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## EDITORIAL

It is one of the most deflating, disconcerting, humiliating and worrying experiences for most people, whatever their profession, when, after a lapse of years, they are faced with their past prognoses and decisions, which subsequent events have proved quite wrong. Whatever excuses are put forward – a lower level of professional knowledge so many years ago, different prevalent concepts, a complete change of circumstances no one could have foreseen, etc. – nagging doubts remain that misjudgments could have had quite serious, substantial consequences. This is, of course, a situation well-known to every professional person, whether a doctor, an engineer, the pilot of an aeroplane, the general of an army, who must frequently make quick decisions based on their knowledge and experience, and, lets face it, on the hope of being lucky. And it is always expected that instances of faulty prognoses are outweighed by correct ones and decision makers are more often right than wrong. Moreover, as it is, these miserable soul searching post mortem experiences do not occur all that often and in the majority of events decisions are made, the rightness or wrongness of which can not be checked and must remain the subject of controversy and speculation for years afterwards.

We, working in the field of mental handicap, are very fortunate in respect of our decision making and recommendations to be made. There is scarcely ever an occasion when circumstances force us to make snap decisions on vital matters – on the contrary, there is, as a rule, plenty of time to think it over. Seldom is there a situation elsewhere with a more favourable combination of experience and knowledge available for a decision making process. In the institution, for example, an adult m.h. person is known to the small team of experts over often many years. There are the consultant psychiatrists, highly qualified persons with expert knowledge of the specialised area of mental handicap, and a practically daily occasion to observe their individual patients over a number of years – a rather unique situation which gives them opportunities for making professional judgments based on their scientific knowledge and close acquaintance with the patients – a situation which is denied to their colleagues outside the institutional laboratory set. There are also the qualified nurses, who, though they may not possess the wide psychiatric knowledge of the doctor, have nevertheless long years of specialised experience with a focused interest in their patients through lengthy daily contact with them. The nurses' practical knowledge of individual patients rivals that of the doctors and must be taken into consideration whenever a prognosis is made, a decision arrived at. Indeed one can not imagine a better combination of circumstances where professional expertise, professional experience, an intimate knowledge of a "patient" and his behaviour, give a small number of professionals a unique opportunity for forming considered opinions without pressure of time or situation enforcing quick decisions. In these circumstances one would expect a high degree

of unanimity in judgments and prognoses in the majority of cases even though there will be a few exceptions where individual professional judgments deviate from the majority opinion.

These opinions matter — and they matter very much in mental handicap, because the m.h. individual is generally unlikely to participate constructively in decisions concerning him, and he is, therefore, very much at the mercy of the experts. There is, for example, nowadays a queue in hospital for taking up those few precious places in community group-homes, etc. for which there is strong and successful competition from people admitted directly from their parental homes. Who are the most acceptable candidates of the hospital population for these group homes? Who are the most "deserving" ones? Who will benefit the most? Who, indeed, could be looked after by non-hospital staff? These are not difficult questions on which agreement could not be reached by the combined expertise of the professionals concerned, and experience shows that usually a consensus is fairly easily obtained. Yet, one must not be complaisant when observing a satisfactory general trend and therefore disregard alarming exceptions.

What repercussion on the future of individual residents of a particular hospital has, for example, the fact that one body of responsible professionals regards 45% of this hospital population as capable of living outside the hospital, whilst the other body of professionals considers only 3% of the same population as capable of living outside? 1) Irrespective of the correctness or incorrectness of these prognoses, the existence of such divergent attitudes, based on the same facts and experiences, makes one realise even more that vital decisions are not necessarily the outcome of a careful weighing of the evidence, but are often determined by other factors which must require a thorough investigation.

Take another example: Hospitals X and Y are two medium sized hospitals. Hospital X has fewer highly dependent residents or people whose behaviour is characterised as "difficult" and has also more relatively able people than Hospital Y. In this hospital only 3% of the people were perceived as capable of living elsewhere. Yet the other hospital Y which had reported 30% difficult behaviour cases and 53% "low ability" people (in contrast to 11% difficult and 37% "low ability" people in Hospital X) considered 83% of its residents capable of living elsewhere.

Inconsistencies of this kind — which are, of course, not always so extreme and obvious — must worry us as a profession. Wrong prognoses by one person are worrying enough, but a consistent tendency by a whole body of professionals of being wrong — after all one or the other has to be wrong — must be even more disturbing because it seems to defeat the multidisciplinary safety procedure. These inconsistencies may be due to the inability of a team of professionals to perceive any better "treatment" (in its widest sense) elsewhere than they are offering themselves — then it is time for them to learn that the world has moved forward since they entered the profession. Inconsistencies may also be due to some professional pessimism and scepticism which makes them expect very little from people in their care — then it is time they are made to find out about developing potentials in people with a handicap.

Considering only 3% of a hospital population as being able to be transplanted to other than hospital conditions, could not be regarded as an overcautious

1) This and the following example have been taken from: *The Balance of Care for Adults with a Mental Handicap in Scotland* by Nicki Baker and James Urquhart. Published by ISD, Edinburgh 1987 (see Book Reviews).

Continued on page 149