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INTEGRATING A POSITIVE CONCEPT OF DISABILITY INTO PROFESSIONAL CURRICULA

Report of a Workshop held at

King's Fund Centre

Wednesday 10th December, 1986

June, 1987

King's Fund Centre
126 Albert Street
London NW1 7NF

INTEGRATING A POSITIVE CONCEPT OF DISABILITY INTO PROFESSIONAL CURRICULA - 10th DECEMBER, 1986

INTRODUCTION

JAMES SMITH, Assistant Director of the King's Fund Centre welcomed everyone to this the third in a series of workshops, that had grown out of a meeting set up by the Long Term and Community Care Team and the Prince of Wales' Advisory Group on Disability, to discuss the training needs of professional staff working with disabled people. He wondered whether participants had heard the previous weeks radio interview with the Prince of Wales about this very subject. The Prince's interest had extended to a luncheon at Kensington Palace which had been attended by several of todays participants.

The Long Term Care Team at the Centre was concerned that there were difficulties facing some disabled people coming into contact with staff of health authorities and the workshops with nurses at the Centre on September 1st and October 20th, 1986 had highlighted issues around gaps in curricula and attitudes to this client group. It was clear we needed to get at the people who did the training and developed the curricula. This meeting had been set up to bring together multi-disciplinary professional trainers to look at the subject, identify areas of good practice or simply air specific difficulties in relation to training staff to care for disabled people.

He welcomed Baroness Cox, herself a nurse, sociologist, educationalist, and politician, who had taken time out from a very busy schedule to chair the proceedings, which she felt to be very important.

Baroness Cox wanted to highlight two words from the title - integrating and positive - these she felt set the brief for the day.

'Integrating' suggested that the theme of the care of people with handicaps should be an integral part of the education of the health care professionals represented at the meeting - i.e. medical, nursing, occupational therapists or physiotherapists. The concept of integration could imply integration within curriculum for each of these professions; it could also imply integration across boundaries of professional curricula. Either use of the term raised fundamental questions as to what? how? why? when? Was it best done at the level of under-graduate or basic training or later during post graduate or post basic education? Either way, the meeting pre-supposed that some multi-disciplinary training was desirable, where possible - because this might help those working in one professional sphere to appreciate and understand better the roles and contri-butions of colleagues in related fields. This in turn might facilitate commun-ication and positive co-ordination of professional activities for the benefit of those whom we were trying to serve.

She felt that the King's Fund was offering all present a valuable chance to work with colleagues from their own and other parts of the country and from all professions, thus allowing everyone, including herself, to address fairly and squarely the opportunities and problems which were presented. There were problems at the level of principle, of theory and concept; and inevitably practical problems, such as the already overloaded curricula during training, and the logistics of pressures of time for already fully stretched professionals in practice.

The title of the workshop also carried the words positive concept which would seem, if not a contradiction in terms, then at least a major challenge. For her it was understood to be a reminder, inter alia, that we should not over emphasise the medicalised concept of disability - though it was not suggested that we should underrate appropriate consideration of medical aspects. Rather that we should take a wider holistic view of disability in terms of improvements in the whole quality of life for people with varying degrees of disability and provision for enhancement of their independence as well as provision for dependence. Our concern should be to enable professionals to respond more sensitively and on a more individualist basis to people with handicap - rather than the tendency which may have prevailed in the past. to think and speak in more generalised and negative categories or stereotypes.

Whilst being briefed for this meeting she had been told that the expected participants were an exciting group and could be seen as 'trail blazers' and 'exemplars', and collectively could be a powerhouse of inspiration and progress. She looked forward to hearing the presentations and later the results of the group deliberations.

WHY WE NEED TO INTEGRATE A POSITIVE CONCEPT OF DISABILITY INTO PROFESSIONAL CURRICULA

A Professional View

Professor Ian McColl - Director of Surgery at Guy's Hospital, London and lately Chairman of the Government Enquiry into the Artificial Limb and Appliance Centre Services, related the story of the surgeon who had a very uncomfortable and painful operation. He had not realised how painful it would be, and after his operation he was not given sufficient painkillers. When he returned to his work he personally made quite certain that everyone knew how painful operations were, and he ensured that adequate painkillers were given. The surgeon certainly learned from experience. If you were not disabled it was difficult to know what it was really like.

Professor McColl was certain that the doctor or nurse wanted to know how to do things, and that they did try to get it right. The right tutor could help this process, and the student had to be interested and understanding of the problem. One way of instilling this understanding was to put the student in the place of the disabled person. He put each student into a wheelchair for a day and made them go through their daily routine from the chair. With this system they gained some insight into the problems. They also went to the Disabled Living Foundation for a session, and they very much appreciated the experience.

He gave two examples of the difficulties that had to be overcome.

A recent piece of research on people with disfigurements had given some insight into the ordinary persons perceptions and attitudes. When a lady with a disfigurement on the right side of her face stood in a bus queue with normal numbers of people on each side of her. those on the right side would slowly move over to the left side. If she engaged those on her right side in conversation they stayed put.

He showed to the audience an artificial limb, the seventh that had been made for a client, which like all its predecessors was ill fitting, not only did the person concerned not have the use of the artificial limb but had all the personal distress that went with the situation. How did you teach students about the difficulties of walking on such a limb, the pain and discomfort involved. · These were just two elements of a whole range of training needs that needed to be faced, students must know and properly understand the subject.

This brought us to the question how did we teach these issues to students. Should it be done by lectures? He did not think so, we had not always been very clear in our teaching methods - in the past the idea circulated that doctors should have nothing to do with accidents in the street as they were ignorant of first aid. This was ridiculous, doctors do and must always understand first aid. Likewise disabled people did not want to be patronised. so we had to find ways of involving them. He concluded that training methods had prejudiced students, and that now we had to develop ways of giving them insight into more of the problems of disability.

A Client View

Dr Michael Oliver, Senior Lecturer in Special Needs at The Thames Polytechnic. London said that having only been asked ten minutes before entering the hall to do this session, it would be very much an off the cuff presentation.

He had been educating professionals for fifteen years but was still appalled at the lack of awareness of disability at all levels. So, having agreed to undertake this session he would like to take the opportunity to educate the audience, not as an individual client, but taking a professional view.

Disabled people had known for many years that the services did not work, and that there was a crisis in services. It would be a fallacy to dwell in personal anecdotes, however disabled people were becoming more aware collectively about the issues. If anyone doubted that the crisis existed he could list a number of pointers over the last year. The McColl Report (1) Review of artificial limb appliance centre services was an indicator of crisis, the failure of services to provide much necessary equipment that disabled people needed. If able bodied people had the same problem with the shoemaker. the shoemaker would be out of work.

Even the Royal College of Physicians was aware of the crisis and had published the report "Physical Disability in 1986 and Beyond" (2). Whilst the diagnosis of the problems was very accurate, he queried the solutions the College suggested.

A month previously he had attended the meeting of the Alternative Occupational Therapy Group in London. to debate the failure of the occupational therapy profession to respond to various difficulties in carrying out the requirements of their employers. and to meeting the needs of their clients.

BASW (British Association of Social Work) and BCDOP (British Council of Organisations of Disabled People) had had a joint working party sitting for a year. marked by a conference in September 1986.

This then was evidence that professions were acknowledging that they were acutely worried about inappropriate training. inadequate curricula. and lack of professional knowledge of the area and developments.

He did not want to say that the education of professions was the sole reason for this. it was not, there were many other issues involved, but we needed to address crisis issues in order to start to solve them. The response of disabled people collectively to this crisis had been to provide an alternative focus. He did not suggest that there was a coherent disability movement. for like any movement it had its extremes of left and right. However there was a coherence to what had been said by disabled people over the past 5 years. This was stronger than perhaps most professionals realised.

There were three arms to this:-

1. criticism of existing services.

2. attempts by disabled people to re-define the problems and issues.

3. disabled people had begun to take an active role in planning and organising services.

(1) Disabled people sought answers to the following points - no professional services were provided as of right; they had no right in law; there were other areas of concern - race and gender; services were based on professional judgements, (your specific disability, where you live, which professionals assess you).

There were problems about variations in services, a disabled person had no right to challenge professional judgements. Participants might feel that there were examples of attempts to build in these rights - such as the kind of statement in the 1981 Education Act (3) and the Disabled Persons (Services, Consultation and Representation) Act 1986 (4) - however effects so far indicated that professionals continued to make judgements unacceptable to disabled people without consultation. There was no anti-discrimination law and no commitment to provide it.

(2) Part and parcel of this dilemma was that access to services was based on medical definition of disability. Disabled people had been active in pointing out that being recipients of understanding what disability was about, was rather destructive to disability. Disabled people might not see their disability as a tragedy, but after the tenth professional had tendered their views, the disabled persons' perspective might begin to change. An attempt to move away from this perspective was being made and Simon Brisenden in Disability, Handicap and Society (5) had this to say:-

"In order to understand disability as an experience, as a lived thing, we need much more than the medical 'facts', however necessary these are in determining medication. The problem comes when they determine not only the form of treatment (if treatment is appropriate), but also the form of life for the person who happens to be disabled. As well as the 'facts', therefore, we need to build up a picture of what it is like to be a disabled person in a world run by non-disabled people. This involves treating the experiences and opinions of people with disabilities as valid and important; more than this, they must be nurtured and given an overriding significance, in order that they begin to outweigh the detached observations of the medical 'expert', which have invested in them the power of history. Our experiences must be expressed in our words and integrated into the consciousness of mainstream society, and this goes against the accumulated sediment of a social world that is steeped in the medical model of disability".

Disabled people were therefore expressing their dissatisfaction about trying to live their lives in a society that took very little note of needs. Many disabled people had no privacy, no proper support, poor education, inadequate housing, minimal benefits etc. Focus had shifted away from what was wrong with disabled people to what was wrong with society. Ann Shearer in"Disability: Whose Handicap" (6). "The first official aim of the International Year of Disabled People in 1981 was 'helping disabled people in their physical and psychological adjustment to society'. The real question is a different one. How far is society willing to adjust its patterns and expectations to include its members who have disabilities, and to remove handicaps that are now imposed on their inevitable limitations".

(3) The disabled movement had been attempting to re-define and had actually begun to say what sort of range of alternative services were wanted, sometimes in partnership, sometimes opposing professionals, i.e. Care schemes had developed that were successful because they took the disabled person's needs into account. Disabled people still did not have the basic right to decide when to get up or go to bed. Disabled people had begun to take power themselves through Centres of Independent Living schemes. which had their own services.

Derbyshire Social Services and Derbyshire Coalition of Disabled People had gone a long way to working out partnerships and collaborative practice. In the next 10-15 years some of the limits in the curricula were going to become more prominent. If professional services, both in terms of those on offer and how professionals were trained, did not listen, then in a few years time the disabled movement might well come to the collective view that professional services were no longer relevant. It was his view that professionals would be forced to listen and change.

THE VALUE OF THE MULTI-DISCIPLINARY APPROACH TO TRAINING TO THE PROFESSIONAL

Avis Hutt, Nursing Consultant said that the need for training for teamwork had been a priority for health workers, especially those in the primary health care team, since the 1970s when the rapid development of group practices and the attachment of community nurses and other professionals to them had required urgent re-appraisal of traditional attitudes and methods of work. Since then many studies from both industry (especially from the US) and health care systems had produced a significant body of knowledge about the characteristics of teams but there was less evidence of successful teamwork in practice. From a definition of the team as "a group of people who make different contributions towards the achievement of a common aim" Avis Hutt extrapolated the needs of a multi-disciplinary team to function effectively as:-

1. commitment and understanding by each member of his own and others' roles and functions within the team.

2. the pooling of knowledge, skills and resources,

3. the sharing of responsibility for the outcome,

4. a realisation that the team's effectiveness was related to its ability to carry out its work and manage itself as an independent group of people.

Studies revealed complex problems in attempting successful teamwork. They include:-

1. the need for a base from which to work and communicate.

2. differing management structures within the team.

3. changing personnel.

4. team members' stereotype perceptions about their own and others' professional role and status.

5. role ambiguities.

6. status differentials, class, educational and traditional hierarchies.

7. leadership styles - who should lead the team? who decides? could leadership rotate? what was appropriate in different and changing situations?

8. "teams" versus "networks" - was there a difference?

Successful teams could and did exist. In a study of a surgical team in an operating unit (Wiessen 1958) (7) it was found that the roles of each member were so well defined and they were so interdependent in executing the tasks that even those antagonistic to each other could act together in accord. Research concerned with perceptions of GP trainees, Health Visitor, District Nurse and Social Work students towards the primary health care team (Milne 1980) (8) suggested "a need for role learning experiences during training which were subsequently extended and reinforced by interdisciplinary participation in simulated management experiences".

This was an important teaching method used in a multi-disciplinary experimental course in Care of the Elderly for medical, nursing, physiotherapy and occasionally, social work students at the Middlesex Hospital in which Avis Hutt was the nurse member of the teaching team. (Hutt 1980) (9). The difficulties in setting up the course were many:-

1. the students were from different disciplines, at different stages of training with different examining boards and syllabus of training.

2. there was always an inbalance of numbers - more medical students than the others.

3. the need for a Course Organiser - essential for co-ordinating students, teachers and field experience.

4. problems of status and traditional attitudes referred to earlier were notably present in the early stages. This was particularly noticeable in agreeing educational criteria.

Teaching methods included:- informal seminars, problem solving team patient presentations with the students exchanging roles, community visits and field-work with general practitioners as well as team ward rounds. Team discussions could produce strong argument and the students proposed alternative solutions to patients' medical/management problems which were sometimes accepted by the teaching team and acted upon. Thus professional practice could be monitored in an objective setting and enhance the team approach to care. The commitment and enthusiasm of teachers and students had ensured its continuation. The difficulties could be overcome with understanding.

Avis Hutt's personal experience lead her to believe that the main thrust to achieve successful teamwork should be through the educational process. She would like to see the "team approach" integrated into basic and continuing teaching programmes for all disciplines concerned in providing care - whether specialised such as for the physically handicapped - or general. This could generate a positive concept which would become part of the professional expertise of each team member. In any case such an important aspect of care could not be left to chance and ad hoc arrangements. Preparation for team care must be carefully planned, its philosophy understood and based on sound educational principles. Examples could be cited of local initiatives in setting up such courses for different workers serving various client groups - (Hasler and Klinger 1976): (10) Osborne and Wakeling (1985): (11) Jones (1986) (12).

Ten years ago, writing about the need for multi-disciplinary education in the health care team Professor Scott Wright declared that "little more than lip-service had been paid to it so far" and he had argued that "undoubtedly the reason for this had been the reluctance of the professions to put the patient or the client into the middle of the arena rather than on the periphery". (Scott Wright 1976) (13). This was our challenge.

To The Client

Mike Oliver, Senior Lecturer in Special Needs, Thames Polytechnic, London, felt it important to question the real value of the multi-disciplinary approach to solving all problems. As a professional he had seen no evidence that the multi-disciplinary approach to training actually worked. One of the reasons for this, he felt, was that there was no real commitment to the disabled person being included in this approach.

We needed to understand the numbers of professional staff involved when talking about disabled people. For example there may be as many as 23 different professionals involved with a disabled client. Some clients see all of them, some see a few. However he was concerned at this proliferation of professionals, and wanted assurance as to what they are doing, what their value was. Maybe this was an internal problem of teamwork and that the professional would be helped by a professional keyworker. There was evidence that even where two workers exist there was no indication of improved service. Caroline Glendenning of University of York (14) had looked at a 100 families with a keyworker and a 100 families without, but had not found any significant difference. The only notable difference was that the family liked having someone who knew the family. However in terms of improvement in provision of services, the presence of the keyworker had made no difference.

As Avis Hutt had already pointed out professionals did not work in isolation, each profession was underpinned by organisation and service staff. Dr Oliver used Mildred Blaxter's book - The meaning of Disabled (15) to illustrate the complexity of services, which made the point that few professionals understand their own service let alone others. See Figure 1.

He was concerned at the imbalance in multi-disciplinary work. the particular problems raised by professionals competing for services. and the difficulties in establishing the disabled person as a member of the team.

Dr Oliver had the following reservations to multi-disciplinary work:-

1. Multi-disciplinary workers were not prepared to admit that the work was rife with confrontation/hierarchy, any case conference demonstrated this.

2. Professionals worked for/were part of the welfare system and had different requirements. Social Service Departments referrals very different from health or others and did not have common goals. Professionals were constrained by their employers. Organisations were not there to provide for the clients needs.

3. Professional constraints. The issues of training, professional training in different places. different ranges of time, balance between access/ needs of training. We could not assume that professionals were at the same kind of level of ability for teamwork.

4. Professional organisations have different aims, different goals, different ethics.

FIGURE 1 taken from The Meaning of Disability by Mildred Blaxter.

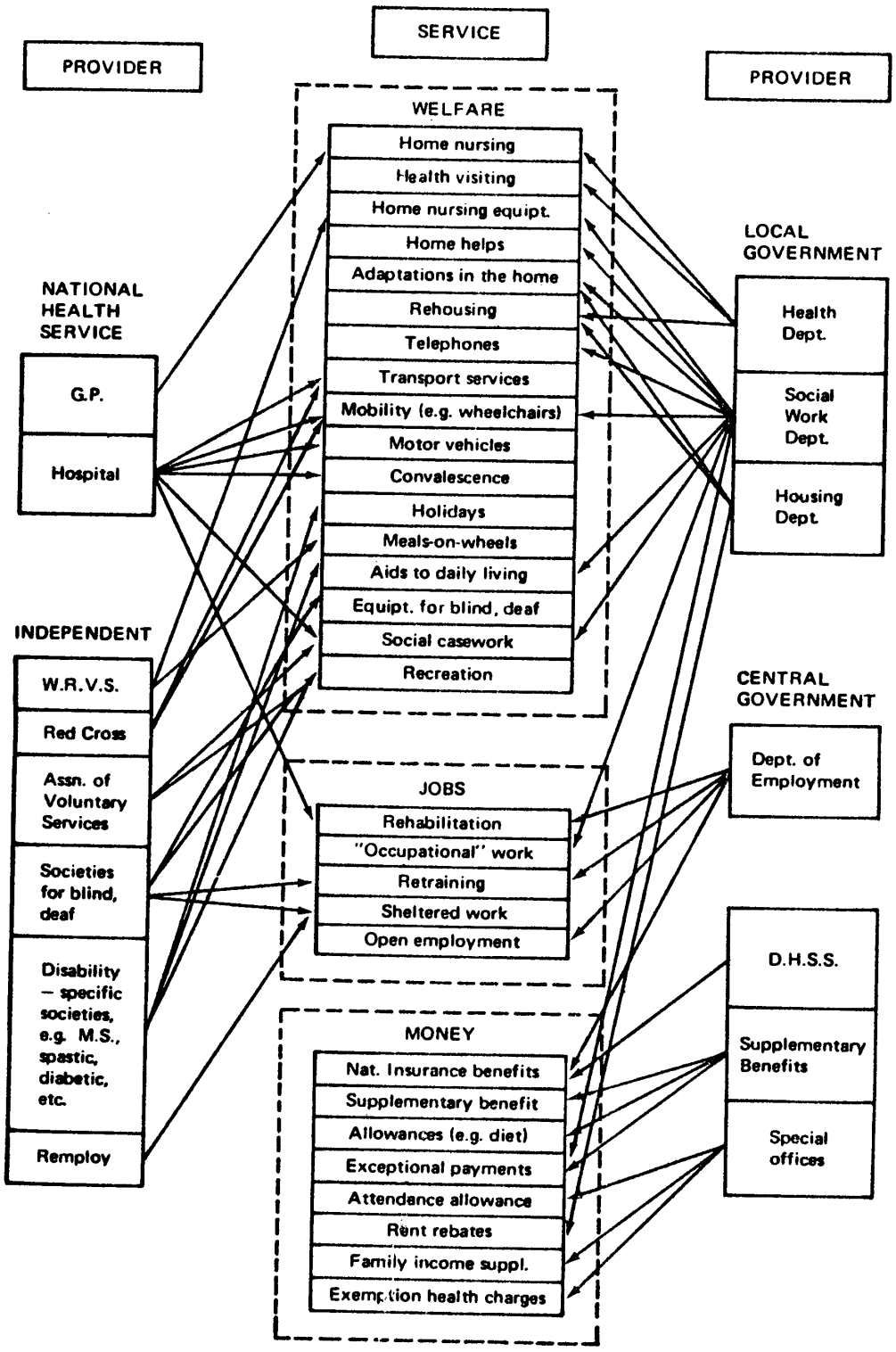


Figure 2.1 **Services for the physically impaired available in the City, and who provided them.**

It had to be said that these could not be ignored. In his area of work which was children with special needs, you could not assume that policies of Social Services and Education had the same views. So how could you make a multi-disciplinary team out of that. We must recognise these difficulties and get them on the agenda.

It seemed to him that by talking about a multi-disciplinary approach we allowed ourselves to make the assumption that we did not need to do anything about services. He felt we needed to do something about re-organising service provision. Secondly it was of vital importance that the role of the disabled person in the team was addressed. This could not be done by just inviting disabled people to attend. If invited then it must be on the same basis as others involved, disabled people must be given the same kind of information, support, that the professionals were given. They must be paid to go, provided with basic information, subsidised transport. For many disabled people, if you talked about real involvement, you had to look at these resourcing issues.

Finally he wanted to address the question how did professionals work with disabled people. If we had a keyworker system there was only one candidate for the job, only one person who was central and this was the disabled person. Thus the disabled person must be the central responsible worker. Professionals must accept this. It might be a resource based multi-disciplinary team that the disabled person becomes a central part of - so how did we achieve this and an equal role for the disabled person. The groups needed to address this in the workshop session.

If we were going to continue with this approach then it was essential that we looked at the training curriculum, and this needed to be done at the initial level of initial training. Dr Oliver did a lot of work with trained professionals and he had to say it, the blinkers were on. Professional training socialised them to a certain view of the world, we needed to influence this training and the question was how could we do this at the initial level of training - it was too late at the post qualifying stage.

WORKSHOP GROUPS

Teams broke into workshop groups for the last part of the morning and the afternoon session.

The rest of this report is a record of the workshop notes the groups produced based on the following questions. To ensure a sense of continuity the notes are recorded in the order in which the groups were asked to report back at the end of the afternoon. It should be noted that some groups worked through all the questions, others only part of them.

Brief for Workshop Groups

1. Critically approach the pros and cons of introducing a positive concept of disability into curricula for professional health workers.

2. Are you convinced that a multi-disciplinary approach to the training and education of professional health workers has any advantages for the client or the members of individual professions?

3. Develop outline proposals (theory + practice) for a multi-disciplinary course to introduce a positive concept of disability.

   (a) identify core group of professionals for this initiative.

   (b) identify other trainers e.g. district training officer, and/or practitioners of the health care disciplines who might be involved.

   (c) could the consumer (disabled person) or other individuals make a contribution to the curriculum development? If so. at what stage?

   (d) where would the course be based?

4. When and how would you implement the course?

   (a) do you foresee any problems associated with the curriculum development and implementation?

   (b) if you do identify problems, how might they be overcome?

5. How could the course be evaluated?

6. What aspects of your plans could you start to implement next Monday?

GROUP E - Leader - Dr A G Craig - Advisor in Health Education. The National Society for Epilepsy.

Teams from
South East Thames Health Authority
National Society for Epilepsy
London Boroughs Disability Resource Team

1/2 There will be a need for considerable professional attention to the curricula. and awareness and empathy essential if you are going to introduce this. Must look at how we value other people. colleagues and clients.

Place a proper value on the involvement of disabled people. be critical about how we gain students empathy - is putting a student into a chair to learn how a person with a disability copes. the best way?

3/4 You need to set up a network of people.
Identify disabled participants, to do this you need to know where disabled people are.

Shift through network to find out how and what needs to be done.
If you pay for a service you need to indicate what is best to give you what you want.

Design a learning experience which you evaluate frequently. do not just plonk someone in situation. you need to work out the support group, the nurse tutor cannot just set up and run the courses.
You need professionals to support you to get the course going.
Convince those in control that it is a good scheme. it is innovatory; very effective cost wise; better use of resources.
You must keep the experience fresh. evaluation will help you to do this.

6 Next Monday - look at ways of developing networks with colleagues. and identify disabled people to help.

GROUP B - Leader - Professor T E Oppe. Department of Paediatrics, St. Mary's Hospital Medical School.

Teams from
South Manchester Health Authority
St. Mary's Hospital Medical School, London

1 Introduction of a positive concept of DISABILITY into professional CURRICULA.

CON Possibility of too great emphasis on SICKNESS model rather than HEALTH model.
Emphasis on Positive aspects of DISABILITY may diminish importance of PREVENTION.
Emphasis on the 'DISABLED' may segregate persons with disabilities from the so-called normal population.

PRO Advantages of FORMAL introduction into curricula include:-

a) reaches all professionals
b) will be taken seriously and
c) will be incorporated into assessment/ examination procedures.

2(a) We accept the value of multi-disciplinary TEAMS in the provision of services for the disabled so long as:-

a) the team acts as a resource rather than a means of intervention.
b) the team focusses on the NEEDS of the disabled person.
c) the team helps the disabled person to identify what help to ask for.

(b) Given acceptance of the service value of a multi-disciplinary team we are of the opinion that a multi-disciplinary APPROACH to training and education may well be appropriate and beneficial.

3 We reject the notion of a 'multi-disciplinary course'or indeed any single 'COURSE'. We believe that the concept of disability should be integrated in and threaded through the curriculum at each stage.

We approve the Manchester approach.
Establishing a multi-disciplinary group that reviews the content of each professional group's curriculum with the aim:-

i) definition of objectives.
ii) organising a conceptual framework.
iii)looking at opportunities for shared learning and
iv) acts as a resource group.

3(a) Members of such a group would be drawn from:-

i) health and social services professionals (medicine, nursing. remedial. speech therapy, social workers).
ii) disabled persons.
iii)educationist.

3(b) Secondments or co-options as necessary, e.g. from transport. works department, architects. etc.

4 We prefer the concept of a 'planned programme' rather than a course. Components of the programme might take place during basic training. intermediate training. advanced training and as part of continuing education.

Mention was made of distance learning; 'attachment' to a disabled person; the Open University as possible items.

Emphasis is placed on the necessity for the programme to be:-

i) organised and co-ordinated by the designated group which must be readily identifiable and adequately resourced.
ii) planned and implemented in accordance with good educational practice (including when necessary the training of teachers).

(a) We prefer to see difficulties as 'challenges' rather than as 'problems'. These may include:-

i) curricula: need to fit in with the demands of professional Examining Boards. finding space in the curriculum; agreement over objectives; professional amour propre and inertia.
ii) resources:-
  a) accommodation group must have a base.
  b) financial - possible scope for Joint Funding; need to pay adequately for the time of teachers particularly the disabled persons; payments for attendance at courses. individuals. employing authorities etc. (special problems with multi-disciplinary courses).
  Role of voluntary organisations, N.H.S.T.A. etc.
iii) Support from central government, colleges, professional organisations. universities.

5 Evaluation: Good educational principles should apply; general feeling that questions about disability should be included in examinations. Need to test knowledge, skills and attitudes; both in the 'core' concepts of disability and in the particular competencies relevant to each profession.

6 Manchester - will carry on its good work.
St. Mary's. London - will try to initiate a 'core' multi-disciplinary group.

GROUP A - Leader - Miss R Barnitt. Head, Department of Occupational Therapy. Liverpool Institute of Higher Education.

Teams from
Liverpool - Liverpool Institute of Higher Education. Depts of General Practice and Community Medicine. University of Liverpool. Salford College of Technology.
Department of Health and Social Security. London

1 Concept of ability/disability should pervade all education of health professions.
It should be <u>health</u> as well as ill health related.

Health Profession ← <u>equal partnership</u> → Consumers

DISABILITY within the medical model inappropriate.

Social/psychological needs/knowledge should pervade all education.
Attitudes/values/etc.
Communication not dealt with as a separate item.
Examined - part of a validated course.

Mental illness
Confused elderly
Mental handicap

2 Inter-disciplinary help professionals but ? client.

NO WE ARE NOT CONVINCED — dilution of responsibility
advantages limited to the professional?

PROFESSIONALS FEEL HELPLESS — admit don't know
COMMON AREA WITH CLIENTS — resource people

Recruit 50% of 'disabled' people on each professional course.

3 Can't answer (YET).

4 Ditto.

5 Did not get this far.

6 a Practice manager set up meeting of all concerned parties. Evaluate contribution of disabled people to course - by selves.

b How to implement disability awareness within the medical school/ health visitor.

c set up forum of inter-professional people.

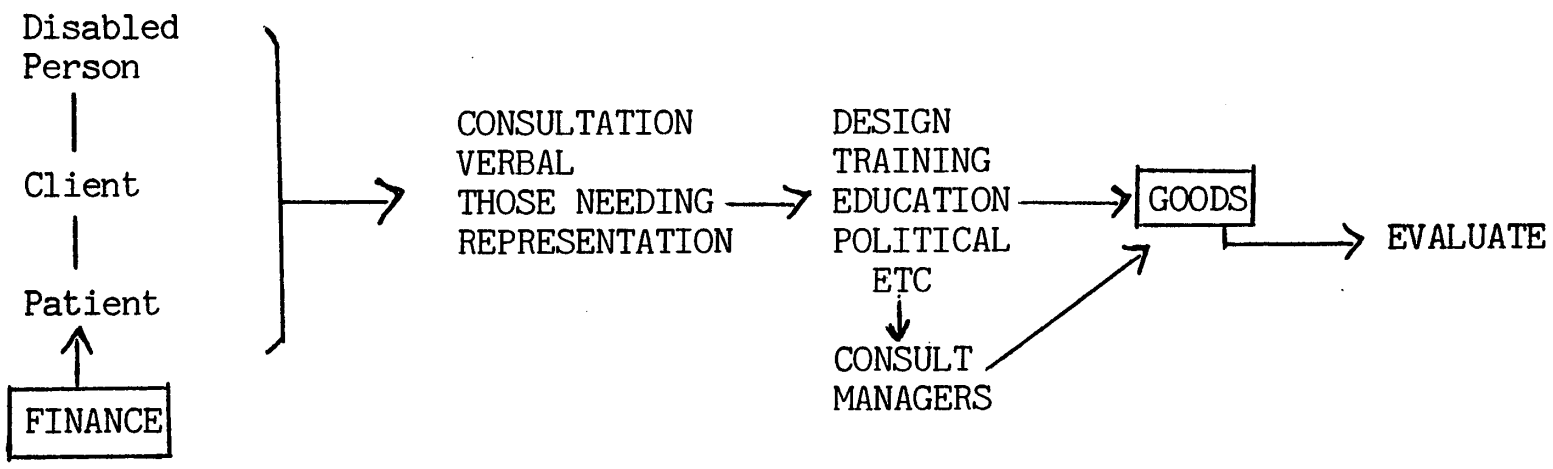
d interviews with consumers.

e planning post graduate course - training people together cross professional boundaries.

f meet with other paramedicals to develop plans for integrated courses.

g improve short course for trainers in chronic impairment.

HOW TO TACKLE IT?



GROUP D - Leader - Mrs M Ellis. District Occupational Therapist. The London Hospital

Teams from
University of Glasgow
Middlesex Hospital Medical School. London
English National Board of Nursing
Prince of Wales' Advisory Group on Disability
Individual professionals from London

1 General Points

Total disability field must be considered. not all disabled wheelchair users!

Each individual's needs should be considered separately
Attitudes and awareness
Time needed to deal with individuals

Positive discrimination TOWARDS disability

CONS Potential downgrading of professional status
Costs money
Takes time

2 We believe in concept
Collaboration essential across professions

Education (of the consumer
(by the consumer

Foundation course

Attitudes (to disability
(communication skills

Part of qualifying process for all professions

3(a) PEOPLE PRESENT + others e.g. Speech therapists
social workers
general managers
architects

(b) New Students

Joint committee for professional groups; + disabled people + disabled professionals

Qualified workers

Educational committees in District and NHSTA
Joint committee for professional groups
General managers

Disabled people

(c) Have to be at all stages

Planning, implementation
Teaching + evaluation

(d) Anywhere from King's Fund down.

4(á) PERSUADE consumers
statutory bodies
financiers
politicians
decision makers

(b) INCENTIVES - merit awards
general managers awards

SANCTIONS

HEALTH AUTHORITIES) schemes for
) positive encouragement
GOVERNMENT DEPTS) to develop collaboration

5 Part of the examination system of each profession
Quality assurance

6 Small local initiatives are possible
Some influences with our own professional bodies
King's Fund could enable us to return to plan foundation course content we have described.

GROUP C - Leader - Miss G Harris, Director of Nurse Education, Gwent Health Authority

Teams from
Welsh Office, Cardiff
Welsh National Board for Nursing
Lewisham and North Southwark Health Authority

Many of the points discussed had already been made by other groups. The group wanted a common foundation course for all professionals around disability issues. They had also discussed who should be contributing to the course, they included carers as well as disabled people.

Multi-disciplinary experience in Wales at University Hospital of Wales. Problems with role definition and disparity in paramedics supervisory status and academic year compared with student nurses continuing 3 year programme in modules. Difficult to match time scale and experience. Disadvantaged nurses!

Specific initiatives were being undertaken by members of this group -

1 The Prince of Wales Advisory Group initiatives have been taken up by the CANO's in Wales and each Health Authority is taking different initiatives this is regularly monitored by the CANO's and CNO.

2 Mentally Handicapped - Welsh National Board and CCETSW have a joint course for nurses and social workers.

ACTION

Publicise the outcome of the Welsh initiatives on the Prince of Wales Advisory Group with nursing.

Set up a seminar on an All Wales basis as a multi-disciplinary forum for discussion. awareness sessions and where are we now? sessions.

In Lewisham and North Southwark they are already well ahead with a multi-disciplinary programme and will contrive to develop and publicise this initiative.

GROUP LECTURE THEATRE - Leader - Dr M Oliver. Senior Lecturer. Special Needs. Thames Polytechnic

Teams from
St Bartholomew's Hospital. London
Royal Hospital & Home. Putney
Thames Polytechnic. London

1(a) Meaning of disability
- establish meanings
- common beliefs/values
- discussion at different levels

issues - stem from 2 views
- the individual respondent
- how society is organised

- consumer of health services
member of society

relationship of disabled person to professionals. professional services should be open honest relationship. NOT paternalistic

conflict of professionals trying to meet
- client needs
- professional code conduct
- org. goals

health - illness
able - disabled

(b) Disadvantage

CONS	PROS
encourage paternalism	meet need of one group of clients currently disadvantaged
time on the curriculum	partnerships

2 Multi-disciplinary approach - includes client/consumer in team - what is their role? Curriculum consultant. Single discipline approach.

(a) discussed what multi-disciplinary approach means and advantages. disadvantages.

(b) multi-disciplinary approach includes

PLANNING	- partnerships - consultancy role. tap experience of disabled people
NETWORK	- greater use of disabled groups
TEACHING	to train professionals (teach)
RESOURCES	- role of professions
ADVANTAGE	- utilise experience of disability more likely to meet needs - understanding and learning from other disciplines which has spin off e.g. training resources

3 Offer learning experience -

- basic - undergraduate) active understanding
) sensitivity
- post basic - graduate) update

CHAIRMAN'S SUMMING UP

In her summation Baroness Cox said that four very definite themes had been apparent to her throughout the day - identification. education. innovation and inspiration.

Identification - it was apparent that there was a need to identify those areas where there were serious shortcomings for this group.

Education - the disabled person must be included in the education process. This partnership with disabled people must be at the beginning of training before the defences go up. but also such involvement must be ongoing.

Innovation - the day had produced some very innovative approaches to involving disabled people in the training of professionals. These could be helpful to those looking for ways of creating partnerships with them.

Inspiration - information about courses. local and regional initiatives had come to light during the day. and this might be helpful to others who were considering what to do in their own settings.

Lastly she recognised that many professionals might be feeling humbled and a little uncomfortable at the end of a day that had looked at how well their training fitted them to care for one client group. She was certain it had helped them to understand a little better their own needs for professional support. She hoped that it might help professionals to be even more responsive and helpful.

WAYS FORWARD

It had been an extremely encouraging day ending with statements of intent. If anyone present. once they had had time to think on the days events. could see ways in which the issues could be taken forward. the Chairman knew that Diana Twitchin. Project Officer at the King's Fund Centre would be very interested in hearing from them.

Diana Twitchin
March 1987

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APPENDIX II

INTEGRATING A POSITIVE CONCEPT OF HANDICAP (DISABILITY) INTO PROFESSIONAL CURRICULA

WEDNESDAY 10th DECEMBER. 1986

PROGRAMME

Chairman - Baroness Cox of Queensbury

10.00 Coffee and Registration

10.30 Welcome, Setting the Scene - James P Smith, FRCN, Assistant Director, King's Fund Centre

10.40 Chairman's Introduction

10.50 Why we need to integrate a positive concept of disability into professional curricula

Professional view - Professor Ian McColl, Director of Surgery. Guy's Hospital

Client view - Kath Sells, SRN RNT. Freelance lecturer in disability awareness

11.20 The Value of The Multi-Disciplinary Approach to Training

To the Professional - Avis Hutt, Nursing Consultant

To the Client - Dr M J Oliver, Senior Lecturer in Special Needs. Thames Polytechnic

11.50 Workshop Group Discussion

12.45 LUNCH

2.00 Workshop Group Discussion (continued)

3.00 TEA (during Tea, rapporteurs will meet in Discussion Room A with Baroness Cox)

3.30 Where Do We Go From Here?

Plenary session - groups report back

4.15 Chairman's summation

APPENDIX III

PARTICIPANTS

Liverpool		
Miss R E BARNITT	Head of Department. OT	Liverpool Institute of H.E.
Dr J HEYES	Trainer	Liverpool
Dr R M HUSSEY	Lecturer in Community Health	Liverpool University
Dr C PARTRIDGE	Head of Physio Research Unit	University of London. King's College
Dr M A PEARSON	Lecturer in Medical Sociology	Dept. of GP. University of Liverpool
Miss M WILLSON	Deputy Head of Department OT	Salford College of Technology
Department of Health and Social Security		
Mrs E GROVE	Occupational Therapy Officer	Physical Handicap Team
Miss B JARMAN	Nursing Officer	Physical Handicap Team
Miss B SUTCLIFFE	Physiotherapist	Physical Handicap Team
South Manchester Health Authority		
Mrs J BOLTON	Sister. Young Disabled Unit	Withington Hospital. Manchester
Miss P R DUFFY	RGN Student Manager	School of Nursing
Miss A GRANTHAM	Senior Nurse Manager	Department of Continuing Education
Mr A MAIN	Director of Nurse Education	School of Nursing
Dr P SEED	Sen. Clin. Medical Officer	Community Health Services
Miss P M WOOD	Prin. School of Physiotherapy	South Manchester
St. Mary's Hospital Medical School		
Mr S J HOLDER	Director of Nurse Education	St. Mary's School of Nursing
Miss D KEATING	Superintendent Paediatric Physiotherapist	Paddington Green Childrens Hospital
Professor T E OPPE	Department of Paediatrics	St. Mary's Hospital
Dr D SMYTHE	Consultant Community Paediatrician	Paddington Green Childrens Hospital
Mrs A HUTT	Nursing Consultant	London
Welsh Office. Cardiff		
Mrs J BEESE	District Nurse Tutor	Department of Nursing Studies. Welsh National School of Medicine
Mrs K DELPAK	Supt. Physiotherapist	Rookwood Hospital. Cardiff
Miss N FRASER	Principal Welsh School OT	University Hospital of Wales
Dr M HALL	Consultant Physician	Caerphilly Miners Hospital
Miss G HARRIS	Director of Nurse Education	Gwent Health Authority
Dr F LEWIS	Senior Medical Officer	Welsh Office. Cardiff
Welsh National Board		
Dr D KEYSER	Professional Officer	Welsh National Board
Lewisham & North Southwark Health Authority		
Mrs EELES	Assistant Director Nurse Education Head of Post Basic and Continuing Education	Thomas Guy and Lewisham School of Nursing
Professor I McCOLL	Director of Surgery	Guy's Hospital
University of Glasgow		
Dr J S BRYDEN	Comm. Medicine Specialist	Southern General Hospital
The Middlesex Hospital Medical School		
Miss S RUMNEY	Divisional Nursing Officer	Local & Community Services
Dr M SHIPLEY	Consultant Rheumatologist	Middlesex Hospital

London		
Ms I BROMLEY	Physiotherapist	London
London Hospital		
Mrs M ELLIS	District OT	London Hospital
English National Board of Nursing		
Mrs F GRAY	Education Officer	Health Visiting
Mr T VIGOR	Education Officer	Mental Handicap
Prince of Wales' Advisory Group on Disability		
Mrs N ROBERTSON	Director	London
South East Thames Health Authority		
Miss B CLAGUE	Head of Department	Bromley College of Technology
Mr J MANSELL	Lecturer in Mental Handicap	The University. Canterbury
Mr P SILLS	Director	London Boroughs Training Committee
Miss J SMITH	Regional Nurse	SETRHA
National Society for Epilepsy		
Dr A G CRAIG	Principal Administrator Adviser in Health Education	Royal College of Nursing National Society for Epilepsy
Ms H SLAVIN	Senior Lecturer in Health Education	Department of Nursing & Community Health Studies. Polytechnic of South Bank
Mrs J WALDRON	Head of Nursing & Care Staff	National Society for Epilepsy
London Boroughs Disability Resource Team		
Ms J CAMPBELL	Borough Liaison Officer	London Boroughs Disability Resource Team
Ms P ROCK	Head of Research & Information	London Boroughs Disability Resource Team
Royal Hospital & Home. Putney		
Miss J M CLARK	Senior Nurse Tutor	Royal Hospital & Home
Mr A DOWELL	Principal Therapy Officer	Royal Hospital & Home
Dr M TUDOR	Principal Medical Officer	Royal Hospital & Home
Dr J WEDGWOOD	Medical Director	Royal Hospital & Home
St. Bartholomew's		
Ms S P DOCKING	Director of Nurse Education	St. Bartholomew's School of Nursing
Professor L H REES	Sub Dean	Medical College
Thames Polytechnic		
Dr M OLIVER	Senior Lecturer	Special Needs
King's Fund Centre		
Miss H O ALLEN	Associate Director	Education and Training
Mr J P SMITH	Assistant Director	Long Term & Community Care Team
Mrs D TWITCHIN	Project Officer	Physical Handicap. Long Term & Community Care Team