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RESEARCH ARTICLE

FUNDAMENTAL APPROACH TO COMMUNITY ORIENTED EDUCATION IN HEALTH ROFESSIONALS' CURRICULUM

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ABSTRACT

Community-oriented dental education provides variable constructive learning experiences for students while working in real life situation. This type of pragmatic approach of teaching and learning will present a student, acquaintance with genuine and tangible facts and data about individuals and groups. Oral health services are no exception, therefore, it becomes imperative to give all clinical students skill and practice of working in most basic units of health primary care centres and the sub centres. The article highlighted key issues of community based learning (CBL) approaches by providing a brief idea of various thought of CBL, different clinical education models which can be executed in existing health professionals' curriculum. Further significance of Community-based research seeks to recognise and build on strengths, resources and relationships that exist in the communities. Community based learning approach offers various advantages not exclusively to students, to faculty, staff and community eventually gives a chance to guide values of the dental faculty and students and to orient them towards public services, engagement, ethics and the public health.

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INTRODUCTION

Community-oriented education provides wide-ranging learning experiences from clinical education in dental schools to community oriented health care centres spread across a geographical region. (McAndrew, 2010; Formicola and Bailit, 2012) Students exposed to a wide variety of clinical setting that is different from real world, leads to a smoother transition to the life of a dental professional. (McAndrew, 2010) Community-based dental education has turned into an essential component of dental school education and in last ten years, this educational approach has increased dramatically. Traditional dental schools particularly, to address the need of making oral health care accessible to marginalized groups (i.e., poor, racial, low-income, and ethnic minorities), have looked to community-based educational experiences (www.ada.org/sect ions/prof essionalResources/pdfs/survey_ ed_vol4.pdf).

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In response to demand for change, rising number of health profession's educational programs including dental schools have integrated community based education into their curricula. (Seifer, 1998) Community-based education holds great promise for preparing students to function as a health professional in the real world. (Skelton *et al*., 2001) This type of experiential education gives students first-hand knowledge of individual and communities and encounter them to the difficulties of professional life. (Osborne *et al*., 1998) Community-based experiences offer a valuable setting for students to act as health professionals into larger social context and apply what they are learning in schools to real situations.[7] They widen students' understanding of the multiple factors of health, improve communication skills, and enhance their capacity for and interest in working with underserved populations. Experiences only however, are not enough to develop such skills and knowledge. A central component of community-based education is reflection. (Eckenfels, 1997; Callister and Hobbins-Garbett, 2000) Research suggests that when compared with dental students trained only in traditional settings, students trained in community-based settings show not only the same achievement of competencies but

"appreciably higher clinical skills and on-time graduation rates.[9] Community oriented activity, needs enhanced education in professionalism, communication skills, and cultural awareness. (Strauss *et al*., 2010) The social, community, behavioural and public health sciences provide key intellectual and interdisciplinary contributions to this educational procedure, facilitating students' understanding and enhancing their experience in providing clinical care to communities (Holmes *et al*., 2003). This is not the only reason, virtually in all countries, dentistry is highly based on primary care. Most of the healthcare is delivered in local clinics and other establishments rather than in university clinics and teaching hospitals. Oral health care is no exception. It is therefore, logical to give all clinical students experience of working in primary care centres away from their alma mater during their pre-licensing training centre. (Eaton *et al*., 2003) Exposing students to such opportunities in initial years of their education appears to shape how they define their careers and their ethical responsibilities. As students have moved beyond dental school walls, it has turned out to be obvious that, to perform optimally in community settings, they require extra preparation in areas beyond their indispensable technical skills.[9] As far as dental undergraduate education is concerned, it has been recommended that the dental students themselves, their teachers (faculty), the universities, local, regional and national governments and, above all, patients advantage from outreach teaching (Holmes *et al*., 2003).

History of community-based teaching programs

The establishment of community-based learning was laid in the late 19th century when Jane Addams and friends built Hull House in Chicago, introduced on a philosophy of service to society through direct engagement with the community. (Jane Addams, 1894) In the early 20th century, John Dewey created intellectual foundations of service learning through his writings. (http://www.utm.edu/research/iep/d/dewey.htm) In the 1950s, the Citizenship Education Project (CEP) at Teacher's College set the system for "active learning" which was followed by numerous state and national reports on educational reform to upgrade relevancy to the broader society in the 1970s. Many states and local boards of education and schools executed service-learning programs or required volunteer services for graduation. (Bringle and Kremer, 1993) The Institute of Medicine report Dental Education at the Crossroads in 1995 require an expansion in community-based experiences for dental students. (Holmes *et al*., 2003) Further in 1999, a feasibility study on community-based dental education programs called as the Macy Project found was implemented. Over the past decade, the pattern to incorporate Community based dental education (CBDE) as a part of the clinical curriculum has gained momentum. In 2009, a report of dental school curriculum trends found that the most significant change has been the increase in time that students spend in community clinics and practices. The number of schools with twenty-five or more days in community rotations raised from eight to twenty-two. Additionally, the Commission on Dental Accreditation now recommends that community-based dental education should be a huge component of the clinical education of all dental students. (Feldman *et al*., 1997) Community based learning can address areas as such critical thinking, communication, professionalism, health promotion and disease prevention, informatics, practice management and patient care which are included in the ADEA (American Dental Education Association) Competencies for the New General Dentist as well as CODA Standards. (Hood, 2009)

Components of Community-Based Learning according to the Campus Outreach Opportunity League (COOL):

Prior to providing oral health care to population in need, community based learning programs need specific academic and curricular preparation that is in addition to the traditional curriculum. In order to meet the learning goals of community learning approach, dental students need to be able to interact and communicate effectively with the patients.

Critical elements include

Training and orientation: Orientation and training are important first steps for any service experience. Students, faculty, and community members should be provided with proper training and information that will help to prepare for the experience.

Community voice / student voice: Both community and student voices are essential in providing well-structured and beneficial community-based learning projects. Make sure that both stakeholders are represented in the planning process.

Thoughtful Action: It refers to the clue that the service being done is essential and valuable to the community itself. When service is not perceived as essential and valuable, students and community members will quickly lose motivation for the service and the partnership.

Reflection: Reflection is a crucial component of the community-based learning experience and works as a vehicle to service experience and academic work.

Evaluation and Improvement: Evaluation measures both the impact of the students' learning experience and the effectiveness of the services in the community.

Reflection is a vital to community experience

Reflection is a vital component of community-based learning consequently making it one of the principal keys to practical designing & implementation of community-based learning curriculum. Reflection thus result in learning experience for student more purposeful and memorable. Various critical reflection activities engage students the deeper meaning behind the service they have provided to community. (http://morgridge.wisc.edu/programs/servicelearning/Faculty-Definition.htm) It can also help students develop critical thinking and problem-solving skills as well as a resilient service ethic. In dental curriculum, community-based dental education is a type of experiential learning that offers students with clinical opportunities in community settings. (Smith and Irby, 1997) However, this cannot be achieved by simply sending students to a community setting; rather, through this experience, students improve their obligation and understanding of the larger social economic, and cultural factors of oral healthcare. The concept of reflection is hidden in experiential learning. Impact of learning is totally depending on community experiences and that do not involve formal reflection otherwise it would be intrinsically limited. (Heise *et al*., 1976) There are various rewards of self-reflection which can be achieved by community oriented activities. First and foremost, it enhances self awareness, further, itdevelopsa sense of community, it helps in achieving greater cultural competency and sensitivity and empowering students to continue to serve the community.

Reflection can occur in various form and can be easily implemented in health professionals' curriculum. Various reflection methods such as small-group work, writing reflective essays on last community visit, role plays, artistic projects, guided journals, electronic discussion groups, presentations, case studies, problem-solving papers and portfolios can lead to higher level of cognitive thinking among students. (http://morgridge.wisc.edu/programs/servicelearning /StudentsBenefitsAndDef.html; Heffernan, 2001; Atchison *et al*., 2009; Davidson *et al*., 2007)

Models of Community-Based Learning

(Heffernan, 2001) While revising your course, remember that community-based learning can be implemented in various ways, depending on your course learning outcomes and preferred method of teaching. Below are the six most common methods of integrating service into existing curriculum. Discipline-Based Model: In this model, throughout the semester students are expected to have a presence in the community and reflect on their experiences on a regular basis. The connection between course content and community experience must be made very clear to students. Problem-Based Model: In this model, students are working as consultant for a client in community. Students understand a particular community problem or need make recommendations or develop a solution to the problem while working with community. Although it can be highly effective for some disciplines, caution is needed when using this model for non-clinical subjects.

Capstone Course Model

Its suits subjects of majors and minors in a given discipline and are almost covered in their final year. Students have to apply the knowledge they have obtained throughout their course work and combine it with relevant community work.

Service Internship

This approach is more penetrating than community-based learning approach. Here students working as many as 10-20 hours per week in a community. Service internships focus on reciprocity: the idea that the student and community benefit equally from the experience.

Independent Study Model

Here students can enrol to an additional course credit by making distinctive arrangements with the instructor to complete extra work or explore a subject more in-depth. The course instructor serves as the guide for this alternative.

Undergraduate Community-Based Action Research Model

Community-based research is similar to an independent study option. This approach can be effective with groups of students or small classes. Students work closely with faculty members to learn research methodology while serving communities.

The Practice of Community based research

Community-based research looks for strengths, weakness, resources and relationships that present within communities. It develops a social relationship that contribute to the ability of community members to work together to improve health. Few characteristic need to be followed while planning community based research for universities. First of all, community research should respond to needs of the community that they see as priority, rather than addressing questions hypothesised within the university. Further, it should integrate knowledge and interventions for mutual benefits of all partners, which as a consequence, will encourage a co-learning and empowering process that attends to social inequalities. It establishes the trust and infrastructure needed for conducting research and creating comprehensive interventions and ultimately, improve the relationship with the community. Finally, Community-based research needs to disseminate findings and knowledge gained to all partners involved, in a language that is understandable to all layman. (http://morgridge.wisc.edu/pro grams/service learning/StudentsBenefitsAndDef.html)

Effect of Community Oriented Education

Many studies have been done to assess the impact of community-based learning and its benefits to students. This approach helps in the personal development of students such as a sense of personal efficacy, spiritual growth, personal identity, and moral growth. It also helps in facilitating cultural and racial understanding. Students or faculty report that this approach improves students' ability to apply what they have learned in the "real world." (http://morgridge.wisc.edu/progr ams/servicelearning/StudentsBenefitsAndDef.html; Atchison *et al*., 2009; Davidson *et al*., 2007). Community oriented learning not only benefits students, but it also has tremendous potential to benefit faculty, staff and communities. It serves as a potential tool for faculty to review and alter their teaching and learning methodologies. It increases opportunities for professional recognition and rewards. (http://morgridge. wisc. edu/programs/servicelearning/Students BenefitsAndD ef.html; Heffernan, 2001) Community approach improves student confidence in tackling clinical situations. (Smith *et al*., 2006) It also improves student ability to understand a patient's social history and plan appropriate treatment. It helping students move to a more holistic consideration of the patient's needs and increasing their sense of professional competence. (Smith *et al*., 2006) Finally, it creates new alliances and partnerships with the University and supports the work of local organisation which is often understaffed and under-budgeted by providing resources. (http://morgridge.wisc.edu/programs /servicelearni ng/StudentsBenefitsAndDef.html)

Conclusion

Community oriented dental education has immense potential for affecting the values and behaviour of dental students by delivering health care to underprivileged populations. The effective integration of community based education into the health professionals' curriculum requires identification of key components of community learning by academic supervisors as well as students. Reflective components, evaluation and highly organized community based experiences ensure that student learning is maximized. The most important step is selection of appropriate model which can be implemented in existing health professionals' curriculum. The aptness of this selection eventually will orient values of the dental faculty and students towards public services, professionalism and the health of society as a whole.

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