



CCPH SPECIAL SECTION

Service Learning: Integrating Student Learning and Community Service

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ABSTRACT *Health professions education is directly effected by changes in health care service delivery and financing systems. In the United States, as the health care industry increasingly shifts to a market economy, service delivery venues are moving away from acute care facilities and into community-based settings. Additionally, there is increased emphasis on primary prevention programs, often provided in public health settings. For health professions programs that traditionally provide clinical training in hospitals and long-term care facilities, there are unique challenges associated with identifying new venues in order to insure that students are exposed to a wide variety of patients with a range of chronic to acute disease conditions. One set of tools that has demonstrated usefulness during these kinds of transitions is service learning. This teaching methodology emphasizes increased partnership with clinical training sites, extensive orientation to patient populations and community resources, structured reflection and instilling the ethic of service in future health care providers. Although this article describes utilization of service learning in the context of current conditions in the United States, we hope that the principles presented here can be readily adapted in any setting.*

KEYWORDS *Community service learning, multiprofessional education, community-academic partnerships, health professions education.*

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Introduction

In the United States, clinical training opportunities in traditional settings are shrinking. As the health care industry shifts to a market driven economy, lengths of stay in hospitals are shrinking and patients are more acutely ill at time of admission. These changes cause a general decrease in patient census and in some cases hospitals are closing. Additionally, the Federal Balanced Budget Act of 1997 is having an impact on hospitals' abilities to continue to treat indigent patients. Overall this translates into fewer and more limited opportunities for health professions students to learn in hospitals. Clinical training opportunities in private practice settings are also shrinking. Solo and small group practices have dwindled, and large group practices are frequently part of managed care organizations where time-intensive student training is no longer tolerated in the context of efforts to increase patient volume. Even in major teaching institutions the economic bottom line is increasingly becoming the standard by which priorities are determined.

In response, medical schools, colleges of nursing, allied health programs, clinical psychology and social work programs, dental and pharmaceutical programs—most of which have traditionally provided clinical training in institutional settings including hospitals and long-term care facilities—are moving into a wider variety of clinical settings. Often these settings are unfamiliar to faculty and require establishing new partnerships, redefining roles and responsibilities, and designing different kinds of preparation for students prior to their clinical experiences. In these non-hospital settings faculty must also revisit evaluation procedures providing more opportunities for synthesis and integration of clinical experiences. In short, as health care financing and health care service delivery systems continue to change, health professions education is changing just as quickly. This provides an excellent opportunity to introduce health professions schools, faculty and students to the concept of service learning.

Definitions

Service learning is often confused with community service, volunteering, experiential learning, internships and other kinds of non-classroom-based learning experiences. Methodologically, the National Community Service Trust Act of 1993, which established the Federal Corporation for National Service, defines service learning as “a method under which students learn and develop through active participation in thoughtfully organized service experiences that meet actual community needs, that are integrated into the student’s academic curriculum or provide structured time for reflection, and that enhance what is taught in school by extending student learning beyond the classroom and into the community” (Rhoads & Howard, 1998). Kendall (1990) provides some

useful distinctions between service learning and experiential education when he summarizes that service learning:

- engages people in responsible and challenging actions for the common good;
- is committed to program participation by and with diverse populations;
- clarifies the responsibilities of each person and organization involved;
- articulates clear service and learning goals;
- includes training, supervision, monitoring, support, recognition and evaluation to meet service and learning goals; and
- provides structured opportunities for people to reflect critically on their service experience.

Finally, service learning programs are distinguished from other approaches to experiential education by their intention to equally benefit the provider and the recipient of service as well as to ensure equal focus on both the service being provided and the learning that is occurring (Furco, 1996). As the venue increasingly shifts from institutional to community-based settings, the teaching methodology of service learning provides a critical focus on intentional and systemic changes needed for successful clinical training programs in health professions education.

Service Learning Protocol for Health Professions Schools

In application, service learning can be viewed as a useful tool to assist health professions faculty and students in any country, when changes in health professions education are imposed, as they navigate the uncharted waters of new clinical training sites. In an attempt to facilitate the application of service learning in health professions education these authors have developed the Service Learning Protocol for Health Professions Schools (SLPHPS). The SLPHPS, which is more a set of guidelines and explanations than a protocol, is intended to support health professions faculty in the transition from institutional-based clinical training to community and neighborhood-based experiences. While hospital and institutional-based clinical training will remain an important component of health professions education, the learning community is expanding and the following may prove useful.

Establish Ongoing Relationships between Faculty and Service Sites that Ensure Educational Training of Students and Continuous Service in Response to Community-Identified Needs

The nature of the relationship between the health professions education programs, and the sites at which clinical training is completed is changing.

These expanded relationships within a broader teaching and learning community are not as well or as consistently defined as they have been in hospitals and long-term care settings. In community settings, more clearly articulated specific roles and responsibilities of students, faculty and site staff and supervisors are necessary. Maintaining ongoing interaction with the site, planning in advance for student rotations, and adapting to the less structured routines of the non-hospital-based sites are all important strategies to pursue. Additionally, feedback mechanisms need to be developed and maintained for ongoing communication and evaluation. Not unlike hospital settings each community-based site has its own sets of political agendas and personality, and sites vary broadly in their experiences with educating students. The partnership established between faculty and the site supervisor is a critical component of successful community-based training programs using service learning.

Develop an Orientation Component to Clinical Learning that Focuses on the Population Being Served and the Community in which the Service Is Provided

Non-hospital settings require the rigorous, appropriate student orientation as is typically applied in the hospital setting, i.e. specific needs of patients, and orientation to equipment and procedures. In non-hospital settings special emphasis should be placed on: (a) orientation to basic clinical procedures and services provided on site; (b) orientation to the patient population and their cultural health beliefs and practices; (c) orientation to the community and community resources in which the service is located; and (d) orientation to community-identified health concerns. Comprehensive orientation is critical in preparing students appropriately for clinical training in the expanded learning community.

Develop a Reflection Component in which Students Have an Opportunity to Integrate the Service and Learning Aspects of their Experience

Although any clinical training opportunity should be carefully evaluated and reviewed, unfamiliar settings require the additional step of engaging in active reflection with students about their clinical experiences. Traditionally, during grand rounds or peer review, students review diagnoses, procedures, outcomes of treatment, etc. Equally important are discussions about health concerns which affect particular communities, resources that enhance health in the community, barriers to accessing care, social-cultural-economic reasons for non-compliance with treatment regimens, ways in which the provider can extend service delivery, and available health promotion and disease prevention services. In community-based settings where there is a broader diversity of patient populations and disease states, facilitating the students' integration of treatment and procedures with the larger environment of the patients' community becomes more significant.

Actively Promote the Ethic of Service as an Integral Part of Professional Practice

Though clearly articulated in codes of ethics for health professionals, service to the community is sometimes a difficult concept for students to understand. Discussions with faculty, supervisors and mentors about experiences of service, i.e. opportunities to use professional training and education beyond the confines of the provider's office in ways that support individuals and communities taking responsibility for their own health, are useful for health professions students. Service learning calls for health professions programs to actively work to instill the ethic of service into educational and training activities, preparing a workforce committed to increasing access and utilization of health care services for all citizens.

Rationale

There are service learning programs in hundreds of higher education institutions in the United States and abroad. However, service learning in the health professions schools has been slow to take hold. Although health professions students who train in hospitals typically work with underserved patients and are performing a community service, important components of service learning are not routinely part of the teaching protocol. However, faculty and students from schools who have integrated service learning into the health professions curricula, and the community partners who work with students using the teaching methodology of service learning, offer some compelling reasons for broader utilization of service learning in health professions schools. These include: the changing health care environment which requires a broader range of skills in tomorrow's health professionals; fiscal constraints which require significant changes in clinical training programs and the role of the academic health center; and students who report gaining increased knowledge and experience through service learning.

Changes in Health Care Service Delivery

As health care service delivery in the United States moves increasingly to managed care, health care providers are required to work with larger and more diverse patient populations with a greater variety of health care concerns. Knowledge about a wider range of disease conditions, cultural health beliefs and practices, and community resources to support primary care services are increasingly important to health care providers. Recent studies of health professionals indicate that these are the knowledge areas of professional training programs most frequently cited as being particularly weak (Cantor *et al.*, 1993).

Health professions educators are working to strengthen these weaknesses by placing students with a wider variety of patients, often in areas where health

care services have not typically been available. For example, in Ohio, faculty developed a new clinical training site by placing medical students in a youth services center providing health screenings, education and referral services for adolescents. Professional psychology students at another institution worked with children and families in a publicly funded early childhood development program providing educational assessments and interventions for behavioral difficulties. Nursing students from another program provided health education and basic primary care services for men at an urban homeless shelter. In pre and post knowledge and attitude measures conducted through the Center for Healthy Communities these students demonstrated significant changes in knowledge of community resources and cultural health beliefs and practices (CHC, 1999). In fact, it has been reported that 90% of health professions students surveyed nationally indicated service learning had increased awareness of community needs (Gelmon *et al.*, 1998).

Changes in Health Care Financing

Changes in health professions education are closely related to changes in health care financing. National trends such as the shifts to community-based ambulatory settings, managed care, and the implications of the federal regulations on hospitals have significant economic implications for health care financing, which in turn have an impact on health professions education, in many cases limiting opportunities for health professions education in hospitals, academic health centers and long-term care facilities. Academic health centers, for so long primary training facilities for health professions schools across the United States, are restructuring fiscally and in some cases closing down. Concurrently, academic health centers are being called on to shift their focus to more community-responsive services and research, bringing the knowledge generated in the academy to bear on the pressing health, social and economic needs in the community.

The impact on health professions schools has fostered some innovative responses that often include working in partnership with state agencies, legislatures and a growing number of community partners. For example, in Tennessee, graduate medical education training dollars now follow the residents to community-based ambulatory training sites outside of the hospital. In West Virginia, an annual allocation from the state legislature supports student training in rural health centers that extend primary care services throughout the state. In Michigan, state funds are available to consortia that include a hospital, a university, and a managed care organization in order to foster innovations in health professions education. In Ohio, health professions students are involved in a statewide evaluation of enrollment efforts of federally subsidized health care initiatives.

In forging these new partnerships, service learning has provided useful guidelines for defining roles and responsibilities, better integrating student learning objectives with community service objectives, extending health care

services and education through a growing student workforce in the community, and preparing community-responsive and competent health care professionals.

Changes in Educational Outcomes

Faculty and students involved in service learning are often in the forefront of establishing and expanding partnerships with the community, and these kinds of partnerships are beginning to demonstrate significant educational benefits for students. The successful service learning partnership values equally the contributions of the faculty and students and the contributions of the community partner which in turn strengthens both the service provided and the learning experience for the student. Students in clinical training using service learning consistently report learning more from their service learning experiences compared to other clinical training experiences, and gain valuable knowledge about the communities in which they are working.

For example, at a university in Ohio, a cohort of medical students in a third year ambulatory pediatric clerkship each spent 4 hours a week for 6 weeks in a public school working with elementary school children. At the end of their clerkship the students in the service learning experience in the public schools had seen significantly higher numbers of children with more commonly diagnosed disease conditions than their counterparts in a hospital-based ambulatory care clinic. Anecdotally, students reported more opportunities to work with patients with chronic conditions, as well as more experience in primary prevention programs. Finally, students reported more opportunities to be connected to their patients, and to see the impact of care through the improved health of their patients.

Strategies for Integrating Service Learning into Health Professions Schools Curricula

Health professions schools and faculty interested in being responsive to both student educational goals and community-identified health care concerns will find that service learning facilitates an integration of student learning objectives and community service objectives. We can identify a number of useful strategies by drawing on the experiences of health professions programs that have successfully integrated service learning into their curricula.

First, the primary barrier to integrating service learning into health professions school curricula is a natural inertia that provides resistance to change. Most people are not interested in change until it becomes required, and even then may resist as long as possible. Consequently, when service learning can be seen as facilitating necessary changes, rather than as something new, which *should be* incorporated, it is more likely to be viewed as a useful tool. For example, as health professions programs respond to changes in health care

service delivery and financing through routine curricular reform, service learning can be integrated as a way to facilitate the transition from primarily institution-based clinical training programs to expanded community and neighborhood-based programs. Additionally, as professional accreditation boards require programs to increase community-based clinical rotations, service learning can be integrated to provide guidelines for establishing partnerships and new training sites. Finally, as students increasingly call for a broader range of clinical training opportunities, service learning can be integrated into core curricular and elective courses used to respond to the student interest.

Second, health professions schools administrators are generally interested in techniques to strengthen community–campus relationships, particularly when these relationships contribute to ensuring access to clinical training sites and populations for research. When health professions schools incorporate service learning, increasing the number of community-based clinical training sites, the school is often seen as the source of additional workers who extend services, and community site supervisors are often provided faculty privileges, such as access to the library or clinical teaching status. Over time these partnerships, facilitated by service learning, provide not only excellent educational opportunities for students but also strengthen relationships with the community more generally.

Third, it is important to find ways to affirm and support faculty members who are interested in integrating service learning into the curriculum, particularly as programs are just getting started. Two strategies that have been useful are providing continuing education credit for faculty development seminars in service learning and providing small grants to faculty to develop service learning curricula. In the United States, in addition to school-based resources, federal, state and private initiatives have provided support for integrating service learning into the health professions education curricula. When faculty can get continuing education credit and grant-writing experience through an engagement with service learning, the work of integrating this teaching methodology into the curriculum is greatly facilitated.

Conclusion

Although the focus of this article has been on experiences in the United States, service learning is increasingly gaining global recognition. The integration of service learning into health professions education is an increasingly important resource as trends in health care services delivery shift from acute care to community-based settings. New policies, practices and settings are changing both health career paths and the knowledge base required for serving communities and populations, which necessitate changes in educational

preparation so that future professionals develop the necessary competencies required for the work.

Service learning is a useful teaching methodology to assist health professions schools and faculty as they move through these changes. Additionally, faculty and students will find that applying the core elements essential to service learning—the partnership between faculty and service site, a responsiveness to the community and community-identified needs, and attention to critical thinking and reflection—improves the educational experience for the student and strengthens the community academic partnerships that are increasingly important to the clinical training experiences of future health care providers.

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