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Correspondence

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FACT AND FICTION IN THE CARE OF THE MENTALLY HANDICAPPED

DEAR SIR,

Dr Shapiro's historical account is both elegant and illuminating. But if history teaches us anything, it is not that the solutions of the past were best, but rather that we need not be bound by the solutions we have inherited. If 'community care' in the past was inadequate, this is not to say that it will always be so, given the proper planning and development of services. If the institutions, in their day, offered a service guided by enlightened concepts, this is not to say that institutional care is now appropriate. It is perhaps salutary to note that these same concepts were guiding a service which has thrown up what Dr Shapiro euphemistically calls the 'painful occurrences' at Ely, Farleigh, etc. The gap between the 'concepts' of great consultants and the realities of service provision—care on the wards—has grown too wide.

In the latter part of his paper there is an argument for medical specialization which few could deny. For too long there has been a failure to recognize the special medical and psychiatric needs of many mentally handicapped people. But Dr Shapiro makes an illogical step from the issue of specialization to that of the control of services. He over-stresses these special physical and psychiatric needs, and understates the importance of purely social care. He argues that the medical specialist is uniquely able to perform the role of co-ordinator of the team of specialists, though his unique qualifications for co-ordinating the work of teachers, social workers, psychologists and others are not specified. By a trick of definition, social psychiatry becomes '. . . the adjustment of the total individual to his emotional and social environment'. I imagine the definition would just as easily fit the specialisms of nurses, teachers, social workers, psychologists and others, all of whose work is devalued by Dr Shapiro's argument.

His concern with *control* becomes at times almost obsessive, with mention of assuming '. . . total control of the patient', and the '. . . total management of a patient in relation to his environment'. But his case for the medical specialist assuming this control, this paramount position, is neither clearly nor convincingly presented.

Professionalism is a sentiment which can inspire the highest standards of service and care. But it has another face, which can become a narrow, jealous concern with the privileges, status and rewards of an occupational group. It would be a pity if consultants, and nurses too, allowed this kind of sentiment to cloud their judgement. Services should be planned around the needs of clients, not the career prospects of professionals. The needs of the mentally handicapped can only be met by services which are truly interdisciplinary in character. Medical specialists are a vital part of any caring team—but contributions from nurses, social workers, teachers, psychologists and parents are just as vital. Historically, medical men have not been accustomed to assuming such a role, but it is to be hoped that they will accept the challenge rather than cry for a return to the old ways.

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DEAR SIR,

It is very nice to be able to welcome Dr Forrest (*Journal*, August 1975, 127, p 190) to the increasing number of professionals who believe that the hospital service for the mentally handicapped has become a casualty of the reorganization of the NHS, and that some unification of the service, whatever its disadvantage in 'isolating' this group from other handicapping conditions, should be considered at this stage. This is a realistic view and it has my support.

However, this does not seem to me necessarily to support the views of Dr Shapiro (*Journal*, September 1974, 125, p 286) or to condemn those of Dr Kushlick and his colleagues (*Journal*, May 1975, 126, p 487). Dr Shapiro appears to promote a medically-orientated comprehensive service in which large hospitals continue as the basis for a psychiatrically-orientated service. This seems also to have been the style, if not