

## Understanding the perspective of community co-educators on community-based service learning: a qualitative analysis

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### Abstract

**Background:** Community-based service learning (CBSL) is a core component of the Canadian medical education system. However, the unique role of community partner organizations (CPOs) in supporting CBSL remains unclear. This qualitative study evaluates the perspective of CPOs as co-educators in the undergraduate medical curriculum.

**Methods:** We conducted eight semi-structured, one-on-one interviews with CPOs at a medical school in Toronto, Ontario between 2020-2021. Interviews were conducted following a pre-determined interview guide and then recorded, de-identified, and transcribed. Three reviewers independently performed an inductive thematic analysis of codes followed by a group review of discrepancies.

**Results:** Five main findings were identified: 1) CPOs share a common interest in serving as co-educators; 2) considerable heterogeneity in the understanding of co-education exists; 3) there is an opportunity for increased partnerships between CPOs and faculty; 4) the role of co-educators is limited by curriculum structure; and 5) co-educators facilitate unique teachings of social determinants of health otherwise not available through traditional didactic teaching.

**Conclusions:** There is an emerging, unique role for community co-educators in the undergraduate medical curriculum, supported by interest from CPOs. Its emphasis may contribute to future cohorts of medical students capable of understanding and addressing the needs of the populations they serve.

### Résumé

*Traduction française à venir.*

## Introduction

Strong curriculum delivery requires purposeful development of all necessary actors: faculty and community partners alike. For an educational approach such as community-based service learning (CBSL), which combines academic instruction with community service experiences, the unique concept of community-based organizations (CPOs) as co-educators emerges.<sup>1,2,3</sup>

In the context of medical education, CBSL is a valuable educational tool to reframe perceptions on social accountability and foster community action via critical reflection. By providing learning opportunities in a community setting, medical trainees gain a deeper understanding of the health needs of the populations they serve, and acquire the appropriate skills, knowledge, and attitudes required to address these needs.<sup>1,2,3</sup> This teaching method has been documented in the literature as 'community-oriented medical education,'<sup>1</sup> 'community-based medical education,'<sup>3</sup> and 'community-engaged medical education.'<sup>4</sup> While there is no standard approach to CBSL, a common thread of service learning is the indispensable involvement of the CPO.

Medical schools have already begun to adopt CBSL within their curriculums.<sup>5-11</sup> For example, the University of Toronto's Temerty Faculty of Medicine developed a mandatory service-learning framework under which all second-year medical students participate in 10 service-learning field experiences, five group tutorial sessions, and three advocacy seminars. During their placements, students observe, participate, and advocate for specific community populations under the guidance of CPOs and faculty.

Despite the uptake of CBSL in medical education, current literature mainly describes service learning from the viewpoint of the medical school, with few papers written from the perspective of the community.<sup>5</sup> In fact, perspectives of CPOs were often excluded.<sup>5, 12-14</sup> This can undermine a crucial pillar of service learning which emphasizes reciprocity and critical allyship.<sup>7</sup> Findings on the perspectives of CPOs and their role in teaching medical trainees can contribute to advancing educational programming. Thus, the objective of our study was to understand the perspectives of CPOs on co-education in the undergraduate medical curriculum and identify recommendations for improvement in their utilization.

## Methods

### Study design and setting

We conducted a descriptive qualitative study analysing eight semi-structured, one-on-one key informant interviews conducted at the University of Toronto medical school. The school was selected as it is host to a year long CBSL curriculum titled 'Integrated Clinical Skills: Health in Community'. We hosted individual interviews virtually via Zoom® with representatives from CPOs involved in the curriculum between November 2020 and November 2021 (by YS, HR). Interviews were guided by a semi-structured interview guide and were recorded, de-identified, and then transcribed verbatim. Interviews lasted approximately 60-90 minutes in length. Research ethics board (REB) approval was obtained from the University of Toronto (REB-13238).

### Selection and recruitment strategy

We identified and contacted all CPOs involved in the CBSL curriculum ( $n = 65$ ) from a university-affiliated email account. Study participants were eligible to participate if they were previous or current supervisors of CPOs in the CBSL curriculum, English-speaking, >18 years of age, and able to provide informed consent. A total of 5-30 participants were sought until saturation was achieved.<sup>15,16</sup> Non-respondents had two follow-up invitations. Eight CPOs responded and were then recruited. The eight CPOs were diverse in primary focus, which included addictions and mental health ( $n = 2$ ), personal support and housing services ( $n = 2$ ), and cultural awareness, crime prevention, employment services, and food agency ( $n = 1$ , respectively).

### Data collection

In collaboration with a former CPO supervisor (BD) and the MD Program Director of the CBSL curriculum (FHL), we developed a pre-determined interview guide using two rounds of iterative review (GZ, AT, SP). The interview guide consisted of four questions and seven sub-questions (Appendix A). Topics included CPOs' overall experience as co-educators, their understanding of co-education, supports and barriers to teaching, and their perceived impact on medical education. Steps were taken to safeguard participants' sense of safety and confidentiality. No author had established relationships with participants and did not code transcripts for their respective interviews.

### Data analysis

We performed a thematic analysis of the transcripts using inductive techniques. Three researchers (GZ, AT, SP) independently reviewed all transcripts to identify key words and phrases. Following a group review of

preliminary codes, we developed a final codebook with eight inductive codes. We resolved any discrepancies through discussion with the principal investigator (FHL) until a consensus was reached. Through iterative group discussions and analytical memoing, we identified major emerging themes and supporting quotations. To ensure reliability and agreeability, we used a peer debriefing strategy where we discussed themes and discrepancies with the entire research team.

## Results

Five major themes emerged from the CPOs' perspective on co-education. We discuss these themes by category and summarize them in Table 1.

### 1. Interest in role as co-educators

CPOs commonly expressed interest in serving as co-educators for medical students and noted the potential for greater involvement in undergraduate medical training. Their curiosity was often rooted in personal connections to issues within medicine or previous experiences in teaching as highlighted by the following quote:

*...it was a very good opportunity to be part of the process in which we incorporate our diverse backgrounds and experiences to build a future [of students] responsive and who take into account the interests and concerns that affect diverse communities in Canada (CPO1).*

All CPOs described the experience as enjoyable and worthwhile. One co-educator reflected on the importance of incorporating community within the medical curriculum to "help students understand the populations that they serve and the barriers that they face" (CPO5). They agreed that it was an opportunity where they could "encourage advocacy among medical students" (CPO3) and "learn from the students as they learn from us" (CPO5).

### 2. Heterogenous definitions of co-education

Co-education held different meanings among CPOs. Some shared the understanding that co-education was supportive, noting that a co-educator is "someone who is there to answer any questions but allows students to take direction" (CPO6).

Other co-educators viewed service learning as an opportunity to teach new concepts not taught in the classroom including "the workings of non-profit agencies from the front line" (CPO4) and social determinants of health as illustrated through the excerpt:

*My understanding is that its intention is to give students some immediate experience of the complexities of health, the social determinants of health, and perhaps a better understanding of some barriers too (CPO2).*

All CPOs shared in the understanding that co-education was grounded in reciprocal and active relationships.

### 3. Role of partnerships and support in co-education

There is an opportunity for increased partnership between co-educators and faculty. While co-educators expressed satisfaction with the CBSL curriculum, they described the need for a "good, consistent line of communication" and "discussions with faculty" (CPO6). Unlike preceptors who work in a cooperative teaching setting, co-educators felt isolated in their teaching.

CPOs valued being engaged in collaborative work with faculty as demonstrated by the quote:

*This service requires support. I think the experience has been very positive so far, yet still very compartmentalized. If we could work together [with faculty] either beforehand or in the field, it would create a better, more cohesive curriculum (CPO1).*

Co-educators also suggested improving their understanding of the curriculum to support their teachings as indicated by the quote:

*To receive any readings or information so that I can link what we are doing to the curriculum... I do not want to tell students what they already know. I would always want to make sure that we are satisfying the requirements of the syllabus (CPO2).*

### 4. Logistical barriers to co-education

CPOs perceived the role of co-educators to be limited by CBSL curriculum structure and organization. Specifically, infrequent, albeit longitudinal, exposure to field experience was thought to hinder, rather than strengthen, relationship-building and rapport. One co-educator expressed that: "They come once, and then [once every] two weeks or three weeks or a month. By the time they come back, people do not even remember that they were there [before]" (CPO8).

Instead, co-educators preferred a condensed, 'block structure' field exposure where students have a primary objective over a shorter, focused time as represented by the quote: "For example, they could have a block of

experience where they are coming in more frequently over a shorter period of time” (CPO7).

Such a time framework was thought to promote student motivation, familiarity, continuity of tasks, and foster an improved working relationship between all.

### 5. Impact of co-education on medical education

CPOs perceived the main impact of co-education to be unique teachings otherwise not available through large group or academic teaching. Students gain the opportunity to better understand and identify patient needs as highlighted by:

*I think it is really valuable that students who are in higher education do work within the community because I think if you get too lost in the theoretical and academic aspects of what you're learning, if you do not supplement it with real world and practical experiences, it is not going to hit home (CPO4).*

Through co-education, students may develop “a good understanding of [the] social determinants of health and how they really play out for the clients that we serve” (CPO5). Co-educators hoped that “students who came through the organization would remember [the CPOs] and make connections and referrals [for their patients]” (CPO8).

## Discussion

The study offers insight into the perspectives of CPOs as co-educators in the undergraduate medical curriculum. Overall, CPOs expressed positive attitudes towards co-education in CBSL, despite considerable heterogeneity in the understanding of co-education. The role of co-educators, however, is affected by curriculum structure and partnerships with faculty.

The co-operative nature of service learning is well-supported in existing literature.<sup>17,18</sup> However, the model of CBSL has often been framed with medical schools assuming the leading role and communities as passive bodies. This study is one of the first to understand the perspective of CPOs and their interest in acting as co-educators. With this knowledge, it highlights an identified opportunity for CPOs to engage in interdependent and reciprocally beneficial partnerships with medical schools as active stakeholders. Findings on the unique role of co-educators in facilitating experiential learning have implications for developing future cohort of students aware of social accountability and committed to serving their community.<sup>5</sup>

Our findings suggest that future planning and implementation of CBSL in medical education should encourage greater involvement of CPOs, formally define the multi-faceted role of co-educators, increase partnerships with faculty, and tailor curriculum structure to follow a ‘block’ approach. These recommendations are supported by literature which suggests that despite the uptake of CBSL, the role of the co-educator remains undifferentiated without a consensus on its definition.<sup>19</sup> It is also recognized the importance of combining knowledge, skills, and resources with faculty for the mutual development of teaching capacity<sup>17,19,20</sup> Additionally, limited field experiences impacted by curriculum structure is frequently cited as a barrier to co-teaching in CBSL.<sup>21</sup> Future research with larger sample sizes or that simultaneously collects data from community partners, students, and faculty perspectives of CBSL programs may present additional recommendations for quality improvement.

## Limitations

We report on only the perspectives of a small sample of CPOs, which means that insights are not generalizable to all CPOs in the program. Those who responded are likely inherently interested in medical education and may be biased toward the role of co-educators. Viewpoints may also be influenced by the CPO’s specific focus area and their personal approach to teaching.

## Conclusion

This paper describes five main findings on co-education in CBSL from the perspective of CPOs. CPOs share a common interest in serving as co-educators despite considerable heterogeneity in the understanding of co-education. Quality improvement initiatives to strengthen community-based learning could include building partnerships between co-educators, faculty and students, and favouring time-block placements over longitudinal experiences. Community-based learning is perceived to be a unique and irreplaceable teaching modality for social determinants of health. This study adds to the growing literature on community-based learning and proposes its distinctive role within medical education. Future research avenues may include investigating a broader scope of CPOs to allow for more generalizable findings.

Table 1. Main themes and recommendations for improvement on co-education in CBSL from the perspective of CPOs.

Themes	Supporting quotations	Recommendations for improvement
Interest in role as co-educators	"...it was a very good opportunity to be part of the process in which we incorporate our diverse backgrounds and experiences to build a future [of students] responsive and who take into account the interests and concerns that affect diverse communities in Canada" (CPO1).	Encourage the greater involvement of CPOs in CBSL curriculum. <sup>18, 20,21</sup>
Heterogenous definitions of co-education	A co-educator is "someone who is there to answer any questions but allows students to take direction" (CPO6) (supportive role) versus someone who provides "students some immediate experience of the complexities of health, the social determinants of health" (CPO2) (leading role).	Formally define the multi-faceted role of CPOs a priori through a consensus approach. <sup>20</sup>
Role of partnerships and support in co-education	"This service requires support. I think the experience has been very positive so far, yet still very compartmentalized. If we could work together [with faculty] either beforehand or in the field, it would create a better, more cohesive curriculum" (CPO1).	Enhance communication and partnerships between CPOs and faculty (e.g., set formal agenda-setting meetings between both parties). <sup>18,20,21</sup>
Logistical barriers to co-education	"They come once, and then [once every] two weeks or three weeks or a month. By the time they come back, people do not even remember that they were there [before]" (CPO8).  "For example, they could have a block of experience where they are coming in more frequently over a shorter period of time" (CPO7).	Tailor placement frequency and duration to promote field exposure (e.g., utilize a 'block' structure approach with frequent sessions over a condensed period of time versus a longitudinal approach). <sup>22</sup>
Impact of co-education on medical education	"I think it is really valuable that students who are in higher education do work within the community because I think if you get too lost in the theoretical and academic aspects of what you're learning, if you do not supplement it with real world and practical experiences, it is not going to hit home" (CPO4).  Co-education offers the opportunity to gain "a good understanding of [the] social determinants of health and how they really play out for the clients that we serve" (CPO5).	Formally evaluate the utility of CBSL as a teaching modality for social accountability and social determinants of health. <sup>5</sup>

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## Appendix A. Key informant interview guide

1. Please tell us a bit about your organization and any aspects of healthcare and medicine that medical students can learn about through your organization.
  - a. What can medical students gain from being involved in your organization?
  - b. What are barriers to engaging medical students in your organization?
  - c. What can be done to facilitate medical students in your organization?
2. Do you think students have a better understanding of your organization's impact on the health of the community?
  - a. What do you hope medical students learned from this assignment? Can you think of a learning objective or assignment that students completed through your organization?
  - b. Were the students able to make meaningful contributions?
3. How can the University of Toronto help support your organization in being a co-educator for medical students?
  - a. Do you feel you have adequate knowledge about the learning style of medical students to facilitate in their learning?
  - b. Are there specific resources or training you feel your organization could benefit from?
4. Is there anything else you would like to tell us that we have not asked?

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