# Mental Handicap in Context: Medical Undergraduate Education

In October 1986 the Section for the Psychiatry of Mental Handicap held a day conference about the teaching of mental handicap at St George's Hospital Medical School, London.

A timely publication in the *Bulletin of the Royal College of Psychiatrists* the week preceding the conference entitled 'Undergraduate Training in Mental Handicap' may have contributed to the good attendance; 103 people registered, and at least 17 out of the 27 British medical schools were represented.

Sheila Hollins introduced the conference by reporting on a recent survey of medical undergraduate teaching by herself and Dr Bradley. There have been previous similar surveys. Holt[1] found that one third of doctors graduating in the 20 years up to 1969 remembered no teaching or less than one day's experience in mental handicap. Pilkington[2] reported that in 20 of 32 British schools an average of 11 hours teaching time was made available. The current study also found an 11 hour rough average—an increase in real terms as it related to every medical school in the UK.

In one school mental handicap was not considered a necessary part of the curriculum by the Dean. Elsewhere the survey found considerable variation in time available for teaching from $1\frac{1}{2}$ hours (a lecture) to 24 hours. Time devoted to teaching mental handicap was about to be introduced in two schools, to be increased in 16 and was described as static in seven.

Since the studies of Holt and Pilkington there have been several academic developments in the psychiatry of mental handicap. The first Professor was appointed to St George's Hospital Medical School in 1980 and there are now five Professors in the Psychiatry of Mental Handicap and numerous Senior Lecturers as well as one Professor in Child Psychiatry and Mental Handicap. The data from the survey were gathered and will be reported under the following headings.

### Teaching methods

Despite Holt's and Pilkington's separate recommendations that visits to long-stay hospitals were not a good introduction to mental handicap, this is still the most common teaching method used with 13 schools organising visits to hospital units. However, a wide variety of other learning opportunities is also made available; for example visits to family homes and social education centres, participating in or observing clinical assessments, and watching videos. Face to face contact with people with mental handicap is highly rated by students but difficult to organise.

### Aims and objectives

In the survey it was apparent that few university teachers had formulated clear aims and objectives, and even fewer had obtained official medical school recognition of their aims. Here are some of the aims listed by the respondents:

...to provide enough knowledge and understanding about mental handicap and about services to enable appropriate, sensitive care by any GP or hospital doctor;

...to provide a basic grounding or broad overview of mental handicap;

...to enable doctors in any specialty to give appropriate medical care to people with learning difficulties.

### Course content

Respondents thought that knowledge about services needed by families and handicapped people was the most important thing for students to be taught. Also emphasised were aspects of prevention, the presentation of psychiatric disorders, aetiology, epidemiology and classification. Low on the list of areas taught currently, although considered essential in the College paper, were ethical issues, management of behaviour problems and an understanding of communication difficulties.

*Who teaches* In the majority of cases mental handicap is taught by a doctor who is usually a psychiatrist, or sometimes a paediatrician. Psychologists, social workers and speech, occupational or physiotherapists are often involved.

*Course assessment* The majority of respondents regularly ask students to assess the mental handicap course, and have changed what they offer as a result.

*Student assessment* In two thirds of schools, students are examined in mental handicap as part of the psychiatry end of firm exams and in about a third mental handicap is examined in the final psychiatry exam. However only eight consultants in the psychiatry of mental handicap are examiners at degree level nationwide.

Dr Hollins concluded that there has been an expansion of teaching and an increased interest in how to teach mental handicap which must owe a great deal to the developing Academic Departments in the Psychiatry of Mental Handicap.

Dr Geraldine Holt then reported on her study (in conjunction with Dr Bouras) of medical students' knowledge and attitudes towards mental handicap. A short structured questionnaire was given to 89 medical students prior to their mental handicap placement. The questions referred to terminology (e.g. alternative names for mental handicap), the causes of mental handicap, and to the contact the medical students had had in the past year with individuals who have a mental handicap. The students' responses to a number of statements about adults with mental handicap (e.g. are always happy, have problems in talking clearly) were measured. There were also questions related to their feelings (e.g. knowing what to say, feeling embarrassed).

https://doi.org/10.1192/S0140078900018629 Published online by Cambridge University Press

The results indicated that these medical students had had little contact with people who have a mental handicap, and the students were eager for information not only about aetiology, diagnosis etc of mental handicap, but also on the wider issues such as social interaction with handicapped people. The confusion that often exists between mental illness and mental handicap was present in these students, with some 16% of them considering the term mental illness being equivalent to mental handicap. The medical students seemed favourably disposed to handicapped people which the researchers suggest should be a significant asset in the changing image of mental handicap. There were no significant differences between male and female medical students in their responses.

From their results the researchers emphasised the importance of formal teaching related to the care of people with a mental handicap and suggested that this teaching be made available to medical students within their psychiatric placements.

Dr Paul Laking described his study which examined the effects of a mental handicap course on the attitudes of medical students towards people with mental handicap. The questionnaire was administered to 58 4th year medical students, about half of whom had completed a psychiatry of mental handicap course. A comparison group of 54 professionals (primarily nurses, but the rest comprising doctors, clinical psychologists, occupational therapists and administrative staff) who were working with people with a mental handicap in a community based service was included. The first 20 items of the questionnaire comprised the attitude to disabled persons scale (ATDP) and this was followed by a series of questions asking about demographic characteristics and about contact with people with mental handicap.

The study overall did not provide support for the notion that contact with people with mental handicap improves attitudes towards these individuals. While there is no significant difference in attitudes between male and female medical students, there was a significant difference in these attitudes between professional male and female participants. This raises interesting issues as to how and when these differences arise. The ATDP did not distinguish those students who had done the mental handicap course and those who had not, and the reasons for this were discussed. On the other hand, there was evidence from the comments in the questionnaire and from the experience of teaching on the course that the course had affected students in the way in which they related to mental handicap. The study highlighted the complexity of measuring attitudes and it is likely that some of the variables, for example the nature of the contact with the mentally handicapped person, previous experience with handicap, the type of handicap and the variables relating to the respondent will need more precise definition and to be teased out in a systematic way before definite conclusions can be drawn. Dr Laking concluded that he hoped future work in this area would address not only attitudes but also how professionals *act* towards people with a mental handicap.

Elspeth Bradley then described a survey of a group of doctors from one medical school who had had some mental handicap teaching during their undergraduate medical training and who now also had three years post qualifying clinical experience. This study was designed to look at the actual contact that these doctors had had with people with a mental handicap since qualifying and to what extent these doctors felt the teaching they had had was helpful in this contact.

Questionnaires were sent to all 84 doctors who qualified in one year and the response rate was 79%; 91% of these doctors had had contact in at least one clinical setting with a patient who had mental handicap. For the most part this contact was such that the doctors tended to recall individual cases in some detail. About two thirds felt that the teaching had been helpful, and of these, about half felt that further information was needed. Further information requested related to areas around service availability and difficulties in communicating with clients and families. Many of the 33% who indicated that the teaching had not been helpful felt that to appreciate some problems fully more time needed to be spent with mentally handicapped people, their families and their carers over an extended period.

Dr Bradley concluded that mental handicap is just one area where the needs of the chronically disabled and/or ill need to be understood and the challenge for medical education is how to address an appreciation of these chronic needs in a relatively short undergraduate clinical curriculum.

These three studies taken together were rather like individual pieces in a jigsaw. Dr Holt's study had focused on medical student attitudes prior to the students' clinical placement in mental handicap. Dr Laking had looked at the effects of a mental handicap course on medical student attitudes and compared the latter to the attitudes of a group of professionals working in the mental handicap field. Dr Bradley had looked at the clinical contact a group of doctors three years past qualifying had actually had with mentally handicapped patients, and how the mental handicap teaching these doctors had as undergraduate students had affected this contact. There was the sense that taken together these three studies gave sufficient glimpses of the total picture to inspire a more comprehensive study; the need to address how attitudes change in the same individuals over time given different experiences of mental handicap seemed to be indicated.

During the panel discussion following the formal presentations Drs Peter Hill and Sheila Hollins presented a draft syllabus for discussion which included clearly defined skill and knowledge objectives. This was derived from the course developed at St George's.[3,4]

The panel comprised various teachers from St George's Hospital Medical School including the Dean, an obstetrician, clinical geneticist, developmental paediatrician, psychologist, general practitioner and a parent. Lively discussion ensued. For the final session participants were divided into small groups to formulate one broad aim and some clear educational objectives. These were reported

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back to the whole group before Dr Ken Day summed up the experience of the conference. He concluded that all the best conferences throw up more questions than are answered. For example, is it ever relevant to teach mental handicap without involving the multidisciplinary team? Are video films an effective alternative to meeting people with mental handicap face to face? Should there be a separate core syllabus for mental handicap or a coordinated syllabus on chronic disability with mental handicap as just one of several disabilities? The final session had certainly highlighted a need for medical schools to define educational aims and objectives more clearly.

*A detailed account of each of the research presentations is being prepared by the respective authors for publication elsewhere.*

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## *Woodford-Williams Prize*

Dr Eluned Woodford-Williams, CBE, was a pioneer of British geriatrics, and in recognition of her services to psychiatry both in that capacity and as Director of the Health Advisory Service, the College elected her a Member and later a Fellow. She was an enthusiastic member of the Section for the Psychiatry of Old Age until her death in 1984 and this Prize derives from the bequest which she made to the College.

A Prize (value £300) is offered every three years commencing in 1988 for research in the prevention of dementia. The research should be within the broad heading of the prevention of dementia. It is noted that the wider aspects of prevention (including primary, secondary and tertiary prevention) give a range of possible topics.

Applicants for the Prize must be Members of, or Associates with, the College*. Research involving collaboration between workers, whether psychiatrists or in other disciplines, may be submitted, but the Prize may be shared between no more than two eligible applicants. In each instance where collaborative research is submitted there should be a clear indication of which parts of the research were undertaken by each worker and a statement to this effect signed by all collaborating workers must be submitted.

Applicants are required to submit a summary of their proposed submission between 200 and 500 words for approval by the Examiners at an early stage to ensure that it falls within the scope of the award.

The research may be presented in the form of an essay or dissertation or as an account of recently published work in the field. Submissions, which may include figures and tables, should be between 10,000 and 30,000 words. A concise curriculum vitae, together with a list of any appropriate publications, should accompany each application.

Recipients of the Prize may be invited to present a report at a Scientific Meeting of the Old Age Psychiatry Specialist Section.

The Examiners of the Woodford Williams Prize will be the Dean, the Chairman of the Research Committee and two assessors nominated by the Old Age Psychiatry Section. No prize will be awarded if a sufficient standard is not reached.

Entries for the Prize should be submitted to the Dean before *31 March 1988*. Proposals should be submitted to the Dean by *31 January 1988*.

*"Members of, or Associates with, the College" means that applications can be received from "registered Members and Fellows of the College" as well as the "registered Affiliates, Honorary Fellows, Corresponding Fellows, Corresponding Associates, Inceptors, New Affiliates and New Associates".

## *The Peter Scott Memorial Trust Scholarship*

The Peter Scott Memorial Scholarship is awarded from funds subscribed in memory of the late Peter Scott, CBE, and is awarded biennially.

The Scholarship is intended to encourage young doctors or medical students to further their studies in the field of forensic psychiatry or delinquency by enabling them to carry out research, to travel, to write, to complete a research project or to suggest any other relevant activity. The value of the Scholarship is up to £1,000, and any member of the medical profession, or medical student(s), may apply. More than one Scholarship may be awarded.

Application forms are obtainable from the Education Department at the College and should be completed and returned by *31 March 1988*. The successful candidate(s) will be required to supply a subsequent report and may be asked to present a paper at a meeting of the Royal College of Psychiatrists.

https://doi.org/10.1192/S0140078900018629 Published online by Cambridge University Press