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COMMUNITY-RELATED ISSUES/EDUCATION

Educating Health Professionals in a Community Setting: What Students Value

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ABSTRACT **Context:** *Health care and health professions education has been shifting into community settings. Hawai'i participated in the Community Partnerships for Health Professions Education program, an initiative funded by the W.K. Kellogg Foundation that aimed to develop educational collaboration between community health centers, their respective communities and health professions schools.*

Objective: *In 1998, after completing 5 academic years in this program, former students from one community health center site were polled to begin exploring those components of their experience that were most valuable to their subsequent health care practice.*

Method: *A survey was mailed to 65 former students, asking three questions: (1) what three components of your Ke Ola O Hawai'i experience (Wai'anae site) had the most impact on your practice; (2) is there anything else you would like us to know; and (3) where do you see yourself in 5 years?*

Findings: *Thirty responses were received for a 46% response rate. Students identified three components as having the greatest impact: (1) the multiprofessional approach to health care and learning, (2) the community setting/contact, and (3) understanding the culture of the community. A fourth component that was also revealed was the impact this experience had on their personal and professional growth. Most students reported employment or plans to practice in a community-based, rural, or underserved area.*

Conclusion: *These responses introduce ideas for sustaining a community-based multiprofessional curriculum that is relevant to current health care practice.*

KEYWORDS *Community, health professions education, health profession students, multiprofessional training.*

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Introduction

Recent social and economic pressures in the United States have encouraged a shift of health care locale from hospitals and academic health centers to outpatient community settings. The education of health professionals has followed this movement into the community as the subject of competencies to be acquired (O'Neil & Seifer, 1995). This effort has been supported by several national initiatives, one of which, funded by the W.K. Kellogg Foundation, served as the stimulus in Hawai'i for a program called the Community Partnerships for Health Professions Education administered by Ke Ola O Hawai'i (Richards & Henry, 1993).

This initiative aimed to develop collaboration between four community health centers, their respective communities, and the University of Hawai'i Schools of Medicine, Nursing, Public Health, and Social Work, and has been described in greater detail elsewhere (Feletti & Murry, 1995; Oneha *et al.*, 1998). As stated in the 1992–1993 "Multiprofessional curriculum guide for Ke Ola O Hawai'i students," one of the major goals of the project was "to create a model of community-oriented education for the health professions."

Of the four cooperating health centers, site faculty at the Wai'anae Coast Comprehensive Health Centre (WCCHC) developed a curriculum that promoted multiprofessional collaboration in health care, understanding the relationship between culture and health-related beliefs, effective use of community resources, and learning through contact with individuals in their natural social and cultural context.

In order to explore which components of the community health curriculum were most valuable in actual health care practice, former students were surveyed. At the time of our survey, these students were generally in the early stages of their professional careers, although the medical students were still in training. The following report is based on the responses of the health professionals who trained at the WCCHC site.

Literature Review

Many terms are used to describe multiple disciplines working together. For this project, "multiprofessional" meant professionals from different disciplines—medicine, nursing, social work, and public health—coming together to identify and implement a community project or provide case management services as a team to identified patients.

"Multiprofessional" was a term used at the conception of this project and throughout its implementation. Parsell and Bligh (1998) emphasize the need to be clear about such terms as "interprofessional," "multiprofessional," and "multidisciplinary," suggesting that they are frequently used interchangeably.

They describe "multiprofessional activities" as involving "three or more professional groups" bringing together differing perspectives to solve the same problem (p. 89). Benson (1997) describes "interdisciplinary" teams similarly, differentiating it from "multidisciplinary" teams. "Multidisciplinary" teams consists of various disciplines, all interested in the same patient, but with different responsibilities, training, and faculty. "Interdisciplinary 'teams' openly share decision making, expectations for care, goals for the team, and mutual respect" (p. 285). Several articles focused on this perspective and shared the impact interdisciplinary education has had on students, their practice, and rural communities.

Emphasizing a need for health professions to reorganize and enhance their capacity to provide primary care services, Benson (1997) suggests disciplines share research findings, acknowledge each other's skills, and break down hierarchical relationships which "breed paternalism, sexism, competition, and even contempt" (p. 285). Health profession students emerging now are a generation comfortable with group endeavors and collective responsibility (Benson, 1997). Similar thoughts are expressed in reforming primary health care in Ontario, Canada (Pringle *et al*., 2000). They call for educational and primary care reform that would result in collaborative interdisciplinary teams, indicating that this approach should be a priority in reforming primary health care:

> The only way to truly engender integration and interdisciplinary primary care teams is if the educational models for teaching and clinical practice are integrated so that each professional becomes aware of the knowledge, skills and attributes that colleagues of different disciplines bring with them. (p. 86)

One project that focused on overcoming the shortage of health care professionals in rural areas initiated an interdisciplinary education program in rural Virginia (LaSala *et al*., 1997). Students and faculty from nursing, social work, health administration, pre-medicine, and health education participated in a common course, practicum and community in which they were invited to live with practicing health professionals "to increase their understanding and appreciation of cultural factors that influence the health of a rural community" (p. 294). The impact of assigning students to interdisciplinary teams included (1) developing a role identity as an integral team member, resulting in a respect for each other's training and expertise, (2) greater appreciation of the cultural dimensions of the course through living in the community and experiencing community events, (3) respect for the different strengths each discipline contributed, and (4) experiencing an educational interdisciplinary team approach by having faculty from different disciplines contribute to the course presentation.

Through a survey, the faculty explored student attitudes and perceptions about the rural experience and the interdisciplinary education process.

Although students' attitudes toward interdisciplinary practice were positive to begin with, their attitudes became even more positive, leading their faculty to conclude that the benefits from this focus and potential use of this approach in practice were successfully internalized by students (LaSala *et al.*, 2000).

Lary *et al.* (1997) implemented a multidisciplinary pilot project to prepare students from dental hygiene, physical therapy, and physician assistant programs to work together in multidisciplinary teams utilizing problem-based learning (PBL). Pre and post test results suggested that this project helped to improve the student's ability to work with others in group settings. Students also reported that the experience helped them to learn about the other disciplines. Our current paper seeks to add to this existing body of knowledge by exploring the experiences of students who practiced together in a rural Hawai'ian community.

Setting

WCCHC, located on the western side of the island of O'ahu, is the largest health facility on the Wai'anae Coast, providing care for about half of the local population. In 1996 the Health Center served over 22,600 individuals, drawn from an ethnically and culturally diverse patient population, (48% Hawai'ian, 23% Caucasian, 9% Filipino, 8% other, and 6% other Asia/Pacific Islander). Seventy per cent of the Health Center's patients fall below the federal poverty level. Health characteristics of this rural population include high prevalences of chronic diseases, teenage pregnancy, mental disorders, and drug and alcohol use.

Beginning in the fall of 1992, some students from the four health professions schools at the University of Hawai'i selected a community-based placement, and spent four or more hours per week at the WCCHC for an academic year. In the first 3 years of the program the curriculum was based on multiprofessional teams that developed and implemented health-related student projects in the Wai'anae community (Oneha *et al.*, 1998). In response to expressed student interest in increasing their direct patient contact, the curriculum was revised in 1995 to focus on clinical case management services for patients with complex health, socioeconomic, and other problems.

Both curricula required students to work in teams with colleagues from each of the other professions. Under the supervision of community-based site faculty, student teams learned group process skills. Both curricula included an orientation to the community and instruction in core Hawai'ian cultural concepts, enhancing the students' understandings of the geographic, social, and cultural context of health. In both curricula, students provided community-based care on an aggregate or individual level.

Method

In March 1998 we mailed a survey to students who had completed their placements at the WCCHC during the prior 5 years (up to May 1997) whose addresses we could identify. We asked these students to provide basic demographic information and to respond to three questions:

1. What three components of your Ke Ola O Hawai'i experience (Wai'anae site) had the most impact on your practice?
2. Is there anything else you would like us to know? and
3. Where do you see yourself in 5 years?

Students ranged in age from 23 to 49 years, with a mean age of 34 years. Responses were stratified and analyzed on the basis of the components most often cited. These responses comprise the beginning of the exploratory phase of evaluating this community-based curriculum.

Results

Of the 79 students who completed the community-based training at the WCCHC, addresses could be found for 65. Thirty responses were received, giving a 46% response rate (Table 1). Responses were stratified according to several demographic and educational variables. Response rates were lower for former medical and nursing students, but the total numbers were higher for these groups because more of them had enrolled in the program than public health or social work students.

A majority of respondents indicated that learning a multiprofessional approach to health care and learning in a community setting were important to their current professional practice (Table 2). The multiprofessional approach was valued by former students from every discipline, in both types of curriculum, and in every category of employment setting. Students noted:

> The multiprofessional interaction among the students helped in understanding others' points of view.
>
> Working as a multiprofessional team was great and today where I work we also work as a multidisciplinary team, which I feel patients benefit from most.

Former students in most employment settings, especially those who had participated in community projects, considered community exposure while in training important. One student stated that this experience:

> Allowed me to actually work in the community and see what life is like for many Wai'anae community members. I really felt like I was making a

Table 1. Survey respondents by discipline and curriculum

Discipline	Total students	Surveys sent	Surveys completed Project	Case management	Total
Medicine	27	23	4	5	9 (39%)
Nursing	33	28	6	6	12 (43%)
Public health	11	8	4	0	4 (50%)
Social work	8	6	3	2	5 (83%)
Totals	79	65	17	13	30 (46%)

Table 2. Responses stratified by discipline, curriculum, and employment[a]

Discipline	Multiprofessional approach	Community setting	Understanding culture	Personal and professional growth
Medicine	6/9	7/9	3/9	4/9
Nursing	10/12	9/12	4/12	8/12
Public health	2/4	3/4	2/4	1/4
Social work	4/5	3/5	2/5	3/5
Curriculum				
Project	13/17	14/17	7/17	9/17
Case management	9/13	8/13	4/13	7/13
Work setting				
Community based/nonprofit	7/10	9/10	4/10	7/10
Government	1/2	0/2	1/2	1/2
Private	6/7	5/7	3/7	4/7
Student	7/10	7/10	3/10	4/10
Unemployed	1/1	1/1	0/1	0/1
All responses	22/30 (73%)	22/30 (73%)	11/30 (37%)	16/30 (53%)

[a]Ratios indicate relative number of respondents mentioning the value and impact among each of the four components.

> difference in my patients' lives and they equally made an impact on my life and thoughts about practicing rural medicine.

Other students identified that part of the training that had the most impact as:

> Hands-on experience with case management. It was an experience that couldn't be taught in a classroom or in a textbook.

> You actually have to "walk the walk" with your colleagues in the public, with real problems, not textbook scenarios. True situations cannot be

> encased in the classroom and this is where the experiences are needed before practicing on your own.

Learning about the relationship between culture and health was important for about one-third of the former students. This included an appreciation for the cultural aspects of the curriculum, exposure to diverse cultural groups, and understanding the influences of culture on health care. One student cited the impact of:

> Understanding the Hawai'ian culture and problems that many are experiencing on the Wai'anae Coast (socially and medically).

Another student stated this experience:

> deepened [my] understanding of cultural influences on delivery of health care.

In response to the second question posed to students, about one-half of the former students indicated that the personal and professional growth attained during their training was important for their work. The following are examples of comments:

> Although it was hard work it helped me to prioritize my future employment goals.

> [The] delivery of homeless health care was an invaluable experience. The experience reinforced my goal to provide health care to the underserved.

Another student said this was:

> [the] most memorable year of medical school and looking forward to practicing pediatrics in the Wai'anae community if opportunity is available.

Students entered this training uneasy about calling a patient to schedule a visit. They were anxious about whether their preconceived notions of the community were true. After completing the academic year of working in the community, students had accumulated enriching life experiences, an openness to the "real world" of community-based practice, a clearer understanding of working with people from a cultural group different from their own, and directions for future employment.

An unexpected response was that many of the respondents had plans to pursue advanced training beyond their entry-level degree. Excluding the medical students, 55% of respondents had such plans or had recently completed such training.

Finally, 63% of the responding former students spontaneously reported plans to practice or are currently (at the time of the survey) practicing in a community-based, rural, or underserved area. Students responded to the question *where do you see yourself in 5 years?* with:

> In an underserved area of O'ahu practicing pediatrics and involved in community health efforts for the children of Hawai'i.
>
> Practicing in a rural community and helping to prevent many of the serious diseases that result in high morbidity and mortality rates for the Hawai'ian population.

Discussion

Responses from the former students, discussed within the context of the four components cited, have several implications for health professions education and for health care services.

The Multiprofessional Approach

For many years, training various health professionals together has been advocated, and sometimes taught, both in the United States and internationally (Carlton, 1977; World Health Organization, 1988). This approach was used throughout the program in Hawai'i. The intent was to demonstrate that collaboration is fundamental to providing health care within a community, and to teaching future health care professionals to collaborate with colleagues who have different clinical training. It was purposefully and conscientiously applied during the course of both types of curricula.

In rural settings, where health resources are fewer and more geographically dispersed, the value of collaboration is heightened. Students who trained at the WCCHC had specifically requested placement at this site where multiprofessional teamwork has long been essential, and thus may have been especially receptive to this approach to health care. The survey responses indicated that this aspect of training was almost universally valued for its contribution to practice, and students from both curricula cited it. This suggests that skills in multiprofessional collaboration are fundamental for health professionals and should be taught throughout the professional curriculum, not only to those choosing a community health focus.

Direct Experience in a Community Setting

Fundamental to the Kellogg Foundation initiative in general, and to the Community Partnerships program in Hawai'i in particular, is the belief that health professionals should be trained in the settings of communities (Richards & Henry, 1993). The site faculty at the WCCHC were recruited on the basis of

their direct involvement with community health, and their commitment to training students from this perspective.

It was gratifying to have former students reaffirm the value of training in the community. This acknowledgement was given by most students regardless of the professional discipline or the type of curriculum at WCCHC. It was also cited by most respondents who were employed in a nonprofit community agency and to a slightly lesser extent by those employed in private organizations. This near universal appreciation of direct community experience suggests that it may be a fundamental component of a multiprofessional curriculum.

Understanding the Cultural Setting

This particular component was defined by students primarily as involving an understanding of, or experiencing, the Hawai'ian culture. One-third of the students reported that the integration of the cultural aspects of the community throughout the curriculum provided them with an opportunity to practice cultural sensitivity.

By identifying this as a component that had an impact on practice, students appear to value the integration of cultural concepts in the curriculum and the cultural expertise shared by community leaders/members. Another strength of this curriculum was the ethnic representation among site faculty and the clinical preceptors, which mirrored the diversity that exists in the state of Hawai'i and among the students recruited to the WCCHC site.

However, understanding culture and the cultural setting appeared to have had less of an impact on students than the multiprofessional approach or the community contact components. Perhaps this can be attributed to several factors, including the short duration of time students actually spent at this site, the pre-eminent focus on health and health care from each of their disciplines. This experience provides students an exposure to cultural values, concepts, and practices. They are not immersed in the language or traditional practices of the Hawai'ian culture.

The percent of students who identified this component seems to be consistent across disciplines, type of curriculum, and place of employment. These responses suggest that this component was universally valued and while the cultural exposure was appreciated, it did not have as profound an impact on students as the other components did.

Personal and Professional Growth

A somewhat surprising outcome of the survey was the number of respondents who stated that they were planning to pursue higher educational degrees. It would be interesting to see if this trend occurs at the same rate in the traditional curricula of each discipline.

The educational process for health professionals is often one of socialization, and it may be that students readily identify with their site faculty, who are

chosen to act as role models in community settings. If students in a community-based setting are strongly influenced in personal and professional directions, then attention must be paid to a number of things. Site faculty are likely to be powerful role models and must be chosen with great care. They must have a demonstrated ability to work effectively in the community. The more different the situation is from a familiar university academic setting, the more striking an impression it is likely to make on students. Working for the first time with people who are on the margins of society, students may benefit from extra site faculty attention to ensure that they understand the positive and proactive things that health professionals do rather than focusing on despair.

In addition to professional growth, several former students cited gains in personal growth. Part of this was the natural accumulation of life experience in an employment setting, meeting and working with real patients, and experiencing the satisfaction of helping people. These experiences foster increasing confidence, autonomy, and creativity (Tyree *et al.*, 1998).

Directions for the Future

This paper explores initial feedback in a constantly evolving curriculum. Reworking the curriculum to best fit the emerging health care needs of the community and the community health education needs of the students is a continuous process for site faculty. Comments from former students now in practice proves valuable during these endeavors, ensuring that the educational experiences available to students are consistent with the demands of the health care practice environment.

While the components identified by former students indicate the strengths of this curriculum, evaluating its impact fully requires further investigation. The next step would be to solicit responses from those who did not respond to the first survey, since those who chose to participate in the survey may have characteristics or experiences that differ from those of non-respondents.

This survey examined former students' attitudes at the beginning of their professional careers. Since the medical students were still in training, another area for future exploration is assessing their impressions after beginning employment. These medical students would then be able, like the other students, to evaluate their community education in terms of their actual practice. At that point, the other students could provide an impression from a mid-career perspective.

Conclusions

The responses received from these former students indicate the parts of this curriculum that have had an impact on their early professional practice. Primary among these is immersion in a multiprofessional experience, learning in a community setting, and participating in the life of the community. The

movement of health professionals education into the community requires a curriculum with new features, and faculty with different skills compared to a traditional university-based education. Constantly checking this new education system against reality is essential to ensure that it prepares students to meet the formidable challenges of the health care system of the future.

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