

LETTER TO THE EDITOR

Dear Sir,

I read with interest Dr. Sykes' contribution to "Point of View" in the last issue of the Journal. He seems, of course, to be taking up a position about midway along the continuum between the "avant-garde" and the "reactionary" views on the role of the psychiatrist in mental handicap. However, in stressing the more negative aspect of the influence of the psychiatrist in hospital, he does less than justice to his own considerable contributions as Medical Director and Consultant Psychiatrist at Northgate Hospital and elsewhere.

Nevertheless, many of his observations and suggestions are worthy of study. Few would argue with his views that purely "medical" and "psychiatric" input, in a strictly limited sense, may not be the most important contribution to the care of the individual mentally handicapped and, indeed, probably a fair number of psychiatrists would agree that "social" or, better, an "educational" model is perhaps more appropriate for many handicapped people's lives. (I wonder if anyone has thought of better terms than these—perhaps something related to handicapped people being living, feeling human beings, instead of being used as professional battlefield decked up with respectable "scientific" jargon.) Perhaps it is well to remember a well-established sub-section of psychiatry known as "social" psychiatry (cf. "social" psychology, "social" education, "social" medicine, "social" science—all equally respectable or disreputable). Perhaps here is an alternative area for the psychiatrist to operate within, as opposed to, or in addition to, the more clinical field proposed by Dr. Sykes.

Whilst agreeing with him that a doctor cannot hope to be an "expert" in mental handicap, paediatrics, genetic counselling and forensic psychiatry, all at the same time, by the same token, neither can the paediatrician necessarily be an "expert" in child psychiatry, genetics, etc., etc., or the psychologist in all the variations of his speciality; even the brave new world of the generic social worker already is showing deep cracks. What these various professions do need is enough knowledge of the other aspects to be aware where their own "expertise" ends and others' begins. What many people, in decrying, diminishing or changing the role of the psychiatrist in mental handicap, have failed to do is to apply the equivalent criteria to the examination of other professions' roles. There is an illustration of this in the Editorial of the same issue of the Journal, in discussing the significance of the appointment of Professor Mittler as chairman of the National Development Group (an excellent choice, I believe), in relation to the role of a psychologist as a co-ordinator or manager in the service for the mentally handicapped.

From what I have said so far, it might be assumed that I am making a case for the status quo. This is not so. There are changes needed. Dr. Sykes is correct in saying that the Responsible Medical Officer's personal involvement with individual residents may be very small in many instances. This might not always be due to the fact that he has no contribution to make, but also that he is expected to take responsibility for hundreds of patients, and time just does not allow the kind of involvement necessary to be really effective. I would therefore go along with his suggestion that the psychiatrist ought to have a more intensive commitment to a smaller number of patients, including work with families. This is in fact what has probably happened in a number of hospitals, with the R.M.O. working mainly in, for instance, assessment of children, forensic work, family therapy or research, whilst maintaining an overall responsibility for a larger group in the hospital and presumably having an influence, good or bad, upon their care.

What concerns me somewhat, however, is the fact that with the discharge of the more able residents and the population becoming smaller but more behaviourally disturbed, or more frequently doubly handicapped, the reduction of the medical component might leave a severe gap in the service—a “baby and bathwater” situation.

One sees evidence of this danger already, because, as the community and family work increasingly draws the psychiatrist out of the hospital, inevitably he has less time to devote to the increasingly severe problems of the residents. This means that the medical and psychiatric care will be left in the hands of junior staff and general practitioners. The latter, understandably, have their main allegiance and interest in their own practice, and the former do not get the support and training they need, thereby lowering the standard of future Consultants. This, in itself, is not an argument for retaining responsibility for very large numbers of patients but does, I believe, illustrate a pitfall to be avoided.

I would also agree that for many psychiatrists a joint appointment in another psychiatric sub-specialty would be attractive and, maybe, help staffing, although I am also not sure of the latter point. I am also not certain that Dr. Sykes' (or Sir George Godber's) view that the difference in numbers of out-patients attending general psychiatrists and those attending specialists in mental subnormality necessarily reflects badly on the latter, is correct. Dr. Sykes, like most of us doing our training in general psychiatry, must have found that the conditions in hectic out-patients' clinics were not exactly conducive to good psychiatric practice.

Once again, I feel this shows that there is often more than one way of interpreting observed facts.

One final point which Dr. Sykes mentioned, and I would like to stress even more strongly, is that if there is a further shift to community and family work, away from institutional practice, it is essential that there is still ready access to in-patient and day facilities, under the control of the psychiatric team, for the admission, observation and treatment of the mentally handicapped children and adults with a wide range of problems. Without such back-up facilities, fully successful out-patient care and community support would be difficult, if not impossible, to provide.

Yours faithfully,

B. E. OLIVER,
Consultant Psychiatrist.

Chelmsley Hospital,
Marston Green,
Birmingham B37 7HL.