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PRELIMINARY REPORT ON A COURSE OF MEDICAL PSYCHOSOCIOLOGY FOR THIRD-YEAR MEDICAL STUDENTS, CONDUCTED AS A RESEARCH AND DEVELOPMENT PROJECT.

In the curriculum of the Universidad Autónoma de Barcelona Medical School, the subject of Medical Psychosociology is one among the eight a medical student has to take during his third year of Medical School. This is the last year of the Cycle of Basic Medical Sciences. However, its characteristics are such that frequently it is looked upon as the pre-clinical year. It is during this year that the student, for the first time in his career, enters in contact with patients. He is to learn the general principles of disease mechanisms and pathological processes, the pharmacological and inter-personal basis of therapy and patient care, and he should become familiar with the methodology and acquire the skills needed for patient interviewing and clinical examinations. The role of Psychosociology within the third year is to apply the Behavioral Sciences concepts learned in the previous and in the present year to the general objectives of the course, the content of which deals especially with the doctor-patient relationship within the context of its social and environmental circumstances.

The place of the experience we are to report is the San Pablo Hospital Teaching Unit of the U.A.B. Medical School, academic year 1972-73. There were close to 300 students matriculated in the course; for the subject of Medical Psychosociology a full-time professor was assigned and 15 weeks allotted to the development of a program consisting of 30 hours of lectures and 45 hours of practical work per student. The subject, the same than in general the other subjects of Behavioral Sciences given in previous years in this and other teaching units of the Medical School, was found to be highly unsuccessful and equally frustrating for different reasons to teachers and students. It was felt that those courses lacked relevance and depth, and that from a scientific point of view they were too soft and not practical enough for medical training purposes. The professors teaching these subjects felt that they were not given enough moral and material support by the administration and the other members of the faculty, and not enough time in the curriculum nor professional help to carry out the task adequately. They had resigned themselves to give lectures and reading assignments, to take examinations and evaluate essays. Given the low teacher-student ratio, practical exercises and seminars were considered an impossible dream.

At the San Pablo Teaching Unit a fortunate set of circumstances made possible the development of the course of Medical Psychosociology in its present new form. The professors of the third year worked as a team. They held periodic meetings to coordinate academic matters, the evaluation of students and all decisions about the class were taken jointly as a committee. There was great in-

terest among some of the faculty in medical education research. Also, the students of this class had the year before elaborated a plan for goup teaching, which, although it proved impossible to be carried out, showed their interest and initiative as a group for innovations in medical education.

In trying out a new approach, as a first step the objectives for the course were carefully reviewed and defined operationally. The instructional activities were assigned according to the human and material resources available and basically they follwed this outline:

1. Information was going to be derived from lectures and reading lists.
2. Students were to work in groups of 30 and through group discussion would try to apply the knowledge gained to real problems of their training and jointly carry out small research projects in the field.
3. The practical aspects of the patient-doctor relationship were going to be studied in small groups of 12, following their ward assignments in the course of General Pathology.
4. Medical interviewing was going to be taught in an integrated form with General Pathology.

For teaching and research purposes it was thought that the program should include reliable feed-back mechanisms that would allow a continuous and final evaluation of process and performance at the individual (teachers and students) and group level.

This project was presented and discussed with the faculty of the third year level course, who agreed to the terms on which it was to be conducted and accepted the minor modifications it would impose in the teaching of their own subjects and rearrangements of time schedules. A further advantage was that as an educational experiment it interested two other professors of the Division of Social Psychology enough for them to volunteer their time to observe the process and serve as consultants.

Given the large number of students in the class it was thought that the best way of introducing them to the subject was to divide the class in groups of 30 and discuss with them the objectives of the course, the method of working and the criteria for evaluating individual students, groups and the class as a whole. It should be mentioned that the student group had a characteristic way of functioning and all decisions concerning the class- including the ones concerning the way the course in Medical Psychosociology was to be given - were taken by direct democratic vote in an open assembly. The students systematically refused to delegate to nominal representatives, even for their more routinary dealings with the faculty, such as fixing the date of an exam.

The lecture part of the course and the group work on research was planned to start in January. However, discussion groups and medical interviewing would start as soon as the students began to go to the wards and see patients, which is usually about the end of October. During the first semester of the course the students were seen in small groups immediately after their first week on the general clerkship. All these sessions were taped and a rich material gathered on what

students experience in their first "professional" contact with a patient. A further advantage was that in the small group setting each of the students got to know the professor he was to work with. This was very fortunate, since without this closer personal interaction the basic trust among professors and students needed to carry out the experience most likely would not have developed.

The first term of the course was a quite unsettled and hectic one for the student body; classes were disrupted on several occasions because of student strikes and the whole academic work was falling behind.

When the time finally arrived for launching the theoretical part of the course, the students were handed a detailed outline of its development, objectives and the experimental approach. The underlying philosophy and educational principles of the course, which permitted making major modifications in the program without altering its learning objectives, were the following:

1. It was thought that the best way to teach Medical Psychosociology was to apply it to what the students were actually doing. From here derived the idea of making them work in small groups, where as a team they had to perform a task and simultaneously become aware of the group dynamics involved.

2. In their third year medical students are not yet physicians, so it was felt it was more relevant to them to understand the medical student-patient and medical student-faculty relationship, hoping that if they developed the tools to understand it, they could in the future and by transfer of knowledge understand the doctor-patient one.

3. We considered that small research projects of different psycho-social aspects of medical practice and medical care would stimulate their interest and make the course relevant.

The program, although it was appealing individually to most of the students, was clashing with a group norm that led their behavior as a whole. They could not accept breaking up into small units nor delegating representatives to facilitate communication with the faculty, what in turn was felt by the latter a necessity in reaching an agreement and to start the work of the course. In the discussion with the whole class it became quite obvious to the teachers that the only possible way out of this deadlock situation was to deal with the class as a whole and by using group dynamic principles and techniques. They were familiar with the Institutional Pedagogic Methods used by Lobrot in Paris. With this approach the teacher faces the class as a whole, and functions as a group process facilitator, as an organizer of the group or as a source of information for the class only when the class is ready to accept him in this specific role. That was the technique the professors decided to adopt, and all the events that followed were just a natural consequence. The agreement reached with the students included the following points:

1) The class was going to function as a whole that included professors and researchers.
2) All decisions referring to the class were going to be taken by direct democratic vote.
3) The content of the course was to be covered by group work. The class would be divided in 12 units, and every group would take the responsability of preparing it, presenting it to the class as a whole, getting their feed-back and elaborating a final document.

4) The time allotted to lectures was to be used for small group meetings until the time of their presentation.
5) The final criteria for evaluation and grading would be left to the class, but it would necessarily concern ~~the~~ such aspects ~~of~~ as quality of work, group process and methodology used. Also, the evaluation would be made at the individual, group and class levels.
6) It was ~~accepted~~ stated that the whole development of the course would be examined as an experiment and its end results reported to the medical faculty and student body.

At the beginning faculty and students were quite doubtful about being able ~~of bringing~~ to bring this experiment to a ~~good~~ successful end. A strong feeling of group cohesion and a sense of commitment to the ~~taken~~ accepted agreement helped tremendously to overcome the many ~~lows~~ low periods during the progress of the experience. There were also exciting moments and a growing sense of hope developed, along with the realization that the experience was not ~~falling apart~~ deteriorating, that time schedules were kept, that the quality and interest of the group presentations ~~increased~~ was increasing and that the system efficiently coped with internal stress and external difficulties.

The final test of the system was when time came to evaluate it, which coincided with final examinations in other subjects. Finally it was done hastily but on time. In order to speed up the procedure and to ~~catch up with~~ meet administrative deadlines, this was the only occasion when the commitment to direct democratic decision-making had to be broken. It was decided to delegate representatives of each group and also vote by signed ballots. The final procedure of evaluation was that each student was graded by his own group, on a pass or fail basis. Groups in turn had to proceed to a selfevaluation and write a report on ~~it, and also~~ themselves; also each student filled out a questionnaire

designed to evaluate the class and the experiment on the whole.

A final report is to be written by the research team and they are now organizing and reviewing materials collected: Diary of the experiment, progress notes of the observers, group reports, taped group meetings and the 20-page questionnaire. However, we feel that this advance note is pertinent to the content of this Seminar on Medical Education, and it would be of tremendous help to us to have a feed-back on the experience and the tentative conclusions we have reached so far:

1.- Innovative experiences in medical education can be carried out in a class as long as it is supported by the authorities of the Medical School, does not interfere seriously with the development of other subjects, the objectives are obtained and strong feelings of commitment exist among all participants.

2.- Educational objectives, relevance to students, and active participation can be better obtained in Behavioral Science subjects if large group dynamic techniques are employed in their development.
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3.- To any such experiment a program of research and development should be attached, not only to evaluate its final results, but to assure and facilitate the completion of the project.

4.- Principles and techniques of Institutional Pedagogy can be applied to medical education and to classes with a large number of students as long as the objectives of the course are clearly defined, the responsible for the course is trained in group dynamics and enoug[h] time is given for the course. In this respect we feel that the greatest difficulty of this experience was the pressure put upon it by

the scarcity of time.

Also, there is a question as to whether this approach can be applied to subjects where access to information is the main goal.

5.- We feel that the experience has been an exciting one for the teaching staff, and that the class as a whole has grown in emotional and interpersonal maturity. One of the more pleasant discoveries has been that students can be trusted, and that among them there is a tremendous potential for self-teaching that lies hidden because of the lack of opportunity. Ignoring this may result in ~~and with it go~~ wasted possibilities of learning for students, faculty and medical education alike.

Barcelona, 18 de septiembre de 1973