Editorials

Teaching and Learning in Family Medicine: Setting the scene

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Teaching and learning is perceived as a dynamic and interactive process under the umbrella of education. It is some sort of partnership between teacher and learner. Dual benefits could be achieved for both teacher and learner, where the teacher is learning at the same time as the learner.[1] Such dual benefit for both teacher and learner was conceptualized by James Davis (1993) in what is called Davis's model. It was clear that the relationship between teacher and learner is transactive rather than interactive.[2]

Family Medicine has a peculiarity regarding teaching/learning process particularly clinical teaching. The one–one teaching creates opportunities for active learning in clinical settings while modeling desirable personal and professional attribute. Learner's contact with ambulatory patients enhances development of accurate clinical reasoning and quick decision making. However, time, space for teaching, case-mix, and conflicting demands of learners and patients are considered to be real challenges.[3]

The teaching /learning model in Family Medicine combines three aspects; **(1) Applying key principles of adult learning, (2) Balance and diversity in learning situations (opportunities), and (3)Considering competencies as outcomes of teaching and learning process.**

1- Applying key principles of adult learning: Andragogy consists of learning strategies focused on teaching adults. It is often interpreted as the process of engaging adult learners in the structure of the learning experience. The term was originally used by Alexander Kapp in 1833 (German educationist). Andragogy was developed into a theory of Adult Education by the American educationist-Malcolm Knowles. He introduced the term "Andragogy" to North America, defining it as "the art and science of helping adults learning".[4]

Adult learning is characterized by being self-directed, through; organizing teaching and learning and assuming that learning is within the learners' control. They should choose; what to learn, how to learn, when to learn and where to learn. It is a pre-requisite to identify the goal

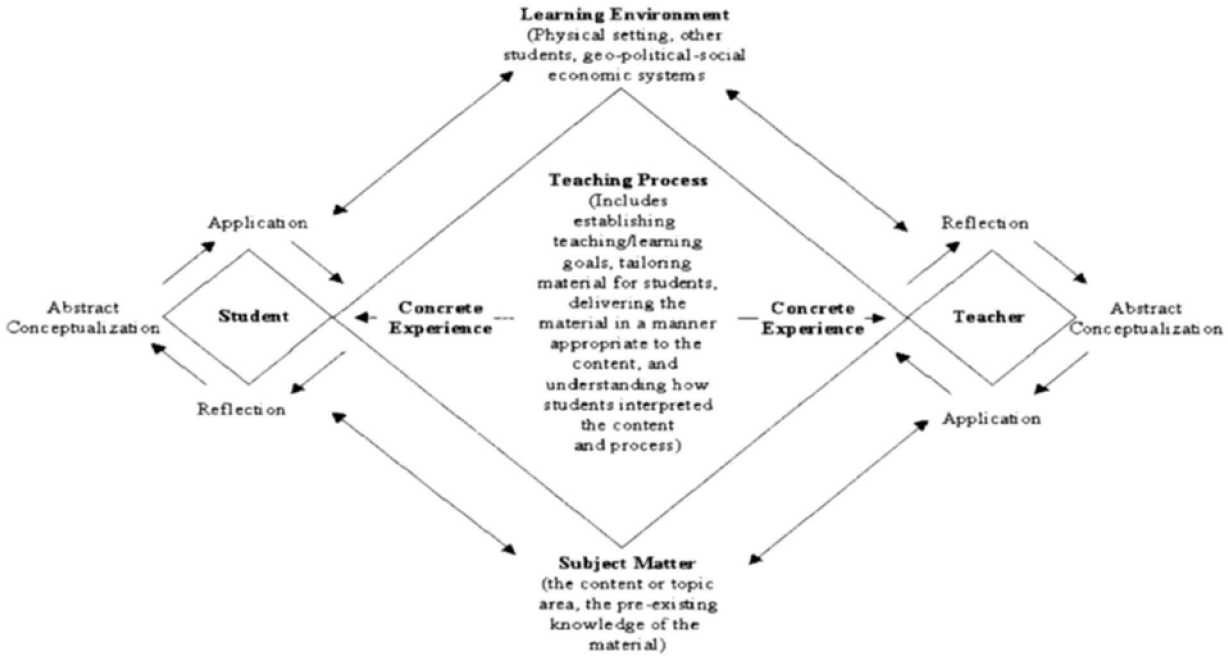

Figure (1): Diamond model of philosophy of experiential education.
Quoted from Itin,CM. The Journal of Experiential Education.1999;22(2),91-98.[2]

towards which learner strives and becomes able to accept responsibility for his/her own learning. The role of teacher is considered to be a facilitator. Adult learning must be need- based and problem-centered that reflecting the relevance in the educational process. Nowadays, self-directed, lifelong learning and self assessment, cognitive expertise, and performance in practice based on problem solving capability are considered among the required criteria for maintenance of physician certification by the American Board of Medical Specialties.[5-7]

Experiential learning and experiential education have often been used interchangeably. Experiential learning is a strong pillar on practicing adult learning. It is the process of making meaning from direct experience, "learning from experience". It is assumed that, the learner is not starting learning from the scratch. Learner is practicing physician and having prior experience that is very important to make use and build on. Transactive process takes place in experiential education (teacher, student/learner, subject matters and educational environments) as addressed in Diamond mode (Figure.1). Reflection is very crucial for both learner and teacher. Unexpected events trigger two kinds of reflection. The first one is "reflection in action" that takes place immediately. Applying current /past experiences and reasoning to unfamiliar events while they are

occurring. The second type of reflection "reflection on action", occurs later on after ending of the event. It is thinking back on what happened in a past situation and whether the actions taken were appropriate or not?.[2]

2- Balance and diversity in learning situations: Family medicine as a horizontal specialty encompasses a wide ranges of knowledge, attitude and skills that are required to graduate a competent physician. A considerable attention must be paid to combine the following activities in the educational process; (1) Practice based teaching and learning.(2) Community based teaching/learning. (3) Integrated departmental teaching/learning (4) Appropriate use of other supporting learning opportunities as hospital rotation for acquiring specific skills or procedures.[8,9]

3- Considering competencies as outcomes.: Competence Based Education (COE) is a newly emerging concept in medical education Europe, USA, Canada and many courtiers. Competency-based medical education is a form of Outcome-Based Education (OBE) employing explicitly defined competencies of graduates as an organizing curriculum for health professions.[10,11] It is an approach to preparing physicians for practice. Competency is an observable ability of a health professional, integrating multiple components such as knowledge, skills, values and attitudes. Since competencies are observable, they can be measured and assessed to assure their acquisition. The COE focuses on learner performance (learning outcomes) in reaching specific objectives (goals and objectives of the curriculum)

The emphasis in OBE is on the product; what sort of doctor will be produced rather than on the educational process. In outcome-based education, the educational outcomes are clearly and unambiguously specified. These determine the curriculum content and its organization, the teaching methods and strategies, the courses offered, the assessment process, the educational environment and the curriculum timetable. They also provide a framework for curriculum evaluation as shown in Figure (2).[10]

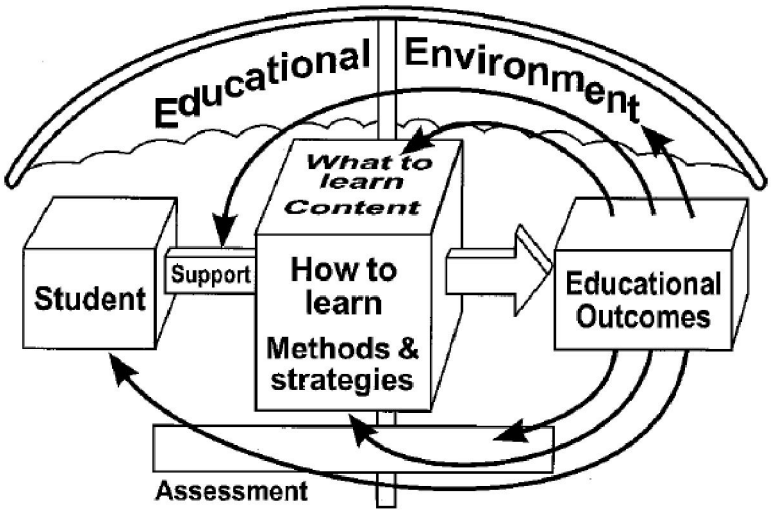

Figure (2): A OBE model for curriculum emphasizing the importance of educational outcome in curriculum planning.
Quoted from Harden RM, Crosby JR, Davis MH, Friedman M.1999;21(1).[10]

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