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# Medical student education

## The role of caregivers and families

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As early as 1863 the education committee of the General Medical Council (GMC) recognised the tendency of medical education to overload medical students with factual knowledge. Since then, there has been a considerable body of evidence that when students spend their time learning facts only, they often fail to apply the knowledge that they have gained (Ramsden, 1992). In 1993 the education committee of the GMC made detailed recommendations regarding a change to more problem-orientated learning and the encouragement of students to learn independently (GMC, 1993). This is currently leading to changes within all medical schools curricula so that students will be helped to integrate their formal learning with the experience of seeing patients and their families and thus be able to apply their factual knowledge.

Doctors and, in particular, general practitioners (GPs) do not have a good reputation among those caring for people with dementia. Iliffe (a reader in general practice) is particularly critical of doctors in their failure to make a diagnosis and in their professional attitudes which often amount to nihilism. He suggests that working with people with dementia and their carers is a test of GPs' ability to work in a community-based multi-disciplinary way and one in which they often fail (Iliffe, 1994).

### The study

In this context and with our interest in undergraduate education, particularly as it applies to producing doctors who would be helpful to people with dementia and their carers, we started an experiment in University College London (UCL) Medical School in 1995, in which a group of carers, as part of the formal lecture programme in undergraduate psychiatry, came to talk to and with the medical students.

Medical students in UCL have their main attachment in psychiatry in an eight-week block in the second clinical year. They are divided into five blocks each of about 40 students and rotate through psychiatry and other specialities

throughout the year. At present they have 10 days of formal teaching during their block and the rest of the time is spent in clinical firms, one of which is general psychiatry, and is mainly hospital-based and one which is specialist teaching and often has a significant community-based component. All students have experience of both community and hospital settings.

The carers' presentation is scheduled directly after a lecture about dementia. In general, the presentation is structured so that one of the carers acts as a facilitator. He or she usually comes to the earlier lecture to enable links to be drawn with it and thus maximise the illustrative nature of the learning experience. At most sessions, four carers take part. The facilitator uses a question and answer format and is able to ask appropriate but also personal and intimate questions, as he or she has personal knowledge of each of the carers. They are chosen to represent a variety of caring experiences; current and past carers; spouses and other relationships; either gender; varying educational background, ages and socio-economic class. This means that a range of experiences of caring can be covered. Most carers have never spoke in public before. The role of the facilitator is to ensure that each of these experiences are expressed. Questions are asked about the various aspects of care which is given and the reaction of the carer to different stressful situations. Enquiries are then made about the effectiveness of services received, the way in which needs have been met and successes or failures of services to provide relief and support.

The carers have to be prepared to speak publicly about issues which are often painful and personal; the ways in which they have been pushed to their limits and sometimes beyond, the guilt which they feel when they have failed to exercise patience and to fulfil their own very high expectations of themselves. Carers are sometimes concerned that if they express too much emotion – their grief or anger or resentment, the students will cut-off from the experience and be unable to bear it. But the students do not appear to find this problematic. The

students are also asked by the facilitator if they have an experience in their own family of caring for someone with dementia and the answer is frequently positive.

## Results

After the first presentation the students who were aware that this was an innovation wrote a letter to the carers, which they all signed saying thank you and that they "found it extremely moving, interesting and useful".

The students assess all the lectures including the carers' presentation on a scale of one to five (1=poor; 5=excellent). The assessment is on three criteria; clarity of presentation, interest and relevance/appropriateness. Both the lecture and the carers' presentations are rated highly with mean scores for the carers' presentation of 4.6 for clarity, 4.4 for interest and 4.4 for relevance. There is no space for comments but the students sometimes make them and they are almost invariably positive, for example, "out-standing" or "excellent" although one student said that the presentation "didn't tell me anything that I didn't already know".

The response of carers invited to take part is at first tentative – "I don't know whether I've got anything interesting to say". At first they do not realise the value of their personal experience in giving the students an understanding of what it means to care unremittingly for 24 hours a day for someone with whom they have had a close and usually loving relationship; to face the need to be endlessly vigilant; to bear the demands of physical care and to adapt to the gradual changes in behaviour, personality and the relationship; the inevitable deterioration in memory and understanding; the endless succession of duties and days (Bayley, 1998). This is an opportunity for the students (in contrast to their role after graduation) to listen without acting and to consider only the experience and its meaning. This illuminates the factual account of dementia and allows the student a unique insight into the effects of one disease, not only on the patient but also on the family.

For the carers an opportunity to speak about what they know at first hand is welcome and may for the first time enable them to feel that the caring, which they have not chosen and may have reluctantly endured, has meaning and value. They have often encountered lack of understanding of their needs. This is an opportunity to enhance the knowledge and practice of the doctors of tomorrow. The time and thought that the carers contribute to the student teaching may save others in the future from reliving some of the distress that they have gone through. Finding that they have something to contribute to the training of doctors and other professionals is for them a therapeutic experience in itself.

## Discussion

We have written this article to disseminate a method of teaching which has been much appreciated by students and which fits in with the ethos of a problem-based approach to learning and in particular the GMC's advice to integrate learning with the experience of patients and families. It is, in addition, to fulfil the brief given to us by the first set of students in their letter to the carers "We hope that you will be able to repeat this event for other medical students".

## References

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