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Position Paper

Community-Oriented Medical Education: Bringing Perspectives to Curriculum Planners in Damascus University

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ABSTRACT

The varying health needs in Syria because of the trend of increasing communicable and noncommunicable diseases necessitate new curricula for all health professions schools in which community health needs, socio-cultural aspects of health and disease can be emphasized. There is a need to produce more primary level healthcare professionals who are trained to apply the principles, policies and strategies of the World Health Organization and achieve better health for all. A new perspective in the Faculty of Dentistry in Damascus University has been suggested and is presented here. Graduates generally are not well prepared to provide primary level healthcare in the community. Community-oriented medical education (COME) can produce health-oriented professionals who are equipped with broad skills and able to work for health promotion, disease prevention, and cure. Health orientation is one of the most radical features of COME, wherein the curriculum is appropriate to learners' future practice in the community. Community orientation enables students to become more people focused so that they can work towards people's self-empowerment, change people's attitudes and behaviors, and improve their self-awareness and esteem. This viewpoint addresses the importance of redesigning the dental curriculum and the need to implement COME in Damascus University. It is proposed as an example of changes needed in all health professions schools in Syria. The call to redesign the curricula to serve the health needs of the Syrian population will be difficult to achieve but is vital. Improving our understanding of the concept of COME and having all sectors of government and society commit to it will make the transition possible and will make the COME a reality.

Keywords: Community-oriented medical education, curriculum, Damascus University

The curriculum in the Faculty of Dentistry, Damascus University is traditional; it is hospital-based and disease-oriented. The primary concern of this academic faculty is to prepare students with the knowledge, skills, and attitudes essential for treating patients with oral diseases, including dental caries, dental abscesses, gingivitis and facial trauma. Graduates generally have not been well prepared to provide primary level dental care. For instance, they are not competent in raising the community's awareness of health issues, in preventing cleft lip and palate and facial trauma, or in oral health promotion to prevent dental caries and periodontal disease. Oral disease is the fourth most expensive disease to treat in most developed countries, and allowing disease to happen and then pay for dental restorative care is an economic burden that most Syrians cannot afford.[1]

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Healthcare facilities in Syria are allocated solely for curative healthcare, with little improvement in health of the population seen and ignorance of the integral aspects of health promotion and disease prevention.[2] Previous research has not shown any decrease in the prevalence of dental caries despite a great increase in the number of dentists practicing in Syria.[3] A recent study of Syrian children attending nursery schools found that 61% had dental caries, 15% had restorations, and 6% had missing teeth.[4]

A new perspective in the Faculty of Dentistry in Damascus

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University has been suggested. It is proposed here as an example of changes needed in all health professions schools in Syria.

The changing health needs in Syria because of growing trend of communicable and noncommunicable diseases[5] necessitate the development of new curricula in all health professions schools in which community health needs and the socio-cultural aspects of health and disease are emphasized. We refer to this here as community-oriented medical education (COME). *Health orientation* is one of the most radical features of COME, in which the curriculum is appropriate to trainees' future practice in the community. Syria has a need for more health professionals who are applying the principles, policies and strategies of the WHO to achieve "*health for all*".[6] COME can produce health-oriented professionals who are equipped with multidisciplinary skills and are able to work for health promotion, disease prevention, and cure.

Focusing the curriculum on health rather than disease demands a focus on people in the community as individuals with rights and needs and where their physical, psychological and social well-being are emphasized. Learning community orientation enables students to become more *people oriented* so that they can help people work towards self-empowerment, change people's attitudes and behaviors, and improve people's self-awareness and esteem. Most dental diseases, including dental caries, gingivitis, and most cases of periodontal disease can be controlled or prevented by raising awareness, changing attitudes, altering habits like smoking and promoting oral hygiene.[1,7]

To introduce a health and people orientation into dental education, it will be important to first get permission from the University Council for greater authority, flexibility, and autonomy. A University–community partnership should be established to move more freely and to minimize expected bureaucracy.[8] It is essential to share responsibility between the Ministry of Higher Education, which is responsible for health manpower education, and the Ministry of Health, which utilizes these resources and is responsible for all settings that provide primary level healthcare (primary healthcare centers, infirmaries and dispensaries).[8] The dean of the faculty and representatives from academic and health sectors will have critical roles in establishing communication networks and creating an academic committee responsible for implementing, maintaining and evaluating the curriculum. Oral health priorities and needs, settings, resources, secure funding and transportation should be identified and discussed. Clearly defined agreement between sectors with rules and regulations should be considered and periodically reevaluated. Continuous training should be planned for existing oral health professionals about the key roles of a health and people-orientation within COME and about their new role they are to play in facilitating the students' learning. To create an atmosphere for partnership, financial, symbolic and moral support for teaching should be addressed.[9] All academic and dental healthcare staff should be involved in curriculum design to build a broad sense of ownership in the new curriculum and to thereby facilitate implementation.

It is important for both the health and education sectors to recognize that learning within communities through an education–health partnership has many advantages. It enables students to develop a level of professional autonomy as lifelong learners as clinicians and researchers. It also helps practicing oral healthcare professionals who serve as teachers keep their knowledge up to date, enjoy their practice more and improve the quality of care they provide.[10] The quality of community health services in rural and urban units can be improved, and students can thereby contribute to *Health for All.* Students can learn how to integrate their psychological, cultural and biomedical knowledge in health and illness. Students early in their training can become familiar with the Syrian healthcare system. They can experience the environment of the country's healthcare delivery during their undergraduate training. They can get both a broader and closer view of patients from different socio-cultural backgrounds to understand deprivation and poverty in the community. Designing community-oriented educational programs in areas with poor health service coverage will enable students to become familiar with fair health intervention and will help in solving social inequality in oral care.[7] Delivering dental care in extramural settings enables students to gain more skills to define and solve problems, and draw conclusions. They can develop leadership and practice management skills. They can improve their skills in working within multidisciplinary teams and learn about career opportunities in public service.[11] Participation in the many community activities and voluntary project opportunities during undergraduate training opens possibilities for greater personal growth and professional development.

COME is a powerful tool. However, success and continuity of COME will heavily depend on the coordination between Ministry of Higher Education and the Ministry of Health. It may be difficult to maintain functional coordination as health personnel responsible for health service facilities (primary healthcare centers, infirmaries and dispensaries) related to the Ministry of Health may not support a program that is not directed by their ministry and not subject to their guidance.[9] A clear definition of roles and responsibilities, together with a continuous monitoring and evaluation plan, should be organized from the beginning to obtain and maintain the expected outcomes. Logistic support and incentives to health service staff will help them respond enthusiastically. Moral,

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academic and economic incentives can promote a feeling of belonging.[9]

With students spending time learning within communities, some might worry that students have less chance to learn about new technologies, specialties, and complex acute and emergency problems in the hospital. In addition, some tertiary care specialists believe that community orientation produces second-rate doctors because of the high variability of learning experiences provided by the many instructors within different community settings.[10] To address this, it is important to scrutinize the overall education process to make sure that students will be technically competent in all aspects of general dentistry. Studies have shown that students in community-based curricula perform similar or better than their colleagues on traditional courses with respect to knowledge, skills, attitudes and exam scores.[10] The difficulty in systematically assessing students' performance and methods of incorporating this into an evaluation system of the faculty[9] is another concern. Some academics believe that the assessment instruments and criteria in a community setting are few and of poor quality.[9] They also believe that differences of sites, students and instructors make achieving valid assessment difficult. In this regard, all facets of community-orientated education, including small-group teaching, high tutor–student ratios, direct observation by mentors, and frequent access to approachable teachers, might be utilized to achieve valid evaluations of students.[10]

In conclusion, this viewpoint addresses the importance of redesigning the dental curriculum and the need to implement COME in Damascus University. It might also be proposed for medicine, nursing, and other health disciplines and for even all health professions schools in Syria. The call to redesign the curricula to directly address the health needs of the Syrian population will be difficult to achieve but is vital. Improving everyone's understanding of the concept of COME and gaining broacd commitment to it will make the transition to COME a doable task and will make COME a reality.

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