

WORKSHOP D:

HOW TO ORGANIZE AND DEVELOP TEACHING AND LEARNING IN FAMILY MEDICINE, USING THE EXAMPLE OF THE GERIATRIC PATIENT

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2. to collect experience in terms of any psychological and psychosocial reactions the patient or his doctor might have. Here, the patient's psychosocial situation will be taken into account and incorporated in the overall treatment plan.

1. Problem definition and objectives

The group discussion focussed on the issue what actually scientific thinking in family medicine is and how to define it in the best way. The group came to the conclusion that mere scientific understanding should be supplemented by the knowledge and experience drawn from the social and behavioural sciences.

Problem solving in family medicine should then give the student the opportunity to obtain insight into the biophysical and psychosocial aspects of the elderly patient and at the same time develop, apply and evaluate different avenues of problem solving.

The student's purely clinical knowledge should be supplemented by emphasizing the **significance environmental factors** have on health and illness, such as real life **family situations** offer. Under professional guidance by an experienced doctor the student would like to get actively involved in out-patient care. This endeavour could best be realized by having a student care for an elderly patient in his family environment over a certain period of time.

A clear and precise definition of what psychosocial learning was necessary, and along these lines a teaching strategy should be designed which will take into account scientific thinking and at the same time exemplify how to practice family medicine in the best way, specifically here when caring for a geriatric patient. Our objectives then were.

1. to gain insight into the nature of illness and disease together with their effects on organs and organ systems.

2. Group work

First the group presented and discussed what psychosocial learning means. According to the given SOEP-anamnestic scheme the patient's subjective statements and the personal impressions the observing student or doctor has are collected, stating all contributing physical, emotional and social aspects (S). Subsequently, all objective data and findings pertaining to these three areas should be listed (O). With taking into account all these factors it will be necessary to reevaluate (E) all past decisions in terms of their validity and then design and implement any future measures and procedures (P). Scientific thinking here extends beyond the purely natural sciences by also applying **empirical thinking** (experience) as well as the **laws of probability**.

Teaching experience also requires giving instruction in **problem solving steps**: After the problem has been defined and described, it should be analysed. According to this pattern the various possibilities of problem solving should be examined. After the evaluation an overall treatment plan should be developed and applied.

When caring for the patient the primary goal of family medicine is to help sustain the patient's **autonomy**, his **social integration** and to prevent **any somatic fixation**. To achieve this, insight into behavioural concepts are significant. Also, too rigid authority and control which the care giver may exert over the patient and which will only foster the patient's disability and dependence, should be detected and counteracted. The concept of **help through self-help** may be effectively supported by a physiotherapist, ergotherapist, or occupational therapist living close by. The **healthy family** in fact is not the one who does

not have any problems, but rather the one who knows how to cope with them. The treatment of chronic states of disease or illness in the geriatric patient requires an attitude from patient and doctor that will promote active coping strategies rather than nurturing a passive, subdued life style which would only increase disability.

The medical student in his long-term contact with families caring for chronically ill, bed-ridden patients, will get acquainted with all aspects of home care and how to apply problem solving effectively. To support the care provider he needs knowledge.

1. how to prevent decubitus, excoriation, infections of the urinary tract, contractions.
2. He needs to re-assess the effectiveness of the current therapy,
3. check the strain on the person(s) who are taking care of the patient.

The effectiveness of the person taking care of the patient will be limited by:

too little time for recuperation	77 %
too little social contacts, such as to friends	51 %
deterioration of his/her own health	37 %.

The most frequent and significant strains on the person providing care primarily are:

the state of health of the patient	60 %
the uncertainty about what the future may bring	53 %
the emotional condition of the patient	51 %
the constant physical presence of the patient	41 %.

The group did not compile a complete catalogue listing essential elements on teaching and learning scientific thinking in family medicine, specifically in the long-term care of the geriatric patient. Such a task would require a collection of data describing past experience drawn from various approaches used in the past. The patient also would need to be considered in his somatic, psychosomatic, emotional, psychosocial and socio-medical concerns and orientation.

3. Discussion

After having defined the essentials how to develop scientific thinking in family medicine in the best way, the group had to think about effective teaching approaches and methods and how to best convey them to the student.

For this task the approach "long-term care and follow-up observation of the course of the disease" as part of the Frankfurt model "practice oriented medical education" was introduced and discussed.

Over the course of one semester students will care for chronically sick people in the patient's family environment. The goal of this practical exercise is to acquire the skills of effective problem solving when treating complaints such as "unwellness", general discomfort of mainly psychosocial origins as well as conflict situations in out-patient care.

After having been introduced by the family physician the student will visit a chronically ill geriatric patient for 1 to 3 days every two weeks in the patient's home. During his first visit the student will discuss with his patient their professional relationship, its time limitation, and what they may expect from one another. In the interim week where treatment does not take place, each student will meet with a group of up to four students under the guidance of a psychosocially trained physician. These groups will discuss student-patient-contacts, describe and analyse problem situations and aim for finding suitable solutions to the given problem.

During the home visits a work sheet will serve to write down the student's observations, perceptions, and findings. Then, problem solving suggestions on an interdisciplinary level are made and evaluated, taking into account the patients ability to cope with disease and illness.

Group members reported that in Sweden the medical student works with a family for one week. Problem situations such as the broken family, the unemployment family or drug- and/or alcohol-related conflicts are discussed with an observing student, aided by the use of video tape.

The group came to the conclusion that instead of "scientific thinking" the term "problem solving behaviour" would be more appropriate to be used during lectures. As we are actually more than "researchers" our motivation is important to

us and besides this the problem how to find. Important to us is our motivation and how to find the right answers to the question: "How is behaviour in a psychosocial system measured in the best way and documented?" The "teacher" here may not even be the best person to impart such capabilities, for studying and learning behaviour takes time. The medical student of the present is busy with studying and memorizing facts. The unsolved issue remains, how to best acquire problem solving behaviour.

In medical studies, our current academic courses neglect **problem oriented learning**. Simultaneously, there are not sufficiently reliable research data on family medicine available. Only insufficiently differentiated **methods on how to handle problems of the psychosocial system** are taught so far. Already a differentiation of the **qualitative** and the **quantitative** could be helpful here.

Parallel to studying the natural sciences the student needs to practice problem solving behaviour at the beginning, during and at the end of his medical studies. "Life experience is half the job" was a fitting statement.

The student feels that the **study of medicine** is not comprehensive enough since it currently lacks the following:

1. The **epidemiological significance** of many diseases and problems of family medicine are insufficiently taught.
2. Students do not get enough insight into the **contributing environmental factors** upon disease and illness development.

Another complaint was that, fostered by the predominantly clinical thinking structure at the

universities, students generally tend to show a stronger interest in the data of natural sciences. The question remains: How can one be motivated to learn and think in relationships and interactions? The integration of patient collectives and the long-term care of the individual patient as a significant component of the studies of medicine were discussed. As one group member commented, "these issues will have to be faced and solved by a new type of physician". The necessary basis for this would be an interdisciplinary structure as well as a different way of distributing the available resources.

4. Summary

To learn about scientific thinking in family medicine, the medical student will not only have to consider natural scientific, but also psychosocial aspects and methods.

Scientific thinking primarily is concerned with the problem solving of complex human conditions, as they are obvious in the various forms of human relationships. The acquisition of knowledge about illness and disease should be supplemented by obtaining insight and experience in how psychological and psychosocial reactions and conflicts may be contributing to ill health. The family doctor should strive for maintaining the patient's autonomy, independence and integration, and also prevent a somatic fixation. An effective approach to reduce the existing deficit in medical education would be to offer problem oriented learning and a more practice-oriented way of teaching. This would include long-term care and follow-up checks on the course of disease within the patient's family environment.