The doctor and the child with learning problems

Parents may go to their family doctor about a schoolchild with difficulties in academic progress, and school doctors and paediatricians may also be consulted about these children. Doctors in any of these three categories may feel some uncertainty and insecurity about how to handle the problem. They may suspect that this is unfamiliar territory for which their training and experience has not equipped them; that the subject of learning difficulties is diffuse and poorly understood and one on which published material is mostly too theoretical to be helpful; and that it is not clear whether clinicians should play any part in helping these children or whether their problems belong in the disciplines of education and psychology.

A child may have many reasons for performing less well at school than most of his peers. Firstly, the child may not have been receiving adequate education. This is usually due to social and cultural factors—the child is not regularly at school or the parents do not stimulate and encourage his educational progress—and is common enough, but the parents will not usually be sufficiently concerned to seek medical advice. Less commonly the child may be missing school because of chronic or repeated illness. When this appears to be the case, however, the doctor should ask whether the child really needs to be away from school as much as he is: such children are often showing a masked form of “school phobia.”¹

The second major category includes the neurological and psychological causes of school backwardness—intellectual retardation (usually recognised before school age but not always accepted by parents), disorders of vision or hearing, specific motor abnormalities such as ataxia or clumsiness interfering with writing and drawing, specific learning difficulties such as dyslexia or specific reading retardation, learning problems associated with epilepsy and its treatment, and emotional causes.²⁻⁵

What place does the doctor have in helping these children and their parents? They will naturally turn firstly to the general practitioner if they do seek medical advice. At the outset he must ensure that the parents understand that the problem is primarily educational and that the solution must be in the school setting. Parents may be looking for a

“medical model” in which a diagnosis will lead to some quick and easy solution—for example, by drugs or diet.⁶ The general practitioner should discover whether the parents have discussed the child’s progress with the school, whether the school agrees that there is a problem, and whether the school has referred the child to the educational psychologist, who will certainly need to participate in planning help. (If the child is in a private school the local educational psychologist can still often be very helpful, but a referral to a private psychologist may be necessary and should again be done in cooperation with the school.)

The general practitioner may decide at this point to refer the child. Alternatively, because of his knowledge of the family background he may wish to find out more about the problem himself, but this will be time consuming. The first part of a further assessment is the history. Points of particular importance are a family history of speech delay or learning problems, the child’s birth history, early development with special reference to speech (early speech delay and later learning difficulties are strongly linked^{7,8}), and the history of his schooling from the start—whether it has been frequently interrupted by changes of school or absence, and when there was first concern about his progress. Such a history will often give a good indication of which of the causes listed above is the most probable. The physical examination is generally much less informative, but it is important for the doctor to check vision and hearing and to exclude obvious disorders of growth and development and medical or neurological disorders. He should not waste time on “soft neurological signs” or arcane matters such as uncertainties of cerebral dominance. Finally, he can speak to the head teacher (with the parents’ permission) to hear the school’s observations on the child and his problems. Looking at the child’s work books often discloses much about the child’s difficulties.

At this point (or at an earlier point if he does not want to take things this far himself) the general practitioner has two possible courses over referral if he believes there is a genuine problem. If the child has normal vision and hearing, no physical or neurological abnormality, and has not been assessed by the educational psychologist, the doctor should

press for this to be done. The educational psychologist will assess the child's intelligence and reading ability, discover any specific learning difficulties, and advise on remedial help. If, on the other hand, the history or examination turns up important medical problems (for example, important neonatal problems or epilepsy) or physical signs of possible importance, or if the child has already seen the educational psychologist but continues to cause concern, the appropriate referral is to a paediatric neurologist (if there is one) or to a paediatrician in a child development centre—or at least with an interest in school problems. The assessment they do will be on much the same lines as recommended above, but the additional resources of the consultant should include the ability to give a specialist opinion on possible paediatric and neurological problems, liaison with a psychologist, and sometimes a speech therapist and occupational therapist who can help in the assessment and occasionally the treatment. The consultant will also have facilities for carrying out special investigations in the very rare instances where these are called for in children with learning problems.

When all has been said and done over the assessment of the child, practical help usually boils down to remedial teaching. The efficacy of remedial teaching has been questioned in long term epidemiological studies,^{9,10} but my experience of individual children suggests that it does help if given by an interested and enthusiastic teacher working one to one or with a small group of children. Management is not, therefore, primarily medical, and drugs such as stimulants for the hyperactive child or antidepressants for the depressed one have only a marginal role in a small minority.

What, therefore, does the doctor bring? Firstly, he may help in diagnostic assessment, mainly because of his skills in history taking—thinking about causation is part of his normal way of working. Secondly, he may act effectively as an advocate for the child—with schools or education authorities—and ensure that he gets the help he needs.

The school doctor may seem to have been left out of the procedure I have described, but in fact the best arrangement would normally be for the school (with the parents' approval) to refer the child who has learning problems to the school doctor and the educational psychologist, who would jointly carry out the assessment. Only the more difficult ones would require paediatric referral. Certainly both assessment and management should ideally be carried out as close, both geographically and professionally, to the child's school as is possible. Referral to distant paediatricians and treatment in remedial units far from school are to be discouraged except as a last resort.

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Epilepsy and the law

In February 1983 the House of Lords, considering the case of *Regina v Sullivan*, upheld the Court of Appeal's ruling that epilepsy is a disease of the mind. Someone who commits a criminal act, however trivial, during or in the aftermath of an epileptic fit, must plead insane automatism with consequent mandatory referral to a hospital for treatment. Sullivan, a middle aged man with epilepsy, had assaulted a neighbour in a confusional state following an epileptic fit.

The implications of this ruling—that people with epilepsy are legally insane during a fit—led to a one day conference on epilepsy and the law sponsored by Labaz:Sanofi and held at the Royal College of Physicians of London on 18 June. Here 250 consultant psychiatrists, neurologists, and others with a special interest in epilepsy discussed the issues with two specific aims in mind: to consider whether a change in the law is desirable and if so how it should be changed.

Disease of the mind, like an elephant, is something the law believes it can recognise even if it cannot define. Mr Lionel Swift, QC, who took Sullivan's case to the House of Lords, pointed out that it was up to the medical profession to agree a definition of disease of the mind if the legal profession was to accept it.

Much of the morning session, introduced by Pamela Taylor, was taken up with the quest for a definition of disease of the mind which would satisfy all the physiological, psychological, and even philosophical criteria demanded of it. How much does duration matter and how much severity? Is the issue purely one of cerebral dysfunction and are we bound to fail if we try to define it within a Cartesian framework? It became evident that time spent trying to redefine disease of the mind was likely to prove unprofitable, though there was general agreement that the present distinction between insane and sane automatisms was untenable. The conference ended the day with rather more sympathy for the legal concept of insanity, which is concerned less with levels of consciousness than with the view of the "reasonable man"—does the accused act as though he is out of his mind?

More fruitful was discussion on the practical disadvantages of the law as it stands. These are, firstly, that a compulsory hospital order is for some people inadvisable and for others unnecessary, both in terms of deprivation of liberty and because they are already receiving adequate medical treatment. Many present thought that the law should be changed as regards disposal after a special verdict and that the discretionary powers of the judiciary should be widened so that they ranged from simple acquittal to referral to a special hospital. Many delegates, too, were attracted to the idea of a two stage trial, in which the first stage dealt only with establishing whose hand committed an act, leaving questions of culpability, mitigating circumstances, and disposal to be dealt with separately at a second stage.

Secondly, a verdict of insanity has social consequences. However it is defined, insanity is an emotive word, and the social stigma attached to it is real. Alec Aspinall of the British Epilepsy Association reminded the conference that however small the number of Sullivans to whom the law has to be applied many more people have epilepsy or relatives with epilepsy and are aware of the ruling and dislike and fear its implications. The necessity for a special verdict which would avoid the labelling of people with epilepsy as insane was commented on by the Law Lords at appeal, and the conference suggested that pleas of not guilty by reason of abnormality of mind, or by reason of epileptic automatism,

¹ Waller D, Eisenberg L. School refusal in childhood—a psychiatric-paediatric perspective. In: Hersov L, Berg I, eds. *Out of school*. Chichester: Wiley, 1980:209-29.

² Critchley M. *The dyslexic child*. 2nd ed. London: Heinemann, 1970.

³ Rutter M, Yule W. The concept of specific reading retardation. *J Child Psychol Psychiatry* 1975;16:181-97.

⁴ Stores G. School children with epilepsy at risk for learning and behaviour problems. *Dev Med Child Neurol* 1978;20:502-8.

⁵ Rutter M. Emotional disorder and educational underachievement. *Arch Dis Child* 1974;49:249-56.

⁶ Taylor E. Diet and behaviour. *Arch Dis Child* 1984;59:97-8.

⁷ Robinson RJ. The child who is slow to talk. *Br Med J* 1982;285:671-72.

⁸ Silva PA, McGee R, Williams SM. Developmental language delay from three to seven years and its significance for low intelligence and reading difficulties at age seven. *Dev Med Child Neurol* 1983;26:783-93.

⁹ Yule W. Issues and problems in remedial education. *Dev Med Child Neurol* 1976;18:674-82.

¹⁰ Hewison J. The current status of remedial intervention for children with reading problems. *Dev Med Child Neurol* 1982;24:183-93.