


Response to a Reader's Letter "Medical School Training Can Improve Patient Care"

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We are happy to note that our article¹ published recently in the *Journal of Primary Care and Community Health* has evoked a lot of interest. This comment is in response to one of the reader's observations² on our article and views on how to optimize the health of vulnerable populations from the standpoint of Pre-exposure Prophylaxis (PrEP) and quality improvement audits.

We, at the National Center for Medical Education Development and Research, agree with our colleagues from the UK² that new teaching modalities for medical students and precepting of residents in primary care clinical practice are needed. We support a mission-based approach to medical education curriculum transformation that embraces the Patient-Centered Medical Home (PCMH) model. The PCMH model we follow in the United States shares some commonalities with healthcare practices in the UK, where quality improvement (QI) audits conducted by the family practice team are used to increase understanding of patient-centered care.

We believe that the education of medical students must take a more hands-on approach. Quality improvement "audits" represent a new teaching modality that provides an opportunity for mentorship and coaching, while teaching students about the effects of social determinants of health in relationship to chronic diseases management.^{3,4} By participating in a QI audit, medical students and residents learn about the need for transforming clinical practice, away from a "traditional" approach that treats patients based on a presenting condition to one that incorporates a team perspective that identifies and incorporates social determinants into a patient's health care plan to achieve optimal results.^{5,6} Central to this model is the use of an inter-professional team of providers (physicians, nurses, social workers, etc.) that works together to ensure patient-perceived needs are addressed in order to promote patient health.

Another approach that we have incorporated into our mission-based curricula in the US is the concept of developing a shared learning agenda through the use of "communities of practice (CoP)." This approach, championed by Wenger et al,⁷ postulates that the shared passion for

something that a group possesses and regular interactions can be harnessed to identify and implement real world solutions. Communities of practice are enhanced by inviting participants who bring different and current perspectives to an issue. The application of a CoP framework can be used to address complex issues such as the need for medical education and/or clinical transformation.⁸ For example, CoP can be used to identify and develop primary care curriculum that introduces new teaching techniques. For instance, new models of training, including the use of audits and the patient-centered medical home,⁹⁻¹¹ are approaches that can be used to train medical students to prescribe PrEP¹² based on a patient's risk and/or circumstance.

The overarching goal of linking mission-based medical education with a CoP approach is to develop in-depth learning opportunities for medical students and residents so that they build their knowledge and skills based on the lived experiences of the communities they serve and become outstanding primary care physicians while serving the "whole" patient. By combining a mission-based approach with a CoP, we seek to establish a common venue for achieving medical education and/or clinical transformation. Achieving a mission-based medical education curriculum will guide the concurrent transformation of primary care clinical practice that achieves both high quality, coordinated, and patient-centered care and culturally competent physicians.

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