

absorb and successfully apply the new investments in the *NHS Plan*.

So how can politicians, managers, and clinicians generate the social capital needed to sustain the NHS? Firstly, they must understand the nature and importance of social capital that holds organisations together. In the absence of trust and mutual obligation staff become mired in mistrust and self preservation, while the organisation declines. Communities and organisations with high levels of social capital work more productively and cooperatively than those with low levels—and are also healthier.⁷

Secondly, managers need to understand why the NHS's social capital has been eroded. Organisational and management structures grounded in market economics have undermined the community's sense of shared ownership. A hospital centrally positioned 20 miles from the surrounding towns may make exquisite economic sense but ignores the social capital.

The social responsibility of doctors, nurses, and other staff—their professionalism—is devalued by focusing primarily on economic and performance accountability. Though performance management is important, it should be treated as a learning rather than a policing tool. Of course, learning cannot be properly organised when there are chronic staff shortages—low human capital.

Thirdly, politicians and managers must rethink organisational roles, nurturing the principle of subsidiarity.⁸ Decision making should be located as closely as possible to the place where actions are taken. The performance of organisations is most effectively governed

when subsidiarity is applied,⁹ and we hope that this will be a key conclusion of the new chief executive's review of the working of the Department of Health.

The three strands of capital—physical, human, and social—must be braided together to make the NHS responsive and sustainable. In particular, all the elements in the NHS that erode the store of social capital must be replaced. Acute and primary care trusts, hospitals, and general practices need to be empowered by the NHS and to engage with and become closer to the communities they serve. If this is achieved the day could return when the NHS is a central but quiet element of our social success.

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Disability discrimination

The UK's act requires health services to remove barriers to access and participation

Discrimination on grounds of race and gender is increasingly acknowledged in medicine,^{1 2} but equal attention has not been given to disability discrimination. Will this change now that the General Medical Council is being taken to a tribunal by a prospective medical student who is disabled?³ Ironically, education is exempt from the section (part III) of the United Kingdom's Disability Discrimination Act on provision of goods and services that has recently become enforceable. But the act must be taken seriously by the NHS and other organisations that provide services to the public.

The prospective student had been offered a place at medical school, but modifications were needed so she could complete the course. The GMC stated that it "could not in law agree an alternative curriculum which covers a lesser order of knowledge and skill," but an employment tribunal said this position showed a lack of appreciation of the possible modifications that could be made.⁴ The tribunal also ruled that the GMC was a trade organisation and therefore not exempt from the act.⁴ The GMC has appealed against the ruling in order to establish this point of law.⁵

Although transport and education are exempt from part III of the Disability Discrimination Act 1995,⁶ health services are not. To comply with legislation, pro-

viders such as the NHS must make "reasonable adjustments" to ensure that disabled people can use their services.^{6 7} Thus they must "provide an auxiliary aid or service"—for example, information in large print; "change a policy, practice or procedure"—ensure that receptionists approach deaf patients directly when it's their turn to see the doctor; or "find an alternative method to make services available"—provide a domiciliary service to wheelchair users if the surgery has stepped access. By 2004 providers must have "removed, altered or provided reasonable means of avoiding physical features that make it impossible or difficult for disabled people to use a service."⁶

There are two broad perspectives on disability—the medical and the social models. Crudely, the medical model holds that individuals' impairments are the problem, while the social model locates disability in society rather than in individuals.^{8 9} Though the Disability Discrimination Act defines disability primarily in line with the medical model, its concept of making "reasonable adjustments" does in practice shift the focus towards dismantling the disabling barriers in society.

Disabled people in Liverpool have provided examples of the sorts of barriers that exclude them from mainstream life.¹⁰ For example, on transport, "They think we have a little outing now and again or go to the

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hospital. They don't think we lead a full social life or even want to attempt to do so." On reliance on the use of print, "I don't see why I should have to have other people read my bills or letters." Deaf women have described difficulties in using health services, such as communication problems in opticians' and dentists' surgeries and in x ray departments, where rooms are dark, eyes are covered, or the staff are behind screens.¹¹

Addressing disability from the civil rights and social model perspectives is consistent with the public health approach of achieving improved health through organised efforts of society. Many disabled people are systematically excluded from aspects of life known to promote good health, such as education, employment, leisure, and exercise. But the disabling effects of society are not usually included in public health debates. A paper on the health implications of transport policies, for example, does not address the barriers disabled people face.¹² Travelling (to work, to the shops, for social events) is essential for full social inclusion. Walking and cycling are not options for everyone, and public transport is currently not fully accessible. This must be addressed when promoting healthy transport, or travel will become harder for disabled people, increasing their social exclusion.

Locating disability in society makes it easier to implement the Disability Discrimination Act because this approach avoids asking the wrong questions. Applying the medical model results in people being asked about their impairments. They respond by stating the name of their medical condition, but this says nothing about their barriers to access. Applying the social model results in questions about barriers, be these stairs, voice only telephones, or print.

Making services accessible means challenging the concept of what is normal and changing how services are provided. If organisations are to implement change successfully disabled people must contribute to its implementation⁷: they know best the barriers they face and can offer practical solutions.^{10 11} But barriers to full

participation must first be addressed. This means taking into account, for example, that some people use wheelchairs, some use visual languages, and some gain information from audiotape.

At a practical level, all health staff should know their responsibilities under the Disability Discrimination Act and understand the social model. Again, disabled people often identify inappropriate staff attitudes and behaviours as the biggest barrier to using health services.⁷ Can they be confident that they will be afforded equal access to health services if they are not also confident that the medical profession will not discriminate against them becoming doctors?

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One Bristol, but there could have been many

Radical change is essential but hard to achieve

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Some will read the well written report of the Bristol inquiry into children's heart surgery as a "whodunnit?"¹ The answer is that "the system done it," but various named individuals behaved dishonourably. Some have been struck off by the General Medical Council.² All will have paid a heavy price with sleepless nights. The report is primarily, as Ian Kennedy, the chairman, says in his introduction, a tragedy. A great many well intentioned people worked hard to do good but did dreadful harm. Over 30 children under 1 year died unnecessarily, the report concludes.³ Many more were severely injured.

The most chilling thought in the report is that there could have been 50, perhaps 500, even 5000 similar reports about other parts of the NHS. The ingredients that led to the excess deaths in Bristol occur throughout the NHS. The report emphasises not only that the NHS had no system for monitoring quality and no reliable

data but also there was no agreement on what constituted quality. "Thus the most essential tool in achieving, sustaining, and improving quality of care for the patient was lacking ... clinicians had to satisfy only *themselves* [the report's italics] that the service was of sufficient quality."

Bristol (and we must accept, as does the inquiry, that Bristol has become a noun that denotes not just a city but also a medical tragedy) came to public attention because there were some data and people concerned to make a fuss. We might have read a report on excess deaths in a general medical unit in Barchester or wholly inadequate psychiatric care in Slagthorpe, but we won't because there were no data, nobody made a fuss, and the bodies are lost. It took decades to spot that Harold Shipman, a general practitioner near Manchester, had become Britain's most prolific serial killer, murdering perhaps 400 of his patients.⁴ The

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