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# General practitioners' attitudes to patients who have learning disabilities

F. GILL,[1] B. STENFERT KROESE AND J. ROSE

*From the School of Psychology, University of Birmingham*

## ABSTRACT

**Background.** Previous research suggests that the inadequate primary health care received by people with learning disabilities may be the result of general practitioners' (GPs) negative attitudes. Few studies have investigated the evidence for this assumption. This study uses psychological theory to inform an investigation of the attitudes and emotions experienced by GPs when working with learning disabled patients, as assessed by reliable and valid measures.

**Method.** A questionnaire comprising an attitude measure and emotion measure was developed and tested for reliability and validity. This was mailed out to a total of 613 GPs registered with three Health Authorities, 310 questionnaires (51%) were returned.

**Results.** GP respondents held positive attitudes to working with patients who have learning disabilities. However, they were less positive about adapting their behaviour. Attitudes varied according to respondents' age and frequency of professional contact with this patient group. There was a strong association between attitudes and emotional experience. Attitudes were unaffected by learning disability training and non-professional contact.

**Conclusions.** Negative perceptions about working with patients with learning disabilities do not fully explain the inadequate healthcare provided to this group. Other factors may include insufficient awareness of the benefits of adapting the format of a consultation, and the quality of the interface between the GP and the carer accompanying the patient.

## INTRODUCTION

It has long been reported by researchers in the UK and Australia that the primary health care needs of people with a learning disability are not being met adequately (Howells, 1986; Howells & Barker, 1990; Wilson & Haire, 1990; Welsh Health Planning Forum, 1992; Department of Health, 1995, 1998; Kerr *et al.* 1996*a*; Whitfield *et al.* 1996; Band, 1998). To investigate this, a number of studies have surveyed health care professionals, particularly general practitioners (GPs), about their experiences and beliefs concerning the provision of primary health care to this group (Kerr *et al.* 1996*b*; Bond *et al.* 1997; Lennox *et al.* 1997; Singh, 1997; Stanley, 1998; Stein, 2000). GP respondents have identified various factors that impede the delivery of primary health care to patients who have a learning disability (e.g. insufficient training, service constraints and communication difficulties).

In addition to these reported barriers, researchers also have reported the role of psychological processes in the delivery of health care to this client group. The most frequently cited causal factor concerns the perceptions that a health professional may hold about a patient who has a learning disability. More specifically, negative GP attitudes towards people who have learning disabilities are said to explain the inadequate health care provision to this patient group. For example, Howells (1986) asserts, '… among doctors there are widespread prejudices and low expectations regarding mentally

[1] Address for correspondence: Dr Fiona Gill, Solihull Primary Care NHS Trust, 5/6 Downing Close, Knowle, Solihull B93 0QA.



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handicapped people' (p. 452). Scott & Rutledge (1997) take this suggestion further by stating: '… physicians' negative attitudes may detrimentally affect the delivery and outcomes of medical services and may influence the beliefs and attitudes of others who assist in this health care' (p. 246). These statements propose that negative attitudes somehow prevent the delivery of health care, though the exact nature of this process is not explained.

Specific suggestions of how attitudes may influence health care provision are offered by several researchers. Day & Jancar (1994), in their review of work exploring the mental and physical health care needs of older people with a learning disability, describe a possible reluctance among doctors to provide medical treatments to this group of patients because they are perceived to be too difficult to manage. Furthermore, Bond *et al.* (1997) state that health care professionals may make inaccurate assumptions about the health-related behaviour of a learning disabled patient. For example, they may believe that people with learning disabilities do not smoke, drink, experience stress or have sexual relationships. Consequently, the patient may not receive relevant health checks or appropriate treatment based on their health needs. Similarly, Patel *et al.* (1993) and Beange *et al.* (1995) both suggest that inadequate health care is the result of 'diagnostic overshadowing', the tendency for clinicians to ascribe all abnormalities to one diagnosis, the person's learning disability.

Thus, it appears that researchers are suggesting that there is a link between a doctor's beliefs about a patient with a learning disability and the health service that the person receives. However, these proposals have not been discussed theoretically or explored empirically, using standardized measures of attitude. Without evidence to support these claims they remain hypotheses and have little use in guiding interventions to improve health care for this group.

To date, three studies have attempted to investigate the attitudes of practising GPs towards working with people who have a learning disability (Kerr *et al.* 1996 *b*; Bond *et al.* 1997; Stein, 2000). Findings from the three studies were similar in that GP respondents tended to agree that they were responsible for the medical care of people with learning disabilities in the community and felt confident about undertaking this work.

This research is valuable because it has explored the beliefs of those central to the provision of health care, the GPs (Kerr *et al.* 1996 *c*). However, neither of the measures used were investigated for reliability or validity. Without standardizing an assessment it is uncertain whether the items are consistently measuring one idea or indeed comprise an accurate evaluation of attitude at all. Furthermore, the authors do not refer to a theoretical framework that underpins the design of their attitude measures. In fact, it is difficult to differentiate between the items of these two 'attitude scales' and those used in measures designed by Lennox *et al.* (1997) and Stanley (1998), which claim to explore GPs' 'views' of working with patients who have a learning disability. It is essential to state whether a study is measuring a set of general beliefs, or specific evaluative beliefs that are clearly related to each other and so can be identified as comprising an attitude (Ajzen & Fishbein, 1980).

A review of literature on attitude theory from the field of social psychology illustrates a wealth of writing on attitude structure, formation, measurement and the relationship between attitude and behaviour. This study will use an empirically tested model of attitude to investigate whether the attitudes of health professionals towards working with people with learning disabilities influence the health care that is delivered.

The most sound research which has investigated the role of attitudes to predict behaviour within clinical practice is Fishbein & Ajzen's (1975) Theory of Reasoned Action (Tesser & Shaffer, 1990; Olson & Zanna, 1993). Fishbein and Ajzen define the term attitude to be: "… a person's evaluation of any psychological object or specific behaviour" (Ajzen & Fishbein, 1980, p. 27). Their theoretical model outlines a causal link between various cognitive and social processes and the resulting behaviour. One of the underlying cognitive factors is the person's attitude towards performing the behaviour. Recently this model has been developed into an Integrative Model of Behavioural Prediction (Fishbein, 1998) by including factors from other social psychological theories (see Fig. 1). This model will be used to guide an investigation of GPs' attitudes towards working with patients who have a learning disability.

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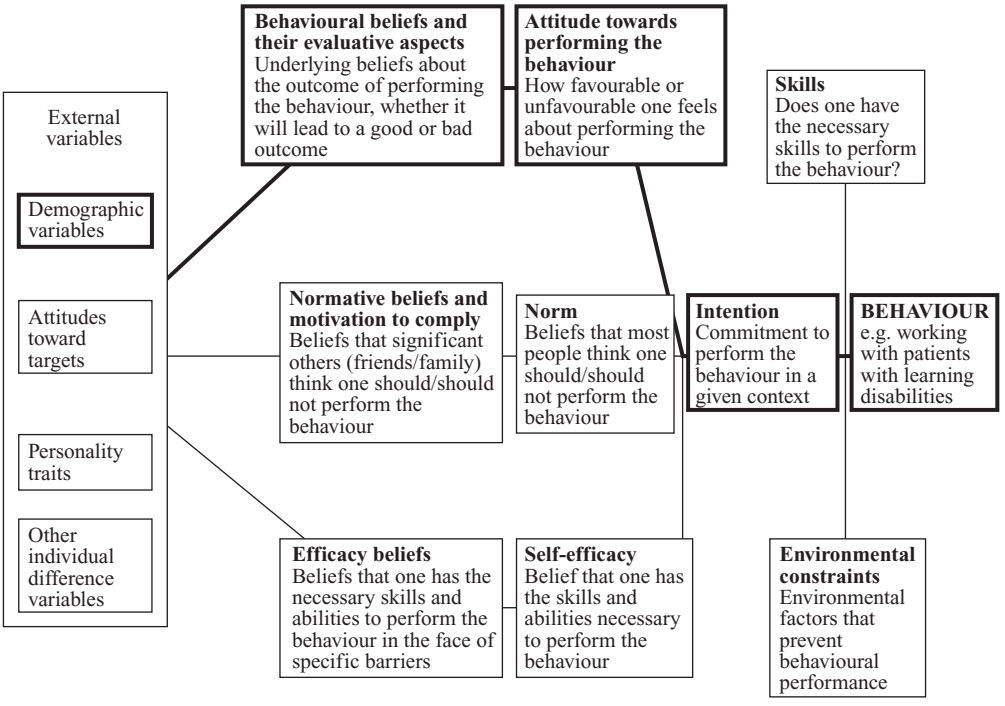



FIG. 1. An integrative model of behavioural prediction (from Fishbein, 1998, reprinted with permission from Elsevier Science: Oxford). (—, Particular focus for this study.)

In addition to attitude theory, this investigation will also be informed by a second psychological perspective that includes the role of emotional experience in understanding the relationship between cognitive processes and behaviour, i.e. Ellis's (1962) rational–emotive behaviour theory (REBT). REBT states that a person's thoughts, feelings and actions are best conceptualized as a set of interacting psychological processes (Dryden, 1996). Thus, when a person thinks about something (e.g. treating a patient who has a learning disability) they have a tendency to experience an emotional reaction and act in a certain way. Several researchers have used Ellis's (1962) REBT to underpin their work with care staff (e.g. Kushlick *et al.* 1997) and other studies have illustrated the role of emotional experience as influential in understanding staffs' behaviour (e.g. Bromley & Emerson, 1995; Dagnan *et al.* 1998; Mitchell & Hastings, 1998).

Fishbein's (1998) integrated model does not explicitly describe a role for emotions in predicting behaviour. Therefore, it is suggested that including a measure of emotional experience, will improve the understanding of GPs' behaviour obtained by measuring attitudes alone. The current study will utilize these two empirically tested theories to guide an investigation of GPs' attitudes and emotions associated with working with patients who have a learning disability. This will further the initial findings of Kerr *et al.* (1996*b*), Bond *et al.* (1997) and Stein (2000) and so assess: (1) what GPs' attitudes towards working with people with learning disabilities are; (2) whether GPs' attitudes vary according to their demographic characteristics, training received and contact with people with learning disabilities; and (3) whether GPs' attitudes relate to their emotional experience.

## METHOD

### Design

To test the hypotheses it was necessary to obtain information from a large, non-biased sample of GPs that was representative of the GP population as a whole. The use of a postal questionnaire (see measures) was the most appropriate research design to achieve these aims.

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## Participants

Questionnaires were mailed to all practising GPs registered with three Health Authorities (A, B and C) within the West Midlands. In total, 613 GPs were contacted: 249 GPs in Health Authority A, 286 GPs in Health Authority B and 78 GPs in Health Authority C. The response rate for the first mail-out was 38% (229 out of 610 returned), after excluding three retired GPs from the sample of 613. Seven questionnaires were returned incomplete by GPs who explained that they did not have enough time, or did not wish to complete the measure. After the second full mail-out, another 81 questionnaires were returned to produce a total return of 310 completed questionnaires (total response rate of 51%).

Responses were received from 226 (73%) male GPs, mean age 46·8 years (S.D. 9·05, range 30–68 years) and 84 (27%) female GPs, mean age 44·8 years (S.D. 9·52, range 28–68 years). The mean length of time that the respondents had been working as a GP was 15·57 years (S.D. 8·71, range 1–40 years). Respondents' characteristics accurately reflect those of the total GP population in England and Wales (see Royal College of General Practitioners, 1990). Further information regarding learning disability training received by participants and their contact with people with a learning disability in a professional and non-professional context is provided in Table 1.

Table 1. *Participants' training and contact with people with learning disabilities* (N = 310)

| GP variable | *N* (%) |
|---|---|
| Undergraduate training (h) | |
| None | 211 (65) |
| 1–10 | 87 (28) |
| ⩾11 | 12 (7) |
| Postgraduate training (h) | |
| None | 215 (69) |
| 1–10 | 66 (22) |
| ⩾11 | 29 (9) |
| Number of LD patients on caseload | |
| 0–5 | 61 (20) |
| 6–10 | 93 (30) |
| 11–15 | 58 (19) |
| ⩾16 | 98 (31) |
| Frequency of professional contact | |
| None | 6 (1·9) |
| <Once a month | 129 (41·6) |
| Monthly | 105 (33·9) |
| ⩾Weekly | 70 (22·6) |
| Frequency of non-professional contact | |
| None | 117 (37·7) |
| <Once a month | 138 (44·5) |
| Monthly | 24 (7·8) |
| ⩾Weekly | 31 (10) |

LD, Learning disability.

## Measures

### *Development of measures*

A questionnaire comprising two short scales (an attitude scale and a measure of emotional experience) plus a section concerning demographic information was developed to address the study's research aims. The scales were informed by psychological theory, relevant to the work of a GP and designed with consideration of factors that influence the participation of GPs in survey research (McAvoy & Kaner, 1996).

### *Attitude scale*

The attitude scale comprises 18 items worded into the form of an attitude statement (Azjen & Fishbein, 1980). Ten items are worded with a positive bias and eight with a negative bias. Each statement aims to explore how GPs evaluate their practice with patients who have a learning disability on a range of general and specific 'health care behaviours'. Participants are asked to express whether they perform each behaviour described, by rating the degree to which they agree or disagree with the attitude statement. This is completed by placing a single mark on a 5 cm visual analogue scale that ranges from 'agree' to 'disagree'. This scale has been successfully used in previous work (e.g. Kerr *et al.* 1996*b*) and allows respondents the freedom of placing their responses in any position, rather than being forced into categories (Loewenthal, 1996).

Results from a pilot study with 31 GPs indicated that with the amendment of three items, the attitude measure showed reasonable internal consistency (Cronbach's alpha = 0·72) and good test–re-test reliability (Pearson's $r = 0{\cdot}838$, $P < 0{\cdot}01$). The criterion validity was established by examining gender differences in the mean attitude scale scores for all participants in the pilot study (Hastings *et al.* 1998; Laking, 1988), see below (Attitudes and Participants' Gender).

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*Emotion scale*

The emotion scale assesses the experience of 12 different emotions considered as relevant to the experience of a GP working with a patient who has a learning disability (sad, hopeless, confident, nervous, relaxed, sympathetic, frustrated, optimistic, disgusted, awkward, incompetent and frightened). Participants are asked to rate the frequency with which they experienced each emotion by placing a single mark on a 5 cm visual analogue scale which ranged from 'always' to 'never'. These items were based on the outcome of recent empirical studies that have investigated care staffs' emotional reports of working with people who have a learning disability (Dagnan *et al*. 1998; Mitchell & Hastings, 1998). Emotion scales from these studies were shown to have high internal consistency (Cronbach's alpha $>0{\cdot}80$) and good test–re-test reliability (Pearson's $r>0{\cdot}70$).

Numerical scores for each item on the attitude measure and the emotion measure were derived by measuring the length of the visual analogue scale from the extreme left hand side to where the mark was made by the respondent. Scores for individual items ranged from 0–5, and some scores were reversed before data analysis so that high scores always indicated positive attitudes or a high occurrence of emotional experience.

### Procedure

Names and addresses of all GPs practising in the three Health Authorities were obtained directly from their GP registers. A pack containing a copy of the questionnaire, a covering letter and prepaid return envelope was posted to each GP. As all questionnaires were anonymous, a second mail-out of questionnaire packs with an updated covering letter was sent to all 610 GPs, 3 weeks after the first was originally posted.

## RESULTS

### Data analysis

To address the research aims, the analyses were completed in four stages. In the first stage, the reliability of the attitude and emotion measures were again explored by examining the existence of any independent subscales and ensuring that the items comprising any resultant scale were internally consistent. In Stage 2, a descriptive analysis of participants' attitude and emotion scale scores was completed. Stage 3 involved exploring first, how participant characteristics were associated with attitudes towards working with people who have a learning disability, and secondly, how attitudes varied between participants who had different characteristics (e.g. between genders, between participants who had received training and those who had not, and between those who had frequent contact with people with learning disabilities and those whose contact was infrequent). The fourth stage explored the association between participants' attitudes and their emotional experience of working with people with learning disabilities.

### Stage 1: data reduction

Further reliability analyses of the attitude and emotion scales were completed by first using a principal components factor analysis to reduce the data. This was computed according to the criteria given by Child (1970) and followed the procedure outlined by Rose (1999).

One significant factor was extracted from the attitude scale which accounted for 21·1% of the total variance and contained 11 items that had significant positive loadings. For each respondent a total 'general attitude scale' score was calculated by summing the scores of each individual item comprising the factor. The internal consistency of the 'general attitude' factor was acceptable (Cronbach's alpha $=0{\cdot}72$) and scores achieved were normally distributed.

One significant factor was extracted from the emotion scale. This accounted for 38% of the total variance and contained nine items that loaded significantly onto it. The value of each loading related to the emotion: positive emotions achieved significant loadings that were negative in value, and negative emotions achieved significant loadings that were positive in value. Therefore, the factor was named the 'negative emotion scale' and the scale scores for each respondent were calculated by summing the scores for each item shown to load on the factor (taking into account the direction of factor loading). The internal consistency of the 'negative emotion' factor was high (Cronbach's alpha $=$ $0{\cdot}85$) and scores achieved were normally distributed.

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Table 2. *Descriptive statistics for 'general attitude scale'*

| Scale items (abbreviated) | Mean score ($N=310$) | (S.D.) | Range |
|---|---|---|---|
| 8 LD people have right to receive primary health care* | 4·73 | (0·29) | 3·2–5·0 |
| 9 Important to see LD patients personally* | 4·51 | (0·66) | 0–5·0 |
| 10 Accepting LD patients on personal caseload | 4·13 | (1·18) | 0·1–5·0 |
| 13 Not much point in seeing LD patients | 4·40 | (0·63) | 0–5·0 |
| 16 Not possible to provide service to LD patients | 3·42 | (1·44) | 0–5·0 |
| 17 More useful to talk to the carer first | 2·95 | (1·57) | 0–5·0 |
| 18 Treating LD patients is part of GP's role* | 4·35 | (0·79) | 0–5·0 |
| 20 A LD patient does not experience discomfort | 4·20 | (1·08) | 0–5·0 |
| 21 Provision of health screening* | 4·41 | (0·81) | 0–5·0 |
| 23 Communicating with LD patient* | 3·64 | (1·23) | 0–5·0 |
| 24 Running over schedule* | 3·85 | (0·97) | 0–5·0 |
| 'General attitude scale' total | 44·61 | (5·85) | 25·1–54·7 |

All individual item scores could range from 0–5. A high score denotes a positive attitude; either agreeing with a positively biased statement (* item score was reversed) or disagreeing with a negatively biased statement. A low score denotes a negative attitude; either agreeing with a negatively biased statement or disagreeing with a positively biased statement.
LD, Learning disability.

Table 3. *Descriptive statistics for individual emotion items and total 'negative emotion scale'*

| Scale items (emotion) | Mean score ($N=310$) | (S.D.) | Range |
|---|---|---|---|
| 27 (hopeless) | 1·81 | (1·09) | 0–4·7 |
| 28 (confident) | 2·88 | (1·04) | 0·1–5·0 |
| 29 (nervous) | 1·57 | (1·11) | 0–4·5 |
| 30 (relaxed) | 2·98 | (1·10) | 0·3–5·0 |
| 32 (frustrated) | 2·31 | (1·18) | 0–4·7 |
| 33 (optimistic) | 2·48 | (0·97) | 0·4–5·0 |
| 35 (awkward) | 1·78 | (1·26) | 0–4·5 |
| 36 (incompetent) | 1·89 | (1·27) | 0–4·8 |
| 37 (frightened) | 0·99 | (0·90) | 0–4·9 |
| 'Negative emotion scale' total* | 17·02 | (6·75) | 0–36·8 |

All individual emotion scores could range from 0–5 (maximum possible range 0–45). All scores provided in the Table have been reversed such that a high score denotes a high occurrence of emotion and a low score denotes a low occurrence of emotion.
* The negative emotion scale score has been calculated according to the direction that the emotion loaded onto the emotion factor during factor analysis.

## Stage 2: descriptive analysis of attitude scale and emotion scale

The mean score and range of the individual items comprising the 'general attitude scale' are provided in Table 2. It can be seen from Table 2 that overall respondents had a positive attitude towards providing primary health care to people with a learning disability. The mean total scale score for respondents was 44·61, close to the maximum possible score of 55 for the scale.

The mean score and range for each item comprising the 'negative emotion scale' are provided in Table 3. It can be seen from Table 3 that overall respondents reported a low occurrence of negative emotions (lowest mean scores) and a moderate occurrence of positive emotions (moderate mean scores) associated with providing primary health care to people with a learning disability. Out of the negative emotions, frustration was the most frequently reported emotion (mean item score 2·31), and feeling frightened was the least frequently reported (mean item score 0·99). Out of the positive emotions, relaxation was the feeling most frequently reported (mean item score 2·98) and feeling optimistic was the least frequently reported (mean item score 2·48).

## Stage 3: factors affecting GP attitudes

### *Attitudes and participants' characteristics*

Pearson correlations were used to explore the relationships between the participant variables that were normally distributed (i.e. age and length of time working as a GP) with 'general attitude scale' score. There was a significant negative association between respondents' age and 'general attitude scale' score ($r=-0·301$, $P<0·01$). Similarly, there was a significant negative association between the length of time respondents had been working as a GP and 'general attitude scale' score ($r=-0·19$, $P<0·01$). These associations indicate the older GPs, and GPs who have been in practice longer have less positive attitudes than younger GPs, or those who have been practising for less time.

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Table 4. *Results of independent samples t tests between participants' characteristics and 'general attitude scale' scores*

| Participant characteristic | Levels of variable | *N* | Mean score | (S.D.) | *t* | df | *P* (two-tail) |
|---|---|---|---|---|---|---|---|
| Gender | Male | 217 | 44·05 | (5·98) | 2·75 | 299 | ** |
| | Female | 84 | 46·11 | (5·22) | | | |
| Number of ID patients | 0–5 | 58 | 43·73 | (5·71) | −2·60 | 151 | ** |
| | ⩾16 | 95 | 46·05 | (5·17) | | | |
| Training as undergraduate | 0 h | 194 | 44·37 | (5·86) | −0·96 | 297 | NS |
| | >0 h | 105 | 45·05 | (5·85) | | | |
| Training as postgraduate | 0 h | 209 | 44·75 | (5·86) | 0·64 | 297 | NS |
| | >0 h | 90 | 44·28 | (5·87) | | | |
| Frequency of professional contact | <Monthly | 130 | 44·07 | (5·46) | −2·56 | 196 | * |
| | Weekly | 68 | 46·18 | (5·59) | | | |
| Frequency of non-professional contact | None | 116 | 44·48 | (5·57) | −0·46 | 164 | NS |
| | At least monthly | 50 | 44·94 | (6·51) | | | |

Values for total *N* are less than 310 where data were missing.
* $P<0{\cdot}05$; ** $P<0{\cdot}01$; NS, not significant.

Independent *t* tests were used to explore the difference in attitude scale scores achieved by participants with different gender, training and contact characteristics. The results of these analyses are presented in Table 4.

### *Attitudes and participants' gender*

It can be seen from Table 4 that female respondents had significantly higher mean 'general attitude scale' scores than male respondents: $t(308)=2{\cdot}75$, $P<0{\cdot}01$.

### *Attitudes and training*

An independent *t* test showed that there were no significant differences between the mean 'general attitude scale' scores achieved by participants who had received some training in learning disability (either at an undergraduate level or postgraduate level) and those that had not received any training (see Table 4). Although training did not appear to affect attitudes (undergraduate, $t(297)=-0{\cdot}96$, NS; and postgraduate, $t(297)=0{\cdot}64$, NS) it was clear from the frequency of training reported that the majority of respondents had received very little training in learning disability.

### *Attitudes and contact*

The amount of contact respondents had with people who have a learning disability was measured from two different contexts, professional and non-professional. Contact within a professional context was explored in two ways, by asking respondents how many patients with a learning disability they had on their personal caseload and how frequently they saw people who have a learning disability in the surgery. It was predicted that respondents who had more frequent contact would have more positive attitudes about working with this client group.

An independent *t* test was used to compare the mean 'general attitude scale' score of respondents who reported having the least number of people with a learning disability on their personal caseload (0–5 patients) with the respondents who reported having the largest number (16 or more patients). It can be seen from Table 4 that respondents with the larger caseload achieved a significantly higher 'general attitude scale' scores than those with a smaller caseload, $t(151)=-2{\cdot}60$, $P=0{\cdot}01$.

In a similar way, the 'general attitude scale' scores of respondents who had the most frequent professional contact with patients who have a learning disability (weekly) were compared with the scores achieved by respondents who had the least frequent professional contact (less than once a month). From Table 4 it is evident that those respondents with the most frequent professional contact had significantly more positive attitudes than those with the least frequent professional contact, $t(196)=-2{\cdot}56$, $P<0{\cdot}05$.

There was no difference between the 'general attitude scale' scores achieved by respondents who had frequent contact with people who have learning disabilities (at least monthly) within a non-professional context and those who have

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no non-professional contact with this group, $t(164) = -0{\cdot}46$, NS.

### Stage 4: the relationship between participants' attitudes and their emotional experience

A significant negative association was found between respondents' 'general attitude scale' scores and their scores on the 'negative emotion scale' ($r = -0{\cdot}237$, $P < 0{\cdot}01$). This finding indicates that the higher the attitude scale score (more positive attitudes), the lower the negative emotion scale score (less negative emotion).

#### *Qualitative comments*

Ninety-nine (32%) out of the 310 GPs who returned questionnaires provided additional comments about their experiences of working with patients who have a learning disability in the open-ended section of the questionnaire. These comments were transcribed and grouped into nine themes: training, positive attitudes, negative attitudes, remuneration, emotional experience, consultation time, carers, communication and treatment difficulties. To illustrate the themes of 'positive attitudes', 'negative attitudes' and 'carers' two comments are provided as examples below. They will be explored in the discussion.

Example of a comment categorized as 'Positive Attitude':

'As a GP I see all who demand to be seen. You cannot start differentiating between groups of patients, learning difficulty or not. All patients are equal.' (Respondent 140).

Example of a comment categorized as 'Negative Attitude':

'… the unpalatable fact is that a subgroup with severe LD exists in which attempts to provide a primary care service along the lines of what is provided to patients of normal intellectual function are simply futile, and it is often inappropriate to do so … I am thinking particularly of a care home in my practice for adults with LD where it is more like veterinary medicine than general practice.' (Respondent 41).

Example of a comment categorized as 'Carer':

'My main frustration is that when such patients are not living in their own family they come to the surgery with a succession of different carers so continuity is difficult …' (Respondent 193).

## DISCUSSION

Attitude scale scores achieved by GP participants were high, indicating that they held positive attitudes towards providing primary health care to people with a learning disability. The range and distribution of individual scores indicated that this finding was not due to a ceiling effect in the attitude scale, as reported in previous attitude studies with health professionals (e.g. Beckwith & Matthews, 1995). Positive attitudes were also apparent in 9% of comments made in the open-ended section of the questionnaire.

Applying these general findings to Fishbein's (1998) model of behaviour prediction initially indicates that GPs' attitudes alone may not explain why the health needs of people with learning disabilities are not being met. However, it is recognized that Fishbein's model does not propose a direct relationship between attitudes and behaviour, other factors also play a role (e.g. normative and efficacy beliefs). Additionally, it is interesting to note that the individual items concerning attitudes towards specific behaviours necessary to improve health care for people with a learning disability (e.g. adapting communication, or allowing more time), although positive, achieved lower mean scores than items that explored more general beliefs about the provision of primary health care (e.g. belief that working with people with learning disabilities is part of a GPs' role). This suggests that participants believed in accepting learning disabled patients onto their caseload, but may be less willing to spend more time and/or develop their skills to meet individual needs. Again, this is a tentative suggestion but, if GPs do not facilitate the participation of their learning disabled patients, inaccurate diagnoses may result and potentially correctable health problems will not be identified.

Unfortunately, some comments made in the open-ended section of the questionnaire indicate that a minority of participants held negative attitudes towards providing health care to people with learning disabilities. Such comments partly confirm the suggestions made in previous work that some GPs hold negative attitudes (e.g. Howells, 1986; Day & Jancar, 1994). Using Fishbein's (1998) model, it could be predicted that the health care received by patients with

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severe learning disabilities on those GPs caseloads may not be adequate, though as already stated, other factors play a role in determining how a GP actually behaves.

Fishbein's (1998) model proposed that demographic factors are associated with attitudes towards performing a particular behaviour. Findings from this study showed that younger GPs had significantly more positive attitudes towards working with people with learning disabilities than older GPs. Age differences may reflect the significant changes in health and social care policy for the learning disabled population that have occurred in the UK over the past two decades. Younger GPs may have developed more positive beliefs about providing integrated services and so more positive attitudes. In addition, results indicated that female GPs had significantly more positive attitudes than male GPs. Such gender differences reflect findings from previous studies that have explored attitudes towards people with learning disabilities (Slevin, 1995; Hastings *et al.* 1998; Laking, 1988), although the reason for this is unclear.

It was hypothesized that GPs who had received more training in learning disability would have increased knowledge of the prevalence and nature of medical conditions associated with learning disability. Consequently, it was thought that these GPs would hold more positive attitudes regarding their role in health care provision, compared with GPs who had received little or no training. However, analysis indicated that there was no difference in attitude scores achieved by participants who had received some training and those who had not received any. This may be because few participants had received any more than a minimal amount of training (10 h). Participants' comments also illustrated dissatisfaction with the training received. More extensive skills based learning disability training for doctors has been recommended by several researchers as a means of improving the health status of this client group (Hollins, 1988).

Results showed that the amount of contact participants had with people with learning disabilities within a professional context, as measured by the size of their learning disability caseload and frequency of consultations, was an important factor in determining their attitudes. Respondents who had frequent contact and/or larger caseloads had significantly more positive attitudes towards working with this patient group. It may be that those who hold positive attitudes choose to accept more patients who have a learning disability onto their caseload, compared to their practice colleagues, and so see them more often. On the other hand, the presence of favourable attitudes may act as a means of motivating contact, as described in much of the attitude literature (see Olson & Zanna, 1993). Interestingly, the association between positive attitudes and more frequent contact was not evident within a non-professional context. This may be because a large majority of participants (approximately 70%) reported very infrequent informal contact with people who have learning disabilities.

Participants' emotional experience when working with people with a learning disability was related to their attitudes, such that the GPs who had the most positive attitudes also reported the least negative emotions. This accurately reflects the perspective provided by REBT (Ellis, 1962), which proposes that the emotional experience associated with a given behaviour (e.g. working with a person who has a learning disability) reflects beliefs about performing the behaviour. This emotional experience will in turn influence the development of future beliefs. From these findings it could be argued that adding an emotional component to Fishbein's (1998) model provides a more accurate prediction of a GPs' behaviour. Further investigation could test this suggestion by exploring the extent to which emotions mediate attitudes and intentions (e.g. using a path analysis).

The emotions most frequently reported by participants were feeling confident and relaxed, perhaps surprising given that they had received little learning disability training. Lennox *et al.* (1997) have suggested that such confidence may reflect the belief that the principles underlying medical care are universal across all people. Feelings of frustration and optimism were given similar ratings of moderate frequency. This indicates that although GPs hold generally positive attitudes they may still experience frustration and do not always feel optimistic about working with people with learning disabilities. Increased training to improve communication skills and the provision of longer appointment times could reduce this frustration and support GPs develop

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more accurate beliefs and increased optimism about providing health care to this patient group.

Some participants' used the 'comments' section of the questionnaire to report two other factors that reflected their experience of delivering health care to learning disabled patients. First, 22% of the comments given by respondents indicated strong statements about receiving remuneration for providing annual health checks to people with a learning disability (e.g. Kerr *et al.* 1996*b*; Lennox *et al.* 1997; Stein, 2000). Participants also queried the need to perform annual health checks and indicated that they were not aware of evidence for the efficacy of this.

In fact, recommendations for providing annual health checks to people with a learning disability without remuneration have been in place for 10 years (RCGP, 1990; Welsh Health Planning Forum, 1992) and have recently been reinforced in the UK through health documentation (Department of Health, 1998, 1999).

Secondly, several participants stated that the most efficient way of conducting a consultation was to ask carers to provide information, instead of the patient with the learning disability (e.g. Crocker *et al.* 1987). However, other respondents indicated that often carers were unable to provide the information that they required, forcing them to make diagnoses on little information (e.g. Howells, 1986; Wilson & Haire, 1990; Lennox *et al.* 1997). Seeking information from carers is understandable if the patient uses an idiosyncratic method of communicating (Prosser & Bromley, 1998). However, a reliance on information provided by carers alone has been shown to result in biased, and possibly inaccurate information (Gill, 2000). If GPs had skills in adapting their communication to allow patients with learning disabilities to participate more fully in consultations, fewer problems would be missed. For some patients who are unable to notice or communicate symptoms independently it would also be beneficial to teach carers how to assess their relative's health, and which symptoms and health checks they should be supporting if their relative has a particular health risk.

It is acknowledged that several limitations exist in the way that Fishbein's (1998) model was utilized in this investigation of GPs' attitudes. It is not appropriate to suggest a direct link from the attitude data obtained, to the practice provided by GPs. Fishbein's (1998) model proposes that other factors mediate behavioural performance (e.g. normative beliefs, efficacy beliefs or intentions) and these were not directly explored in this study. Further work should seek to measure all of these components, together with emotions, to obtain a better understanding of those that contribute most to GPs' behaviour. It is also acknowledged that the generalizability of the present study is somewhat limited. Despite the large number of questionnaires returned, this reflected a 51% response rate and there is little information concerning the GPs who chose not to respond. We assume that non-responders were less positive.

Findings from this study can be used to identify factors that may help improve the provision of health care to people with learning disabilities. Results support the proposal made by Hollins (1998) that harnessing the GPs with the most experience in providing health care to people with learning disabilities who also had the most positive attitudes could have a role in educating their practice colleagues. This could go hand in hand with the recent government White Paper, 'Valuing People' (Department of Health, 2001) which sets out plans for the development of a new 'health facilitator' role for members of the specialist Community Learning Disability Teams. The health facilitator will, '… help GPs and others in the primary care team to identify their patients with learning disabilities … and facilitate and advocate to ensure the person with the learning disability gains full access to the healthcare they need …' (p. 64). Furthermore, GPs must not be penalized for offering longer appointment slots for their learning disabled patients. With additional support for carers in recognizing symptoms and a specialist facilitator to support consultations, GPs may feel less frustrated and more optimistic about this clinical work, so ensuring that the health needs of people who have learning disabilities will be better met.

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