A Structured Experiential Curriculum in Community Medicine

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In order to provide experiential training in community medicine, a structured curriculum has been developed. Specific methodological skills in community medicine are identified and nine content areas are presented in seminar form during the three-year training program. Each resident is expected to participate in a community health care project and demonstrate one or more of the methodological skills identified. The experiences of two residents are reported. One involved a community health needs assessment and one, the development of a mechanism to ensure continuing consumer/provider communication.

In order for the family practice resident to become proficient in comprehensive care there must be an interwoven fabric of learning experiences in the three-year curriculum. Ability to utilize community medicine is an aspect of comprehensive care which is vital to the training of the family physician.

Competencies in community medicine most applicable in family practice include skills in:

- public health and preventive medicine: disease prevention and early detection in individuals and groups
- epidemiology in diagnosis and disease control
- occupational health
- utilization of community resources
- organization and management of health care
- assessing community health care needs
- providing for community health education.

Expertise in all areas of community medicine would reach far beyond the needs of the practicing family physician. The family practice resident needs to identify those skills to pursue which are most appropriate for his or her future practice, or personal interests.

Previously unstructured experiences in community medicine obtained by residents in family practice at the University of Washington were reviewed by the faculty. At the same time the university affiliated Network of family medicine residency programs developed a statement of objectives for training in community medicine. Inquiry of the residents confirmed that their perceived needs for training in community medicine were individualized according to their future practice plans and personal interests.

These efforts yielded a curriculum in community medicine which provides the residents with a core content of the identified competencies in community medicine, while providing for individualization of experiential training.

Curriculum

Goal

Skills in community medicine enable the family physician to address major health care issues. A clinician practicing within his or her office will strive to improve the health status of individuals and families; a community medicine-oriented

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clinician will improve the health status of large groups of individuals and entire communities through collaboration with others and with community health resources.

Objectives

1.0—Each resident will actively become involved in a community health project.
2.0—Each resident will demonstrate methodological skills in community medicine during the experiential segment of this curriculum. It is expected that each resident will demonstrate one or more of the following methodological skills:

2.1 Community health care needs assessment
2.2 Structuring and analyzing policy problems
2.3 Research design
2.4 Survey and health screening techniques
2.5 Community "health education"
2.6 Data analysis and interpretation
2.7 Program development and evaluation
2.8 Administrative and managerial techniques

in community health care services or agencies.
3.0—Each resident will submit a written report on the selected experience in community medicine prior to the conclusion of residency training for discussion at periodic seminars and conferences.

Implementation

Throughout the three-year training program, lectures and seminars will be presented to provide the resident with the appropriate tools to understand the following aspects of community medicine:
1.0—Community health care needs assessment (availability, accessibility, acceptability, demand for health care services)
2.0—Assessment of medical care quality (auditing)
3.0—Determinates of health care services (clinical strategies, health care protocols development)
4.0—Health care manpower (management, allocation, training)
5.0—Economic aspects of health care services
6.0—Effects of the delivery system on the health of a defined population
7.0—Health behavior and belief models
8.0—Organizational and integrational aspects of health care available to a community, eg, availability of primary care services
9.0—Prevalence and incidence studies of common illnesses.

During the first year of training each resident will be given the opportunity to visit and assess existing community medicine organizations. A written report on one of these agencies is required from each resident.

Prior to the end of the first year of training each resident will select the area of experiential learning he will pursue during the next two years from the following list of experiences:
1.0 *Health Care Services Research*—The major emphasis in this type of experience is to undertake or become a part of an investigative effort addressed to a problem affecting the health care services of a community. The resident should acquire some proficiency in hypothesis formulation and testing, survey techniques, and epidemiological quantitative procedures.
2.0 *Policy Analysis and Decision Making*—The resident would become an active participant in a specific health policy making group such as the Area Health Planning Board, State or County Medical Association, State Hospital Association, State Professional Standards Review Organization, Congressional Health Committees, and Community Clinic Health Policy Boards.

He/she would acquire an operational level of expertise in issues currently under consideration. In addition, he would learn how to analyze policy and actively participate in decision making, or even develop an independent hypothesis for consideration by the group.
3.0 *Community Services*—In this experience, the resident would participate in an identified ongoing public health project, such as a mass immunization project, the Environmental Pollution Control Task Force, the Migrant Farm Laborer Health Task Force, the Health Department, a family planning project, or a school health planning group.

The resident would obtain some proficiency in providing this public health or community service, with emphasis on the physician's contribution as well as on program administration.
4.0 *Community Health Education*—The resident would participate in some form of teaching and learning with a target group in which he would expect to identify a need, plan a curriculum, and develop skills in lecture delivery and audiovisual communication techniques appropriate to the particular community need.
5.0 *Case Study*—The resident would conduct a study of the health and illness behavior and/or be-

liefs of an identifiable group within the resident's own practice. The experience would emphasize the dynamics of health care expectations and utilization interacting with social and cultural behavior and beliefs.

Evaluation

Prior to the end of the first year of training, the resident will submit a proposed project to his advisor. During this selection process the resident will be prepared to discuss his reasons for selecting the specific area and requirements of time and resources needed to achieve the intended result.

Prior to January of the second year of training, the resident will submit a written outline of the project which will address the goals and plans.

During the third year of training the advisor will critically review the final written report with the resident and arrange for the resident to present the report to an appropriate forum. The final evaluation of the resident's performance should include an evaluation from the community in which the resident became involved.

Examples of Resident Projects

During the second year of training each resident devotes two months to a non-urban practice site of one or more of the family medicine department's clinical faculty. During this time, the resident may elect to devote time to study the system of health care in this community.

Example 1

One of the authors (HD) used this time to conduct a community medicine needs assessment in Kalispell, Montana. After compiling a list of all community health care resources in the area, each was systematically evaluated as to:

- personnel in each agency
- level of training of the personnel
- agency geographic location
- funding source
- population served
- quality of service as perceived by the community
- community acceptance
- physician acceptance
- interagency relationships.

The results of these evaluations were compiled into a resource manual which is available to physicians and residents in the community to improve their utilization of existing health care resources.

The resident reported learning that within a community there are differing viewpoints concerning health needs and approaches to them. In order to conduct a needs assessment which would allow for: (1) a systematic definition of health problems, and inclusion of (2) consumer opinion, (3) provider opinion, and (4) data sufficient to develop a problem solving plan, his report suggested utilizing a problem-oriented format analogous to that popularized by Weed[1] for the care of individual patients.

S—Subjective identification of the health problems of the community as perceived by a carefully selected cross section of the people living in the community.
Subjective identification and assessment of existing resources in the community.

O—Objective documentation of the community health problems through statistical data collection and analyses using county and state records as well as reviews of physician practice profiles.

A—Appropriate assessment for the community by determination of the optimal health care for the community from the subjective and objective data compiled, which would help to establish the local objectives for the community.

P—A community plan to approach the solution of needs or problems utilizing the existing community agencies and available fiscal and person power resources with the physicians in the community acting in the role of coordinators and advisors.

Example 2

Physicians in Pocatello, Idaho, had secured funding to establish a satellite clinic in Lava Hot Springs, Idaho. The development of the satellite clinic was proceeding without the input of the community of consumers. The resident (HB) proposed that the providers needed to obtain the opinion of the consumers concerning the establishment of the new clinic to identify any potential conflicts within the community. He also wanted to develop a system which would provide the new health care resource with continuing consumer feedback. With the support of the physicians involved, a house-to-house survey of the service area (Lava Hot Springs, Idaho; population 616) was con-

ducted. This survey provided answers to the following questions:

1. Where was the population obtaining health care services?
2. Did cultural factors exist which might affect the delivery of health care in the area?
3. What were the health care needs, wants, conflict areas, and future directions of the community?
4. What differences existed between the consumers and future providers of health care?
5. Could the new health care system be developed to ensure consumer input and implementation of their ideas?

From the information gained through the survey, an assessment of community need and potential areas of conflict was drafted. The physicians agreed that the results of the survey needed to be shared with the community. Further, they felt that the community should have a mechanism for both the consumers and providers to continually discuss present and future needs, wants, and conflicts.

A meeting was arranged by the town mayor, at which time a determination was made by the consumers and providers about community needs, wants, and conflicts. The meeting also produced a system to ensure continuing communication between the consumers and providers.

This project pointed out to the resident that:

- Providers need to be knowledgeable of the existing health care resources in their service areas.
- Providers need to develop appropriate informational gathering techniques in order to assess community needs.
- Continuous consumer and provider communication is needed to address changing needs and conflicts.

Conclusion

This curriculum provides the residents with a base of knowledge in community medicine needed to apply the concepts of comprehensive care within his or her own practice and community. Additionally, the use of selective experiential learning resources enables each resident to tailor his experience to specific personal goals and needs.

Reference

1. Weed LL: Medical Records, Medical Education: In-Patient Care: The Problem-Oriented Record as a Basic Tool. Cleveland, Press of Case Western Reserve University, 1969