COMMENT

Community Based Education

Everybody is talking about it. Just another gimmick; or is this for real? Something to lead us into a better future?

The Academy of Family Practice/ Primary Care started promoting it for post graduate training with the Kwa Zulu Vocational Training programme in 1985.[1] This community based - problem based programme is run in association with the Dept of Family Medicine at Medunsa.

In June 1988 the Academy held a joint workshop[2] on Community Based - Problem Based Learning (CB-PBL) for undergraduates with the new Faculty of Medicine at the University of Transkei, the Development Bank of Southern Africa and Warner Lambert as co-sponsors. In November of the same year Namda and Wits held a workshop on CB-PBL with sponsorship from the Kelloggs and Kaiser Foundations. In April 1990 we met again under the banner of Namda and the University of Natal with help from Kelloggs to discuss and promote CB-PBL at South African universities.

Today there are a large number of people who promote the concept and possibly more who oppose it. If I tell you now who likes CB-PBL, it may sink or swim by association. So, let's first look at what it is.

In essence: *Community Based* is for relevance. *Problem Based* is for superior learning. In problem based learning you link your information and insights with the problem at hand.[3] In this way learning is embedded in a problem solving or clinical structure.[4] Information stored or linked into the structure of a disease classification is more difficult to recall and use, as patients present with symptoms and signs and not with diseases. If PBL takes place in the community, then the context and problems that form the stimulus for learning have a greater chance of being appropriate to the needs at community level. Presently students work and study mostly with uncommon, tertiary care, hospital based problems. This should not cease but be brought into balance with health related problems to be solved at community level. Students who spend sufficient time in the community with problems faced by individuals, families and communities, learn to respect the practice of medicine in this setting. They will become competent in recognizing and solving the more common community based problems. They will learn that such labour often needs more cerebration and resourcefulness than following an internationally standardized protocol to investigate and manage a rare condition in a high tech environment.

To return to the promotors of CB-PBL. So far I have met, in person or from reading, the following: The Academy, The Unitra Medical School, Namda, a number of teachers and students at every Medical School in South Africa, the Dept of National Health and Population Development, the ANC (see Maputo Declaration p 319), the Progressive Primary Health Care Network and the Development Bank of Southern Africa. They are all finding a stimulus and support from various members of the international Network of Community and Problem Oriented Medical Schools.

Who can be against us with so good a cause? Mainly two groups of medical academics. The first are those

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who say, "we don't move till the 'white' schools adopt CB-PBL, especially Wits and UCT". These two schools are supposedly the most prestigious. "Just do not come and experiment with blacks anymore. We have had enough of Bantu Education." Such people will cling to the bad old days in medical education for understandable, but the wrong reasons. Worldwide change has come in new schools. In South Africa, new medical schools are, and will be predominantly black.

The reason why the other academics don't want change is the reason why established, prestigious places do not change. Typically they say, "if it's not broken, why fix it?" They see their graduates eagerly welcomed all over the world as "good" doctors. This generation of teachers will need to pass on before change can readily come. They cling to the myth of an international standard of excellence. As long as this excludes relevance to the local community and a commitment to the South African taxpayer, one can argue that the excellence they strive for, is irrelevant. At times it looks more like arrogance than excellence!

In a few years such people might find themselves asking for participation in CP-PB education programmes to regain their prestige and a stake in undergraduate teaching. Patients, politicians and dwindling budgets will join forces with "progressively" oriented academics to lead this new, most exciting phase in medical education. It holds out the hope of producing better educated and more relevant doctors for the future: doctors oriented to the person as well as disease; to the individual as well as the community.

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References

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