Teaching medical students about disability

The logical place to start

If something is to be done about doctors' widespread ignorance of the special needs of disabled people then medical school is the logical place to start. It is there that tomorrow's doctors need to develop positive attitudes to disability and begin to understand the medical and social problems of impairment. At present the attention that medical schools pay to the topic varies widely and is generally inadequate.

Medical Education on Disabilities reviews the current state of play.¹ Produced by University College London Medical School and the Prince of Wales's Advisory Group on Disabilities, the report lists different approaches to the subject, discusses the problems encountered in teaching students about it, and recommends objectives for such teaching.

The report reveals a wide variety of teaching methods. Some medical schools use case histories to illustrate the practical problems that disabled people face in hospitals and the coping strategies that they develop. Other medical schools encourage their students to experience an outpatient clinic from the receiving end by sitting with a disabled patient before, during, and after a consultation and listening to his or her impression of the health service.

Some medical schools send their students on attachments to disabled people's families to improve their understanding of the social effects of disability. Others use experimental methods, in which students simulate the experience of disability by living in the community for a day in a wheelchair, with their leg in a cast, or wearing glasses smeared with petroleum jelly. University College London Medical School uses people with disabilities to teach their students. Bristol University encourages applicants with disabilities to improve the opportunities for further education for this group and to extend the experience of other students and staff.

In addition, the report focuses on teaching the type of care in which the search for physical signs does not lead to the "person" being ignored. It recommends that students should learn about the causes of disability and understand the concepts of impairment, disability, and handicap. They need to know what services and aids are available and that disabled people are experts in their own disabilities and can devise their own coping strategies.

Both the General Medical Council² and the Royal College of Physicians' working party on rehabilitation³ want teaching on disability and rehabilitation to be part of the new core curriculum. The next stage must be to increase communication among medical schools so that the curriculum planning committee can compare the effects of different teaching methods on medical students' attitudes, skills, and knowledge. Representatives of Britain's six million disabled people should be consulted: we need to learn more about disabled people's perceptions of medical care and how they think medical education might improve it. An integrated approach to teaching is needed, with students learning about different disabilities and the possibilities for rehabilitation in the context of the appropriate specialty rather than as an isolated topic with no immediate relevance.

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1 Inman C, Kahtan S. *Medical education on disability: a report from University College London Medical School and the Prince of Wales' Advisory Group on Disability*. London: University College London Medical School, 1993.

2 General Medical Council. *Undergraduate medical education. The need for change*. London: GMC, 1991:9.

3 Royal College of Physicians. *Report of the working party on rehabilitation*. London: RCP, 1978.

Failure in community care: psychiatry's dilemma

Health care professionals will be more accountable for failures in the future

After decades of scandals associated with substandard care in institutions¹ come scandals in the community. Concern has mounted as fears for the plight of abandoned mentally ill people on the streets² and in remand prisons³ have been overshadowed by a series of incidents in which discharged patients have harmed themselves or others.^{4,5} The media have seen through political policy and professional dogma that state that the mental hospitals can close and seriously mentally ill people can be conveniently and easily managed in the community. Some health care professionals have argued that more resources are the answer. But others privately doubt the suitability of community care for a substantial minority of patients and suspect that unquestioning enthusiasm for its implementation has contributed to the current problem.

The response of the secretary of state for health has been to make professionals more accountable for these failures in the future. Detained patients will be subject to supervised discharge, whereby a named professional is directly responsible for their care.⁶ A treatment and follow up plan must precede discharge, and subsequent failure to comply with conditions will result in a review of the case and a multi-

disciplinary meeting to decide whether the patient should be recalled to hospital under the powers of the Mental Health Act 1983. No new resources are being provided to set up supervision registers or to meet the inevitable increase in sessional commitment from health and social services professionals. There are no guidelines on what constitutes an acceptable workload for a carer.

For patients who refuse treatment there are no additional legislative powers to enforce it, although legislation to facilitate supervised discharge may be introduced. There is no specific guidance on the level of professional accountability for any future failures. But there are clear guidelines for the independent inquiries that may follow a suicide and are mandatory after manslaughter or murder. The care that a patient actually received will be scrutinised, as will the judgment exercised by the responsible professionals. The medicolegal implications of these proposals may not have been considered.

Could psychiatrists be partly to blame for this unsatisfactory situation? As a former psychiatric social worker, Mrs Bottomley understands many of the shortcomings of community