600 people).

Problems: Some of the key health problems identified

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included.

- Poor health conditions
- Poor vaccination
- Poor birth control (family planning).
- Hepatitis C. 33% of healthy donors coming from this area for donating blood were found hepatitis C positive.
- Tuberculosis

Need identified:

Students will gain firsthand experience of working to improve health within the community.
Some of the commonest health problems of the community will be addressed.

Programme:

Group of 20 students will spend 2 months to observe, understand d, document and manage the health problems identified above. They will work under supervision of two doctors from department of community medicine.

Curriculum Organization:

20 students belonging to 3d year MBBS will be posted at a time. A student will have primary responsibility of a family of 6, though they will interact and discuss with each other to identify and learn to solve the health problems of families assigned to their colleagues.

Curriculum content:

- During their attachment, students are expected to
- Learn concepts of health and people orientation and community basis.
- Focus their studies on 5 problems identified above.
- Develop forms to record the general problems of health, vaccination records, birth control, hepatitis C and tuberculosis.
- Learn the Extended Programme of Immunization (EPI) and its acceptance in the community.
- Learn about various methods of birth control at community level.
- Learn the natural history of hepatitis C & tuberculosis and their prevention.
- Learn the diagnosis and management of tuberculosis and Hepatitis C in community.

(These facts are specifically mentioned in table given below).

FEATURE OF COMMUNITY ORIENTATION INCORPORATED IN PROPOSED CURRICULUM

S.#		Health Orientation	People Orientation	Community Basis	Natural History of Disease	Life Cycle	Case Study	Team Work
1	Living in Community	√	√	√				
2	Daily assembling & discussing the families allocated		√	√				√
3	General Health Condition	√						
4	Vaccination	√		√				√
5	Birth Control (Family planning)	√	√	√				√
6	Hepatitis C							
Prevention,		√	√	√				√
With intact liver infection,				√	√	√	√	
Compensated Cirrhosis				√	√	√	√	
Decompensate Cirrhosis				√	√	√	√	
7	Tuberculosis							
Prevention,		√	√	√				√
Treatment				√	√	√	√	

It has been agreed in the meeting of academic council that Muhammad Medical College (MMC) should incorporate features of community orientation into its curriculum. It would strongly recommend that the curriculum committee of MMC may kindly start with incorporating the above programme in 3rd Year curriculum so that we can make progress in achieving the above goal.

References:

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