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Part I.—Original Articles

"PSYCHIATRY LTD."*

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I AM satisfied one of the results, if not the objective, of medical education is for doctors to judge their success, or the state of progress of any branch of medicine, against a pathological rather than a sociological criterion. This is the inevitable effect of the amount of time and attention given to pathology in the medical curriculum, and is further reinforced by what is asked in examinations.

Traditionally, the problem for the doctor is to try to determine the pathological lesion, using this term at best in a wide sense, and to control this if he can ; and the pathological criterion of disease he has in mind is an objective physical criterion, demonstrable in life or after death.

As we all know, no pathological lesion in this traditional sense is demonstrable in a large number of patients who go, or are brought, to see doctors. All physical examinations and investigations prove negative. Medicine is therefore faced with the dilemma in these cases of either (*a*) coming to the conclusion that there is nothing wrong, which is often clearly untenable, or (*b*) of expanding its scope almost indefinitely to cover every type of maladjustment.

What I am mainly concerned with in this address is where it may be prudent to call a halt in an expansionist campaign, with special reference to psychiatry.

Expansionist claims are widespread and have authoritarian backing. For example, Dr. Brock Chisholm, Director-General of the World Health Organization, has written : " Perhaps there has never been in all history a more authoritative definition of any word than that provided for the title of this chapter." (It is entitled " Health.") " In a historic document, The Constitution of the World Health Organization, sixty-four nations have decided just what the word ' health ' meant. The first statement of principle in that Constitution is the definition of health in these uncompromising terms : ' Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.' Here (adds Dr. Brock Chisholm) is one word concerning the exact meaning of which dictionaries will not have to worry from now on."

The worrying thing about this definition of health to doctors, if not to dictionaries, is that the logical implication of not being healthy is that you are ill ; and it would be a poor psychologist who did not realize that the average man in the street believes that if he is ill he needs treatment, and moreover, that he equates illness with irresponsibility or at least diminished responsibility, and since nobody is in a " state of complete physical, mental and social well-being," everybody is sick.

Dr. Brock Chisholm goes further. He writes of " The acute need of the modern world that modern psychological medicine shall expand its goals beyond the mere helping of individuals. . . . Practitioners of psychological medicine must now advance much further into the preventive field and concern themselves with positive mental and social health, which means that their chief concern should now become the prevention of mental and social disability rather than just its treatment." Later in the same chapter he writes : " Natu-

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rally parents, educators, youth workers, social workers, politicians and many others have very important responsibilities, but the technical guidance can come only from the students of human mental and emotional development and function "— or in brief, from psychiatrists. In psychiatry, too, you will not be surprised to hear, lies the best hope of resolving international tensions and so preventing war. The great need is that everybody should reach " emotional maturity free from neurotic drives." How this desirable objective is to be brought about is only sketched in outline, but " amongst factors that commonly tend to slow, to distort and to prevent satisfactory social development " Dr. Brock Chisholm lists : " 6. Teaching children to believe in the reality of fantasies such as fairies and Santa Claus . . ."

You may recall that in " The Importance of being Earnest " Gwendolen says to Cecily : " On an occasion of this kind it becomes more than a moral duty to speak one's mind. It becomes a pleasure." And Cecily replies : " This is no time for wearing the shallow mask of manners. When I see a spade I call it a spade." Fortified by this precedent, when I see bosh I call it bosh.

It will be observed that according to the Director-General of the World Health Organization—and he is not alone—the proper sphere of psychiatry is very wide indeed and extends far beyond the mere helping of individuals ; it would seem to involve world reform. All this is put forward, not as a vague aspiration for the future, but as something to which the " technical guidance" of psychiatry can and should be applied now.

How then are these vast claims to be justified and on what is this technical guidance to be based ? It seems to me that the clue to the answer is sought and given in terms of psychopathology of an analytic type. Excluding the bigger questions of international tensions and the like and turning to the mere individual, neither patients nor doctors are likely long to be content with the bare assurance that a departure from complete physical, mental and social well-being spells sickness ; they will want to know the cause—the pathology ; and when no pathological lesion in the traditional sense is forthcoming, the cause or pathology is sought and found in terms of psychopathology.

Now as I see it, the difficulties about psychopathology as a cause and criterion of sickness are : (1) psychopathology is not objectively demonstrable ; and if objection is taken to this statement, it is at least true to say that it is not obectively demonstrable in the same way as traditional pathology ; and (2) in the " psychopathological " there is much that is not abnormal. No clearly cut dividing lines can, of course, be drawn between the normal and abnormal in many fields ; but with psychopathology the dividing line from allegedly normal psychology seems to be particularly fuzzy. For example, I have served on committees concerned with medical education in psychiatry. It is usually advocated in such committees that medical students should receive instruction in normal psychology in their preclinical period. Leaving aside the distressing differences that are apparent as to what this instruction should be, it has been my experience that my more analytically minded confrères have advocated instruction in what they claim to be the normal phases of sexual development in childhood, more or less directly derived from Freud. If, in fact, the Oedipus situation is a normal phase of development, the persistence of a mother-fixation becomes less convincing as an explanation and excuse for anti-social behaviour in later life ; and if the criterion for abnormality is quantitative, how is this to be measured, except in terms of the anti-social behaviour itself ?

You may think this mother-fixation example an extravagant one, but I have met with it and in circumstances that were irritating at the time. I am sure many of you could cap it with others, as I could too. The case I have in mind was a naval officer recalled early in the war who soon got into disciplinary difficulties from drinking too much. Invaliding and exculpation were advocated by a psychiatrist (not a naval psychiatrist), on mother-fixation grounds, and a report of this kind took some explaining away to the surgeon rear-admiral, who regarded it as just the sort of nonsense psychiatrists are apt to think and to write. " There would be no end to it if this went through " was what he said with the best, but firm, service manners.

I submit that just as general physicians and surgeons tend to be too exclusively concerned with pathological questions (hence " social medicine " ?), so psychiatrists tend to be too exclusively concerned with psychopathological questions. The

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dangers of the latter preoccupation are greater; for whereas the demonstration of a pathological lesion in the traditional sense is, on the whole, good evidence of disease, the demonstration of a psychopathology is not necessarily so, unless we wish to extend the term "disease" to include everybody; for in a sense we all have a psychopathology.

I would further submit that this preoccupation with psychopathological criteria, rather than, as I would wish to see, with clinical and prognostic criteria, is one of the reasons why psychiatric claims have got out of hand. It is not easy to prove or disprove a psychopathological interpretation, whereas a prognosis can be shown much more readily to be right or wrong.

Crime and Criminal Responsibility.

Some of the points and the difficulties I have in mind may be illustrated by medical and psychiatric claims in the fields of crime and criminal responsibility.

I think, in general, medical claims are as follows. The first claim seems an eminently reasonable one, namely that the sick should be regarded as medical responsibilities. The second is that sickness implies irresponsibility, or at least diminished responsibility. And the third claim is that the criterion of sickness is the demonstration of a pathology.

I have been involved in two murder cases that showed, as I thought very strikingly, how deeply rooted these conceptions are in medical thought. The first case had a typically epileptic spike and wave E.E.G., and the second an E.E.G. which was suggestive of a localized brain lesion. The first man had no history of epileptic fits, and his crimes disclosed very clearly a capacity for rapid adaptation to altering circumstances and other features that were not consistent with epileptic confusion or automatism; whereas the second man showed no organic mental changes and at the autopsy no evidence of a cerebral lesion was found. Nevertheless it was argued, with considerable feeling, that the demonstration in both cases of a "brain pathology" should have modified the operation of the law, which was the death sentence; in fact both men were hanged.

Now I am not concerned here as to whether the death penalty should or should not be abolished; personally I think I would like to see it go. Consider the practical consequences if the discovery of pathological findings such as these men showed, which could not be directly related to their criminal acts, necessarily conferred immunity from the legal consequence of crime. That this happened to be the death penalty in these two cases is irrelevant. For if immunity is conferred, preventive steps should be taken—in the same way that epileptics are now prevented from holding a driving licence. Could it seriously be proposed that the possessors of an abnormal E.E.G. should be prevented from entering into business contracts or partnerships or in other ways be deprived of their civil rights? If we did not do this, would we not be making the possession of an abnormal E.E.G. a criminal asset?

Thus, the question of criminal responsibility raises many difficulties even when there is a pathology for which objective evidence can be offered. The difficulties are greater in those cases where no organic pathology is demonstrable. It may be recalled that according to the World Health Organization definition of health—"positive health"—all criminals lacking, as they must, complete social well-being are necessarily sick. Crime, according to this view, must be a manifestation of disease, and the treatment of disease, so the argument runs, is a job for the doctor. Further, since we all have a psychopathology, this can always be adduced to back up the thesis that the criminal is a sick man, as in the case of the naval officer whom it was claimed was suffering from a mother-fixation.

I fear that comparable psychiatric evidence is too commonly given in the courts, as any barrister will be pleased to tell you, and I believe it does psychiatry a lot of harm; for the judiciary echo my surgeon rear-admiral's "There will no end to it if this goes through."

Working Capacity.

Expansionist dangers can also, I think, be seen in connection with the assessment of working capacity. For example, in so far as the doctrine of positive health spreads, inefficiency, like crime, is necessarily rather than possibly a medical

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problem, and, in so far as this is accepted, the medical profession, and in particular psychiatry, will increasingly be asked to shoulder burdens I think they will be wise to repudiate.

The first illustration I have in mind shows how this is happening already. I would submit as a basic point that a man's efficiency must be assessed by his employer, his state of health by his doctor. I think it is absurd to suppose an inefficient man is necessarily sick. We all know, however, that in Government Departments, for example, it is extremely difficult to be sacked for inefficiency on executive grounds. Inefficients and ineffectives are consequently referred for medical disposal, but of course far more common is the problem of the man who claims he is unfit for work or for duty. It was a problem met with repeatedly in the services in the war, and is one still very much with us.

I think we should firmly face the obvious and make a stand. I am not suggesting that the decision should be taken lightly or without careful investigation, but I think we can and should say, when the occasion arises, that we can find no evidence of disease, or any reason why the man should be discharged on medical grounds (even if he is inefficient), or any medical reason why he should not work as the case may be.

The sensible view is surely that many individuals present social rather than medical problems, as in the case of the work-shy; and for these people responsibility should be shouldered by society rather than by medicine. In addition, there is a group of betwixt and between, such as certain psychopaths, where responsibility should be shouldered by both, and not by doctors alone. Is there not a real danger of falling into the fallacy that because a problem has psychiatric implications or aspects it should be regarded as a purely psychiatric affair? Apart from our ignorance as to what we could do, I do not see how many of these para-medical or para-psychiatric problems could be tackled without resort to compulsory powers; and since the exercise of compulsory powers interferes with the liberty of the subject, they should only be sanctioned by society as a whole, if sanctioned at all. In brief, as I see it, we should be reasonably strict in our standards as to what constitutes sickness and our job. The concept of positive health is either meaningless or has—as a recent government publication said in another connection—" unacceptable implications." Down with it! *Ecrasez l'infâme!*

Psychotherapy.

A " practical art " such as medicine may be judged by what it can do. What can we claim to do? Psychiatric treatment is not of course synonymous with analytic psychotherapy; and this is no place to discuss the value of psychiatric treatment as a whole. As mentioned previously, if you are told or believe you are sick, you expect to be treated; and increasing numbers expect to be treated by some lengthy form of psychotherapy or analysis. I believe quite unjustified expectations have got about. The following is a case in point: The patient " Elmer," an American, was brought reluctantly to my out-patients at St. George's by his girl friend. She at once explained to me that she was not his wife; that as a member of the communist party it was against her principles to be married, but she had a child by him. She was clad in what looked to the male eye like warp and woof and was shod in sandals. She had been a student at the London School of Economics. She said she had brought Elmer to see me since obviously he needed analysis. There must, she thought, be some fixation, since he seemed to lack literary inspiration and what he wrote was banal. It was curious, she added, since sexually he was quite potent.

Elmer, who must have been at least twenty years older than she was, had thick white (American) hair and looked like a bogus and embarrassed senator. It turned out that he had not worked for many years but had led a reasonably successful and not unhappy life living with and on various women. The price he had to pay for his latest venture (being an " artist " had always been his line) was to be placed in front of a typewriter each morning and urged to release his pent-up inspirations, but he found he had nothing to say. The allowance given to his girl friend by her parents had satisfied his material wants.

You will not be surprised that my attempted explanation to the girl that not everybody was born with creative literary gifts that could and should be released by psycho-analysis was countered by the questions: Did I not believe in psycho-

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analysis ? Did I not believe in psychotherapy ? If in fact Elmer had not creative literary gifts, what would I advise him to do ? There must surely be something he was best suited for ? What about vocational guidance ? What treatment would I prescribe ?

Ever since I can remember, or rather ever since I began to take an embryonic interest in psychological and psychiatric matters as an undergraduate at Cambridge, I have read repeatedly of the vistas opened by the light shed through the discoveries of Freud, of how psychology and psychiatry had become " dynamic," and of how treatment by psychotherapy had been revolutionized. One of the results of these repeated claims has been, I think, that the girl friend's psychotherapeutic hopes for Elmer are only an extreme example of widely held views, namely the belief that psychotherapy *should* be able to transform an individual's personality, and that there are no limits to people's potentialities when freed from the emotional ties and entanglements rooted in their childhood. The buried treasure school of psychopathology, the faith in the hidden complex which if unearthed leads to cure—or even transformation—is far from being dead and gone and is very much alive and kicking. Indeed I think that with only slight modification this is a view commonly held on psychiatry and psychotherapy, not only by the man in the street, but also by many of our medical colleagues as well.

No one I think doubts that psychotherapy can be of real value, but what are the claims that can be made for analytic psychotherapy ? As I see it, and as the majority of psychiatrists with whom I have worked or discussed the matter have seen it, prolonged psychotherapy or analysis is only called for, and is certainly only practicable, in a small minority of cases. I think we should say so, and say it loud and clear, for it is a quite different view to that which has so long been shouted in the public ear.

The position is that, happily, a very large number of patients get better without analysis, either with the aid of simpler measures—or other measures—or with no specialized aid at all. (When I once wrote a small paper mentioning this point I was, strangely enough, accused of pessimism.) There is another large group in which I believe the only sensible possibility is to try to get the patients to accept their limitations, with no hope of making them new men. I believe it is thoroughly bad mental hygiene and thoroughly bad psychotherapy to encourage the public or the patient to expect the probability of a transformation scene from psychotherapy or analysis. Indeed, the sad fact is that after all these years a convincing case for the special efficacy of analysis as opposed to other or simpler procedures has not been made out, or if it has I should like to know where. At the same time I personally believe that, although the majority of cases do not need it or do not benefit from it, a case for prolonged psychotherapy or analysis does exist in a small group—perhaps 3 per cent. of those seen by someone like myself. Treatment by psychotherapy is certainly more widely available ; this is an advance ; but are the results achieved by psychotherapy of any kind any better than they were thirty or forty or more years ago ? The results seem to me to depend so largely upon individual gifts, irrespective of schools and, within limits, irrespective of the procedures adopted, that I doubt it. Did Freud, for example, get better results than Forel ? Who now can claim better results than either ? Is not the answer that we do not know ?

I would submit that the reason for this astonishing state of affairs, namely that we still are waiting for evidence as to the special efficacy of analysis as a method of treatment, lies in the direction of interest of the analysts. This often does not seem to be clinical or prognostic so much as concerned solely with the psychopathology. I have tried to read some of the literature and I am sure many others have had the same experience as I have, namely that whilst interpretations abound, it is remarkably difficult or quite impossible to determine what was the patient's condition before, during or after treatment.

It is surely reasonable to want to know what were the disabilities the patient showed and whether the treatment did good and what good it did, in addition to interpretations of the dynamics of the situation in psychopathological terms. For example, in a recent discussion on the treatment of obsessional states at this Society, the two opening speakers gave no data about the results of treatment at all, but were exclusively concerned with psychopathological theories and problems. This would have been fair enough if the subject for discussion had been the psychopathology of obsessional states ; but it was not.

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I think these preoccupations with psychopathological rather than with clinical problems must be the explanation why publications concerning the results of psychotherapy should be so few in number and uninformative practically.

What then is the remedy ? I know that to advocate a clinical approach is apt to be regarded as a reactionary desire to return to the bad old days of descriptive psychiatry before our subject had become " dynamic " (a word that deserves to be paid over-time). I can however see no objection to it and many advantages ; and clinical psychiatry can be combined with a certain modicum of human understanding.

The main clinical problems are diagnostic, prognostic and therapeutic, and the three are of course intimately connected. Clinical studies are necessary for their solution. Who can doubt, for example, our ignorance of the natural history of many disease groups or the unsatisfactory state of many of our present clinical groupings ? To illustrate the first, or natural history problem, I have been struck by the fact that the majority of the severe obsessional states I have seen have been in the twenties or early thirties. I have seen fewer in the forties and fewer still in the fifties. What happens to severe obsessional states as they get older ? I have asked a number of experienced psychiatrists, and after humming and hawing they have in the end come clean and confessed that they did not really know.

The difficulties of clinical studies are obvious ; they flow inevitably from the nature of psychiatric disturbances, for however these may be mediated, they are manifest in disturbances of social effectiveness and social relationships. They cannot therefore be judged without taking social criteria into account. I cannot share the view that the lack of an objective criterion, such as may be said to obtain in traditional pathological studies, make the difficulties insuperable ; and as you will have gathered, I do not believe that pathology can be replaced by psychopathology for purposes of assessment ; the analogy is false. In any case, social questions can only be answered in social terms. I believe that the questions as to how the patient feels, what can he do and what do others think of him, lend themselves to more definite answers than can be described intelligibly.

Still, if we do not know as much about prognosis and treatment as we should like to know, the knowledge that is available is not inconsiderable.

Selection.

When anything goes there can be no limit to that expansionism in psychiatry which I feel to be so injudicious. I have tried to convey something of the undesirable implications of psychiatric attempts at dominance in the social fields of politics, criminal responsibility, and employment—attempts that seem buttressed by a false analogy between psychopathology and pathology, and are promoted by a sales technique that leads the public to unwarranted expectations of what we can give. I should like, however, to touch on just one more expansionist field, namely that often referred to as personnel selection.

There can of course be no doubt about the desirability of placing people in jobs best suited to their desire and capacity, even if there is a danger of this becoming regarded as a right. The last war showed a remarkable expansion in psychiatric selection, both in claims and in practice. But are we wise, as psychiatrists, to stake our claims as regards positive selection ? By which I mean, for example, the selection of good officers rather than the exclusion of those likely to break down ?

It seems to me that the difficulties in positive selection have been glossed over with special reference to (*a*) what we can claim to do and especially what we can claim to do in our *professional capacity*, and (*b*) professional confidence.

(*a*) The traditional medical role in selection has been one of exclusion. It has not, in the past, been the doctor's job to choose the football eleven, but merely to express his opinion as to whether a man was or was not fit to play. It is true that if a doctor happened to be an expert on football he might be elected a member of the selection committee, and he might even be the most valuable member of it ; but he would not have been chosen a member of the selection committee because he was a doctor.

It is important to distinguish what we are doing in our professional capacity and what we are not so doing. Now I might be able to choose officers better than Brigadier Blimp ; but if I could, I think it would be mistaken for me to suppose that this resulted from my psychiatric training and was another feather in psychiatry's cap.

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On the other hand, a psychiatrist can claim that as the result of his professional training he is better able to predict men likely to be unstable and to break down than those who have not had this training; and further, that as a result of his specialized skill he is better able to assess the type and severity of a breakdown if this occurs. At least I hope he can make these claims, although I must add at once that the prediction of breakdown is a remarkably difficult task.

I believe psychiatry would do well to try to become more skilled at negative selection, which is its job, before embarking upon more ambitious projects, which I submit are not.

(*b*) The other objection to positive selection is that of professional confidence. It seems to me that the type of difficulty about to be outlined must have occurred in any co-operative selection procedure such as the W.O.S.B's of the war; but I have not seen it mentioned. Executive bodies are unlikely, and I think that would be unwise, to leave positive selection solely to psychiatrists; but in any co-operative selection procedure the problem of a breach of professional confidence must surely arise. For in order to assess a case adequately, a private interview is essential; and in a private interview, matters may readily emerge that it would be a breach of professional confidence to disclose.

This is no theoretical danger or possibility, as the following illustration will show. Shortly after being demobilized I was asked to see cases for the Civil Service Commissioners. So far as I could ascertain they did not have a psychiatrist, nor indeed any medical man on their selection board; but they proposed to refer cases they considered doubtful as regards stability. Almost at once a candidate, whom I saw privately, told me about certain intimate details of past difficulties when I was going through his work record. I am sure he would only have disclosed them confidentially to a doctor; he was no fool. I wrote a report stating, rightly or wrongly, that I could find no medical reason why this candidate should not be accepted. A long correspondence with the Civil Service Commissioners ensued. I was asked to amplify and give full details of what had come out. This naturally I refused to do; and perhaps equally naturally the Civil Service Commissioners have not employed me since.

Now it seems to me obvious that if I had warned the candidate, like a police officer, that anything he said might be used in evidence against him, he would not have spoken freely. This would surely have handicapped me in forming an adequate opinion. Whereas if I had not warned him, and then conveyed to the Civil Service Commissioners what he told me, I would have been guilty of a gross breach of professional confidence.

I would submit that, quite apart from the questions of the capacity and qualification of the psychiatrist to contribute to positive selection, this question of professional confidence will, or should, permanently limit our contribution to positive selection procedures. I believe reasonable lay people (amongst whom, for obvious reasons, I would not include the Civil Service Commissioners) would be less likely to complain of lack of co-operation if they understood this point, which is not, I should have thought, a difficult one to appreciate.

I conceive it possible—in fact I know very well—that some will regard what I have said as merely destructive. I would not agree; but I think I should end on a more obviously constructive note. I am not arguing that we should be like an assembly of filleted civil servants, with " pass to you " as our pass word.

The practical point is what can we do; and if I draw largely on illustrations from my own hospital, this is because I know this best. Our allotments differ; mine happen to lie in a teaching hospital; and everyone knows that teaching hospitals in this country have no reason to be superior or up stage so far as psychiatry is concerned. An inspiring example of what can be achieved in psychiatry was evident to all who attended this year's meeting of the R.M.P.A. and saw something of the work of the Crichton Royal, Dumfries.

But before turning to more parochial problems, I should like to touch upon a general issue. It has been suggested to me by a friend that having attacked the analysts for their restricted approach to aetiology, an alternative theory of causation in psychiatry should be proposed.

As a staunch Meyerian one sees the cause of " functional " mental disorders in an ensemble of factors. Causation, in other words, is a process; and to incriminate a single factor within this process is often to misrepresent its character. At the same time, one factor—sometimes more than one—may exert a specific effect

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within this process which others do not. Thus the available evidence suggests that a gene is the specific one among the factors associated with schizophrenia; and if the analysts could demonstrate specific psychopathological factors in mental illness they would be on strong ground. In fact the " lesions " they find seem to be quite unspecific and are rarely proved even to be relevant. Unsolved conflicts that can be discovered in people who are quite healthy by any reasonable standard are blamed, when found in patients, as the cause of schizophrenia, obsessional neurosis and depression; or so it seems to me.

To return, so to speak, to my parish mission; owing to the widespread incidence by far the major part of psychiatric work will necessarily always be tackled by those who are not psychiatrists. Adequate instruction of the doctor-to-be is therefore of fundamental importance, and constitutes—potentially—one of the most constructive contributions to psychiatry that can be made. Nor must we forget nurses. It is therefore essential, quite apart from the urgent demands for treatment, for all teaching hospitals to have a reasonably large psychiatric out-patient department supplemented by in-patient beds.

At St. George's the Board of Governors have taken an enlightened view of psychiatry. We have for example been given facilities that permit of some 65 " doctor sessions " for out-patients weekly (45 for adults and 20 for children). To show that we do believe in the value of psychotherapy, I find that we refer about 20 per cent. of our new adult cases specifically for this; but the treatment they receive varies enormously, ranging from very few to 50 interviews or more. Under 2 per cent. are seen as often as twice weekly over months. This is not the result of any central directive, for my psychotherapeutic colleagues have naturally complete discretion as to how many patients they take on and how often they see them.

Turning to nurses, a new sister tutor, who is mentally trained, has just been appointed, and it is hoped that as soon as our in-patient unit is expanded we shall have an affiliation scheme for training with a mental hospital group. We have been handicapped, so far, because our in-patient unit had only twenty-eight beds (with an average duration of stay of between five and six weeks), but within two months we should have fifty beds. We should have had these additional beds long ago but, unfortunately for us, the enlarged mortuary accommodation necessitated by the increasing activities of our surgical colleagues obtained building priority.

We none of us, I think, set much store by set lectures, holding that the average medical student learns far more from lecture demonstrations, and above all from taking cases himself, which all must now do. We try to teach history-taking, that " ancient history " is not the only relevant part of history, that the collection of facts must precede their interpretation and also that the obvious is not to be despised. And as regards treatment, we teach that " one way only " is the worst possible slogan for psychiatry.

I think the majority of our students regard psychiatry as mildly interesting, and recently I was encouraged by one of them saying to me I could say quite interesting. Some are really interested and first rate at it; but, as many have said to me, it is of little use in examinations.

The biggest practical step forward for the teaching of undergraduate students in this country would be to have a compulsory examination, as in Edinburgh, or at least one compulsory question in all qualifying examinations. Examinations are the only effective way to make the average student take a subject seriously. Medical students are practical people; they want to get qualified; and they naturally tend to feel that time spent on a subject that has very little value for this is relatively wasted time.

Psychiatry is such a large and important subject that, without claiming it as the other half of medicine, which is absurd, the case for being examined on it is overwhelming. I think the public would be astonished to learn that many and probably most doctors can still qualify without ever having had their knowledge tested on a group of disorders that fill approximately 40 per cent. of all the beds in the country, accounted for 25 per cent. of all invalidings from the services in the last war and—but I need not go on.

Nor is the postgraduate situation any better. Thus in the five years 1946–1950, inclusive, out of 136 questions set in the Membership, only 3 were explicitly psychiatric, and only 7 more could be conceived to have a psychiatric slant; and a very rum collection of questions they are too.

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In conclusion, when one looks at the vast fields there unquestionably are in the domain of psychiatry and at how much still remains to be done, is it necessary, is it wise, and may it not be rather premature to look for fresh fields to conquer or to fail in ? I am told that a Jesuit when visiting a Benedictine Abbey related how he had been vouchsafed a vision. " We don't see visions at Downside " replied the Abbot, who evidently lacked what Dr. Brock Chisholm would call vision. I think I lack vision too. I have no yearning to run the world, and I can say with no false modesty I do not believe I could. My own job is quite enough for me.

I have called this address " Psychiatry Limited." I understand that a limited liability company is one in which the shareholders, should the company fail or go bankrupt, are not liable for more than they subscribe. The company I have in mind is a respectable company, a large concern with big responsibilities and with a great future before it. The shareholders are quiet, diffident, modest sober men who have a real pride in their business, but they are vexed when others undermine the reputation of the firm by using the name to float bogus companies, with grandiose prospectuses, backed up by balance-sheets that do not add up to make sense.

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