

The Building Partnerships Program: An Approach to Community-Based Learning for Medical Students in Australia

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Abstract - The Building Partnerships Program at the University of Queensland, Australia seeks to address the dual challenge of preparing doctors who are responsive to the community while providing a meaningful context for social sciences learning. Through partnerships with a diverse range of community agencies, the program offers students opportunities to gain non-clinical perspectives on health and illness through structured learning activities including: family visits; community agency visits and attachments; and interview training. Students learn first-hand about psychosocial influences on health and how people manage health problems on a day-to-day basis. They also gain insights into the work of community agencies and how they as future doctors might work in partnership with them to enhance patient care. We outline the main components of the program, identify challenges and successes from student and community agency perspectives, and consider areas that invite further development.

Key Words: Self-Help Groups; Organizations, Non-profit; Primary Health Care; Education, Medical, Undergraduate

The view that medical education needs to equip future doctors for a role that incorporates both the social and clinical aspects of medicine is not new. More than three decades ago, Todd¹ emphasized the value of social and community medicine in bridging the two. Such thinking explicitly acknowledged the value of social sciences in medical curricula and helped pave the way for the introduction of social sciences courses in medical schools throughout the world. Social, demographic, economic and technological forces have since produced dramatic changes in the health care landscape. More than ever, community-focused and team-based approaches that build on understanding of the psychosocial dimensions of health and health care are seen as essential to effective medical practice.²⁻⁴ In Australia, recent policy initiatives (namely, the Enhanced Primary Care package) include funding arrangements that formally endorse such approaches and encourage doctors to collaborate with community agencies without the financial barriers of the past.

Despite evidence of improved outcomes for primary care patients referred to community organizations,⁵ referral paths to the community sector tend to be poorly developed and collaborative links with

medical care providers largely unrealised.⁶⁻⁷ Medical educators need to prepare future doctors to view patients with reference to their wider community and to work in partnership with the community sector. However, teaching concepts and knowledge relevant to the community perspective has long been considered a challenge.^{2,8} Social scientists involved in medical education need to provide a meaningful context for the acquisition of relevant skills in a way that brings to life their discipline's main concepts and provides tangible evidence of their relevance to medical practice. Increasingly medical schools have begun to introduce to their curricula courses and programs that enable students to gain practical experience in the community.⁹⁻¹¹

This paper describes a program of community-based learning for medical students at the University of Queensland, Australia. We outline the rationale and key components of the program, describe challenges and successes encountered, and consider future directions. In terms of its scale and scope, the program is unique in Australia. We hope our experiences may be useful to others developing similar initiatives.

The Building Partnerships Program (BPP)

The BPP is based on the premise that much health care takes place in the community and beyond clinical settings. Community agencies, such as self-help groups and other non-profit organizations concerned with chronic illness, disability and various other health issues, make a substantial contribution to that care and offer a unique but largely untapped learning resource for medical students. They provide opportunities for students to gain first-hand insights into people's day-to-day management of health problems, as well as an enhanced appreciation of the range of factors that influence the health and wellbeing of clients, their families and carers. They are also ideal venues for learning about multidisciplinary teamwork and collaborative models of care. Additionally, these non-clinical settings enable students to gain exposure to modes of practice that derive from a social model of health, thus providing a contrast with the more familiar biomedical model.

The overall goal of BPP is to develop mutually beneficial links between community-based organizations and the University of Queensland's Graduate Medical Program*. The specific aims are to enable students to:

- explore the community context of health and illness;
- learn about people's experiences and day-to-day management of health problems;
- appreciate the ways in which different groups and sectors contribute to maintaining health in the community;
- gain multiple perspectives on health problems and community responses to them; and
- consider the role of medical practitioners in the wider community and their potential to form partnerships with other health providers to maintain and promote health in the community.

The participating organizations represent a diverse range of agencies involved in various non-clinical activities including support of people with disability

* The medical program is a four-year course for graduate students that emphasizes problem-based and self-directed learning. The program is made up of a foundations year, a second year of preparation for clinical practice, and nine core clinical rotations over the 3rd and 4th years.

or chronic illness, self-help, crisis intervention, and community development.

The BPP consists of an incremental, coordinated series of activities through which students progress during their four-year medical course. The activities are discrete, but integrated so as to build upon previous experiences. There is a natural progression through observation and learning to practice, with an emphasis on immersion in community rather than hospital or other clinical settings. The BPP consists of four main learning activities (community agency visits; family visit; practice interviews; community agency attachment) that are supported by classroom based teaching sessions and web-based resources.

Annually, the BPP coordinates learning activities for around 480 medical students in partnership with more than 100 community organizations and 120 individual community members. The program is delivered by the School of Population Health in the University of Queensland's Faculty of Health Sciences with funding from the School of Medicine. A half-time senior project officer is responsible for the overall coordination of the various learning activities, including liaison with students and organizations. A senior faculty member oversees the program and is responsible for curriculum development and review and, with the assistance of a junior faculty member, the delivery of course material. Administrative support, including assistance with newsletters, mail outs, and computer support, including web-site maintenance, is provided on an as-needed basis. Students engaged in community attachments endorsed by the University are covered by its Public Liability insurance policy.

Community Agency Visits - Groups of two to six first year students visit an assigned agency for a minimum of one to two hours to gain a snapshot view of its work. They later share their experiences in a structured tutorial to gain formative feedback on their learning. The intention is to give students a general introduction to community support services rather than to cover a specific health issue in depth. Typically, students also spend time with clients and/or carers to learn directly about their experiences.

Family Visits -First year students travel in pairs to visit an assigned family in their home to learn about their day-to-day health issues while practicing basic communication skills, including listening and empathy. Students and families are given an outline of the topics that might be covered during the interview. They include self-care and health promotional activities, experiences of the health care system,

medication use, positive and negative influences on health and wellbeing, and sources of health information. The families are recruited through community organizations, general practices and word of mouth. They represent a wide cross-section of the community and reflect different household compositions. Since the focus is on learning about people's experiences of health rather than on medical history taking, it is not a requirement that family members have a specific medical problem. Small group tutorial discussions enable students to share and integrate their learning following the family visit. Feedback is obtained from students and families using a short questionnaire.

Practice Interviews - These interviews give students the opportunity to practice, review and enhance communication skills. Volunteer interviewees, recruited as for the Family Attachments, attend one of two university teaching sites to complete up to four interviews, each of about 30 minutes duration. Students assume the role of family doctor and, using a biopsychosocial approach, ask a range of questions about a particular health problem and its impacts. Interviews are videotaped for formative review by a small group of students and their tutor, under strict confidentiality provisions. A further valuable source of feedback is from interviewees who complete a short questionnaire to rate aspects of the interview process.

Community Attachments - As part of their eight-week General Practice and Community Rotation, third year students spend the equivalent of one half-day each week with a selected community agency to learn about the health issues it addresses, the needs of its client group, and how it relates to the wider health system. A website containing information about participating organizations enables students to select an attachment based on their interests and learning needs. Following registration, students negotiate the terms of their attachment with the organization. Throughout the attachment both parties are encouraged to contact BPP staff should they have any concerns or need clarification. Agencies can elect to have up to four students in any rotation. Students do not engage in clinical activity but are encouraged to consider practical ways in which to contribute to the organization. Following the attachment, students present an overview of their learning to fellow students and submit a written report, which constitutes 35 per cent of their grade for the rotation. Organizations do not assess students but provide general feedback about each attachment. Written feedback about the organizations is also obtained from students.

The following discussion draws primarily on evaluations of Community Attachments to provide insight into students' and organizations' experiences of BPP. While some challenges have been rather predictable, there have been a number of quite unexpected successes that demonstrate the potential benefits of such programs. Selected quotes from students and agencies are from regular feedback forms (see below) and are illustrative of the themes in comments received.

The Building Partnerships Experience

Student Experiences - The challenges facing medical educators attempting to orient students towards the community are well documented.² Initial questioning of the relevance of BPP activities and varying degrees of resistance to community learning by some students has been replaced over time by enthusiasm derived from students' own realisation of the experiential learning offered. For example:

I enjoyed my time at [the organization] and found it to be educational in many unexpected ways. I hope that the lessons I learned will translate into a more compassionate and aware medical practitioner.

The learning curve during my time with [the organization] has been very steep, very humbling and very positive.

For me, it rammed home that with every disease there is also a person who needs to be treated, respected and listened to as a human being.

Students have pointed to the extent to which their community work has challenged their previously held views and enabled them to gain knowledge and confidence in a particular area or to identify areas of interest they previously had not considered:

Prior to my community attachment, I did not realize that unplanned pregnancies were a common occurrence, and I am only beginning to acknowledge the type of problems faced by women in such circumstances.

Attachments with organizations in the disability area are of particular value for many students. Students who previously had been unsure how to interact with people with severe disabilities, and had consequently avoided doing so, have found working with clients with disabilities and their care providers invaluable in allaying their anxieties:

My most rewarding experience was to feed a patient his lunch on Wednesdays... I was quite alarmed when asked to do it, fearing a mess, fearing that I would somehow convey an apprehension and uneasiness to the patient and make them feel bad, fearing that the patient might choke or vomit, fearing that I would not feed in a correct manner and annoy the patient. But I didn't. All went well, with minimal mess and a thank you at the end. It made me feel so good. To be honest, it was probably the first tangible difference I had made in someone's life in my medical career to date ...

In some instances, students have pursued a newfound interest in a particular area. Some have maintained links with organizations as volunteers or in more specific roles such as committee or board member:

The feeling gained from attending and helping left me on a high for several days each week. I am at present contemplating a return to volunteer work.

Despite growing student support for the various BPP activities, an underlying perception remains among some students that community learning is "less important" and its concepts more easily acquired compared with basic and clinical sciences. Competition for students' time is such that community work can assume a low priority even among those who acknowledge its worth. An important part of meeting this challenge has been the development of appropriate assessment methods. A written community report with explicit assessment criteria, including a personal reflection component, contributes to students' overall grade.

Negotiating with organizations to develop a clear focus for learning that is supported by a planned set of activities for students is essential to meeting educational objectives. These activities need to balance structure and flexibility so as to take account of differing student learning objectives and interests. Many students and organizations are eager to produce a tangible outcome (e.g., a brochure, survey or website) during the attachment. It is important to ensure that students do not take on tasks or projects that are unrealistic in the timeframe of the attachment or that allow little opportunity for experiential and reflective learning processes.

Organization Experiences The level of enthusiasm, support and commitment from community agencies has been enormous and unflagging. From a handful of organizations in the initial planning phases, around 100 are now involved in BPP. Agencies are recruited and supported in their role as "community educators" by a project officer. Many organizations also now act as "program advocates". Presently, word of mouth is a major source of recruitment with regular requests from various types of organizations wishing to be involved. The active involvement of the organizations in BPP development, implementation and evaluation has been a crucial element of its success, as has been the establishment of information exchange mechanisms. These include detailed guidelines to support organizations in their role and containing answers to frequently asked questions; a quarterly newsletter; a dedicated website; an annual discussion forum; and regular meetings of an advisory group with organization, student and faculty representation.

Providing clear information about BPP goals and philosophy and maintaining ongoing contact with participating organizations is critical in terms of both their continuing involvement and support, and the quality of student learning experiences. Occasionally, organizations have had difficulty in applying BPP aims and underlying concepts. In several instances, for example, organizations have been overly prescriptive in the student's learning experience or have held unrealistic expectations about the student's role and what might be achieved during the attachment. Though infrequent, such difficulties have highlighted the importance of timely feedback from both organizations and students in order to troubleshoot where necessary.

The enthusiasm of organizations is fueled largely by the belief that their involvement in medical education will help to shape the knowledge, skills and attitudes of future doctors. In particular, they consis-

tently highlight anticipated long-term benefits in the form of doctors' heightened awareness of the value of working with community agencies to enhance patient care and of the specific needs of particular client groups:

I believe it is essential that medical students are informed of what community support is available to their patients. I believe this is a positive [program] that will enhance a more holistic approach to patient care.

The ability to educate our doctors of the future with "hands on" experience, and for the students to "get to know" the client, not just recognize the disability.

We hope this involvement will give medical students an insight and understanding of the patients' long-term needs.

The medical students learned a great deal from the group and we in turn felt privileged to be a part of their learning and awareness about support groups.

Organizations have also gained some more immediate benefits through the practical contributions of students, including the development and updating of information sheets, brochures and websites; assistance with survey work, such as client needs surveys; and direct involvement in the provision of services to clients, ranging from simply spending time talking with clients to assisting at week-end camps for children with disabilities.

Links have been made not only between organizations and the medical school but also among the organizations themselves through networks that have formed around the program. The abovementioned information exchange strategies have been instrumental in this respect. The quarterly newsletter and annual forum are opportunities for sharing information about BPP activities and both include contributions from organizations and students. Other relevant information, such as forthcoming events, possible funding sources and useful resources are publicized through these channels.

Some organizations, particularly those with minimal budgets and a heavy reliance on volunteers,

have had to overcome operational or structural barriers to participate. Some smaller organizations have limited their BPP involvement to community visits while others have worked with program staff to develop innovative student attachments. For example, several small organizations dealing with different women's health issues offer a joint attachment.

Discussion: Where to From Here

Despite the enthusiastic response we have received from students and organizations, there is a continuing critical challenge to gain mainstream support and faculty level acceptance for the BPP. Faculty support has been encouraging, and has increased as we have been able to demonstrate student support, but it is clear that ongoing effort is necessary to maintain the BPP as an integral part of the medical program. This challenge is closely related to wider issues pertaining to the role and valuing of social sciences in medical education.

Having developed trust and mutually beneficial working relationships with many community organizations, the ongoing viability of the program requires sustained outcomes that are in keeping with the underlying principle of mutual benefit. To a large extent, this relates to attracting ongoing and specific funding, along with recognition and valuing of program ideals and outcomes. The participating community agencies are already among the most under-resourced organizations in the health system and their contributions to care frequently go unrecognized. Programs such as BPP need to be properly resourced so that agencies can be adequately supported in their efforts for medical education to ensure those contributions are not similarly under-valued. Identifying potential external funding opportunities is an increasing focus for the program.

To date, our main emphasis has been on establishing appropriate educational strategies and efficient administrative functioning. Developing effective electronic registration processes via a website that also serves to communicate with students and organizations has been particularly important in streamlining the program's administration. The focus now needs to turn toward developing a broader research agenda. The overall BPP objectives invite the evaluation of longer-term outcomes. For example, does exposure to patients/clients through community organization attachments increase students' confidence in working with people with challenging conditions (e.g., severe disability, chronic illness)? To what extent do changes in student attitudes observed following a community attachment extend into future

medical practice? Are students who complete an attachment in the community more likely to engage in collaborative models of patient care? These questions require systematic and longitudinal investigation in order to expand the evidence base for community-focused medical education. We hope our experiences will encourage and assist others in developing community based learning programs and, ultimately, help to ensure that future doctors are equipped to respond to the health needs of the communities they serve.

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