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Lecture

The Qualities of a Good Psychiatrist*

By DENIS HILL

There are in the eyes of the world different sorts of 'good' psychiatrists. It depends who is making the judgement; it depends what is asked of the psychiatrist, what role he is expected to take and how successfully he has measured up to it. One would expect that the qualities of a doctor would be judged to a very large degree by his capacity to treat patients. This is what his long period of undergraduate and postgraduate training and education is about. Recently this concept of the doctor, and particularly that of consultant psychiatrist, has been challenged. The expectation that in the future he will continue to treat patients personally seems to be doubted. I wish to make my own attitude clear at the outset. The psychiatrist in my view is a physician in psychological medicine—a clinician—which means that his business and his professionalism are the personal care of patients. He is now called upon to do much more than this, and the reasons are several and complex. But the old view of a psychiatrist as physician may be lost if he accepts only the role of administrator, PR man, member of a multiprofessional team with far-ranging, ubiquitous responsibilities.

The Official View

In 1969 the Department of Health (DHSS) in a document called *The Responsibilities of the Consultant Grade*, the result of a working party chaired by Sir George Godber, the Chief Medical Officer, said this:

> 'A consultant is a doctor, appointed in open competition by a statutory hospital authority to permanent staff status in the hospital service after completing training in a specialty and, in future, being included in the appropriate vocational register; by reason of his training and qualifications he undertakes full responsibility for the clinical care of his patients without supervision in professional matters by any other person; and his personal qualities and other abilities are pertinent to the particular post'.

As late as 1977 the General Medical Council said this about every doctor's responsibilities:

> 'The Council recognizes and welcomes the growing contribution to health care by nurses and other persons who have been trained to perform specialized functions, and it has no desire either to restrain the delegation to such persons of treatment or procedures falling within the proper scope of their skills, or to hamper the training of medical or other health students. But a doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. It is also important that the doctor should retain ultimate responsibility for the management of his patients because only the doctor has received the necessary training to undertake this responsibility'.

Our National Health Service (NHS) of which everyone in the past has been justly proud, has been an expression of the moral renaissance of the democratic western world. It has tried to implement the principle that medical care shall be equally available to every citizen, free on demand. We cannot be proud of our mental health services, because we know that the human and physical resources necessary to implement that ideal have not been made available—and quite simply because they were not sufficiently regarded to be afforded. But this has not been admitted.

When the blue-print for the mental health services was drawn up in 1971, it was based upon several propositions, whose only claim was that they suited the limited human and financial resources of the country at the time. Several

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convenient assumptions about the nature of mental illness and mental disorder were accepted by those who advised the DHSS. The first assumption was that the mental health hospital services should be concerned mainly with the psychotic and the subnormal, and the needs were estimated accordingly. The second assumption was that in the main the neurotic and the disordered in personality should be looked after, as it was thought they always had been, by general practitioners. At the start they actually forgot the disturbed adolescents, the alcoholics, the drug dependent, although the Department had for some years put out papers of advice on all these subjects. The third assumption was the implicit acceptance of the medical model of mental illness. The psychiatrist's primary role was to diagnose and assess the illness and prescribe the appropriate psychotropic drug. The fourth assumption was that social factors were of great importance, perhaps in precipitation but certainly in recovery from mental illness. Here the training and the skills of the psychiatrist were seen as complementary to those of the social worker, who was the expert and the responsible professional person. The psychological element in mental illness, as something which the psychiatrist's training might equip him to understand, and for which treatment by him might be advisable, was ignored altogether. Indeed no provision was initially made in the mental health services for psychologists or psychotherapists.

A New Role

The psychiatrist's role was thus conceived as being no different from that of the traditional hospital physician or surgeon whose job was to diagnose the illness and prescribe the appropriate physical treatment. At this point a phenomenon of double-think appeared—a universal function for the psychiatrist was envisaged. Dr A. A. Baker, until lately Director of the Hospital Advisory Service, has outlined his view of the consultant's responsibilities (1976)—to paraphrase:

> He must assess the needs of the population he serves and the facilities available—and decide how to allocate his time between in-patients, day hospital, out-patient clinics and community service.
>
> He must see every new referral, every admission, every long-stay patient—the new cases within a week, the emergencies within 24 hours.
>
> He should hold some out-patient clinics in large health centres or in group practices and he should not leave to junior staff consultation work in casualty departments or in other areas of the hospital service.
>
> He must be available to provide an opinion on patients in medical, surgical and other wards, and if the number of referrals are great, he should extend his teaching to junior medical, surgical and other staff.

The ideal consultant would appear to be at the centre of a communication or information net. He of course, works as one of a team, and he must be freely available to all other professionals, volunteers and lay-workers, and should meet them for full discussion and exchange of information. Face-to-face communication is obviously better, it is held, than that by telephone, post or through third parties, and the consultant, in addition to meeting his own team, should visit health centres, group practices and social work area offices to meet his other professional colleagues.

Dr Baker admits that a 'significant proportion' of the consultant's time—and one wonders which part of it—is taken up in committee work, but the ideal consultant is a super-chairman, or if not chairman himself can make sure that the discussion keeps to the point, that the relevant information is immediately available, and that everyone's interests are represented.

The consultant also, it is suggested, should be careful not to let any special interest of his own, or particular skills he may have for a particular type of patient, unbalance his model service to the detriment and neglect of other patients.

It is when we come to the questions of the consultant's *responsibility* that we are faced with the new look—or the new 'theology', as a senior physician has called it—in its sharpest form. To quote Dr Baker:

> 'Some doctors, both general practitioners and consultants, consider that full responsibility for patient care lies with the medical profession. As

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noted earlier, doctors do have a prime responsibility for *some* aspects of patient care, particularly diagnosis and prescription of *medical* treatments' (italics mine).

But Dr Baker concluded:

'Many professional staff, therefore, now accept that just as patient assessment and the pattern of care is determined by a consensus, so responsibility for the total care and management of the patient lies within the team, rather than with any one member'.

The extreme position advocated by Dr Baker is not one which is likely to be shared by the majority of our profession. If it were generally adopted it would result in an abandonment of the doctor's role and responsibility. He must, in fact, offer leadership where his skills, his knowledge and his training allow him to do so. Hopefully his personality will be such as to lead others to accept it. It has been said that it has been due to lack of medical leadership, or failure of others to accept it in recent times, that some of the scandals and abuses in the psychiatric services have occurred. (An example was the Whittingham Inquiry Report.)

Dr James Birley has commented on this:

'There are certain risks in regarding the psychiatrist as a leader. It smacks of a return of the medical superintendent. The rest of the team may not be allowed to develop and use their own skills and responsibilities; the latent conflicts may be suppressed or ignored and allowed to erode the efficiency of the team; and the team may be led to concentrate on the doctor's own special interests and not on the needs of all his patients. But to ignore the importance of the most highly paid and highly trained member of the team is equally dangerous. If he participates, he is bound to have a considerable influence. If he does not, his absence . . . will be regarded as an abandonment. So, in addition to clinical skills, our psychiatrist will have to become more sophisticated about the problems of management not only in his organization of others but in the way he sees himself in the organization'. (Birley, 1973).

Psychiatrists are trained to be clinicians, which means trained to the personal care of patients. Long may it last, but are we to accept Dr Birley's harsh conclusion that though psychiatry is a fascinating and rewarding career, in the future we shall be unable to practise it because of lack of staff?

Professor Gerald Russell (1973) has highlighted the position of the consultant operating a hospital-community service based on the guideline of one consultant per 60,000 of the population. His calculations showed that ten sessions of his time would be required to see patients personally—assuming the traditional role that a psychiatrist should do just this. His time would be fully occupied with new patient referrals, new in-patients, follow-up out-patients and his chronic long-stay patients. This means that the psychiatrist, if he is a good psychiatrist, could give almost the whole of this time to patient care. What of all those other functions which Dr Baker in particular considers our responsibility?

Clinician or Administrator?

This issue must be faced and is a personal one. The consultant psychiatrist cannot undertake the role suggested without progressive delegation of his essential functions, without progressive abandonment of his job as a doctor taking personal care of patients. Much that he has learned he can teach others, but the psychiatrist should not abandon his claim that through training and education he has knowledge and therapeutic skills which only he can exercise in his patients' interests.

Professor Neil Kessel (1973) in the same debate said this:

'The development of community links to further the rehabilitation of psychiatric patients has been the recent glory of British psychiatry, but it has been brought about in the sure framework of psychiatry being a clinical and personal subject. Good psychiatrists have never lost themselves either in the prescribing of pills or in the ramifications of social networks, and we must preserve ourselves from having the latter foisted on us just because it helps solve "interface problems" . . . between hospitals and social service departments'.

It is therefore with the qualities of the psychiatrist as good clinician that my main theme will be developed. At the end of the day, when we hope that the District General Hospital units have been properly developed, when the Social Service Departments have adequately

trained staff and money to develop community care, the survival of psychiatry as a specialty needed by society will depend upon whether there are still well-trained psychiatric clinicians who want to care for their patients.

It might appear that viewed from the heights of NHS administration the good psychiatrist at the present time is a good psychiatric community physician. He need not himself treat patients, so long as he shows an ability to organize and help others in teams to do so. The present ethos, although it may have been overstated, is engined by the fact that the population of the mentally ill and disabled is vastly greater than our psychiatric resources can cope with. One way out of this difficulty is, of course, to buttress the belief that the causes of mental disorder are in the main social, not personal; cultural, not biological. We do not, of course, have to believe this. Indeed, we have a moral obligation not to believe it, for as a general statement about mental illness it has not been proven.

One of the most important developments of British psychiatry in the last quarter-century is the refreshing wind of doubt, and this owes its origins to a new scientific psychiatry, which demands that as far as possible our belief systems should be subject to control by scientific evidence and objective validation. Since in the case of most mental illness we are not within sighting distance of this, it behoves us all to keep our minds open, whatever the nature of our work, whatever our special expertise, whatever our particular orientation may be.

This then identifies one characteristic of the good psychiatrist, that he has an open mind to the fundamental issues of the subject, that he is aware of them, and that he has not allowed himself to be committed exclusively and blindly to one total ideology, to one exclusive sort of explanation. The dangers of so doing may be obvious and do not need emphasis, although many are trapped by them. An exclusive commitment to the biological position can lead to therapeutic nihilism or damaging scepticism on the one hand, or on the other to a dangerous polypharmacy or an excessive use of hazardous physical treatments. The psychiatrist on the other hand as amateur sociologist is liable to be a poorly trained social worker who tends to lose sight of the individual patient in the complexities of his social nexus. Again, the exclusive psychodynamic psychiatrist will ignore or reject the methods and opportunities which are now available for reducing his patients' suffering or shortening their illnesses. Lastly, there is the new emergent psychiatrist as exclusive behaviourist. The field of his therapeutic operations, although expanding, is still very limited, and the danger here is that he is only a poorly trained psychologist. All must accept that by the nature of his ideology the exclusive specialist may neglect the patient as individual.

It has been a painful if salutary experience that many of the beliefs about the nature of mental illness, many of the so-called clinical facts which seemed to have been fully established thirty years ago have been shown to be wrong. Others, which seemed obvious from everyday clinical experience, but doubted for decades, are now being shown to be true; but only as a result of painstaking carefully prepared research. For some time it has seemed that authoritative statement and inspired guesswork were the worst enemies of psychiatric progress. There is now an even worse enemy of which we should be aware. It is an insidious and persuasive form of antipsychiatry. This is the invitation to allow our belief-systems about the nature of mental illness to be regulated by what is economically or politically expedient, what fits the social ethos of our times.

In speaking of what makes a good psychiatrist, I am not speaking of what makes the good psychotherapist or good behaviourist. I am also firmly convinced that psychiatry needs these specialists, and in far larger numbers than at present, just as it needs child psychiatrists, forensic psychiatrists and experts in subnormality. I am concerned with the qualities of the general psychiatrist who makes up the majority of our profession.

The all-purpose psychiatrist

Thirty years ago, when the Maudsley set its course for intensive postgraduate training, the objectives were clearly set out by Aubrey Lewis (1947). They were to produce the 'all-

purpose psychiatrist', and Lewis clearly described him:

> 'When he is asked to treat a child, to report on a criminal, to explain the origins of a strange symptom, to supervise a course of insulin, to diagnose a highgrade defective, or to avail himself of the results of psychological tests, he should not have to choose whether he will excuse or hide his deficiencies; he ought not to be nonplussed and as much off his own ground as if he had been called to deliver a baby. His all-round training is not designed to make him a sciolist who thinks he can answer every question, but to put him in the way of getting the experience that will give him scientific grounding, standards and a sure frame of reference, and will fit him for the general practice of psychological medicine as our times require it'.

The times have indeed changed, and the all-purpose psychiatrist is no longer possible, nor indeed desirable, but the general objectives of psychiatric training remain as true now as they were then. They were, however, essentially academic objectives, the emphasis being on knowledge; there was no mention of therapeutic skills, nor of the particular qualities of the psychiatrist as individual, nor the skills which differentiate him from the good physician who happens to be dealing with the mentally disturbed. As Stengel once said, the qualities of the psychiatrist which distinguish him from a physician are only those which come from his psychological knowledge and his psychological skills. I would add to these his attitudes towards the field of his work.

Some goals

One way to examine the qualities of the good psychiatrist is to ask whether he has achieved what are regarded as desirable objectives in his education and training. In 1969 the then R.M.P.A. held a three-day conference on postgraduate psychiatric education. Each of the seven topics chosen was assigned to a working party and each of these produced in advance its working paper, which at the conference was presented and discussed by members of the panel, between themselves and with the conference. The proceedings were published by the Association (*The Training of Psychiatrists, 1970*). The third topic was on Educational objectives. Since then our College has produced much advice regarding training programmes and the content of vocational and educational experience, but since that time the matter of objectives has not been considered in such depth or in such a comprehensive way. There were, of course, different and even contrasting views on matters of detail, but arising from the work a broad degree of agreement on many issues appeared.

Among the general considerations, the contrasting objectives of the physician and of the scientist were discussed. The latter are to increase knowledge. The scientist does not work in the service of the individual. His curiosity motivates him, although he may believe he works in the service of humanity. The physician, on the other hand, works to serve the individual first and last. For him knowledge is not an end in itself; nor is he motivated primarily to scholarship. But he must acquire certain qualities which the scholar and the scientist possess, in particular 'a critical attitude towards the nature of evidence, the capacity to evaluate it, the understanding of what is knowledge and what inspired guesswork or authoritative statement'.

The clinician, moreover, must tolerate the discrepancies in the quality of psychiatric knowledge 'without recourse to any of the common methods of escape, such as clinical non-commitment, denial or disdain of psychiatry, or by contrast a contempt for the relevance of knowledge or a shallow pretence to it'. The future development of knowledge in psychiatry will depend upon the efforts of clinical scientists and research workers in the basic neuro- and psychological sciences, but research ability of itself is not one of the distinctive characteristics of the good clinician. It is fortunate indeed when the good clinician is also an able research worker. Nevertheless the good clinician is alert to developments in scientific research, is able to appreciate and evaluate them. He must thus be a scientifically-minded doctor, who thinks scientifically, who amasses and uses clinical experience and accepts that he must frequently take action on inadequate data. John Ellis gave his opinion that the scientist who seeks only after the truth and never uses clinical experience

is a potential menace with individual patients, partly because he is not prepared to take action on inadequate data. For Dr Ellis the lowest category of medical person is the doctor-technician capable *only* of blindly applying a currently acceptable formula, say the psychotropic drug in vogue, to what is a currently recognized situation—say a particular psychiatric diagnosis.

After outlining the range of knowledge which the good psychiatrist should acquire, attention was directed to skills and attitudes. The former were divided into clinical, therapeutic, teaching and administrative skills. Teaching and administrative skills were held to be desirable for all future consultant psychiatrists. A good psychiatrist will always find that he enjoys teaching. There are a range of objective clinical skills in relation to diagnosis and appraisal of the patient's situation which are needed. There are also subjective skills which the good psychiatrist acquires. They involve the development of sensitivity, the capacity for empathy and identification which enable him to gain access to the patient's experience and to understand it.

This question of subjective clinical skills is intrinsically connected with therapeutic skills, which the working party believed should be broad-ranging, to cover the safe use of drugs and physical procedures as well as psychotherapeutic literacy; 'to be able to enter and maintain a psychotherapeutic relationship with a patient without undue anxiety, but with understanding of its nature and of the hazards involved'.

To recapitulate: having implied some of the qualities which the good psychiatrist will have, one can ask what the good psychiatrist is not. He is not only a physician, although he shares with the physician a basic knowledge of medicine and above all the physician's personal commitment and responsibility to his patient. He shares with the physician the basic ethos of medicine and his professional role. He is not a technician, nor a scientist, but he has technical skills peculiar to psychiatry and he is a scientifically minded doctor. He is not necessarily a research worker. Good clinical research workers are not necessarily good psychiatrists; it is an immense bonus if they are. The good psychiatrist is not necessarily a psychoanalyst, although he may have had a personal or training analysis and justly claim that he has greatly benefited from it. The practice of psychoanalysis is not, of course, the practice of psychiatry. Yet all good psychiatrists have psychotherapeutic skills.

Attitudes

It is when we come to the question of attitudes that our difficulties begin. These are important for two reasons. Attitudes determine to a large extent the professional role which the psychiatrist is prepared to take; and secondly attitudes determine the psychiatrist's fundamental orientation to his subject.

At this point it may be conceded that good psychiatrists are to be found taking different professional roles and having different attitudes. Possibly, then, there are several types of good psychiatrist. Are there, however, attitudes which can be discerned common to all of them? It is a basic requirement of the good psychiatrist that he should expect and acquire the capacity to take actual responsibility for patients, which includes a continuing participation in their treatment, and it is not fulfilled merely by offering consultant advice to others. This is part of the psychiatrist's contract as a physician and is intrinsic to his professional role, whether he is called upon or indeed allowed to exercise it. In this lies a difficulty, for the psychiatrist must combine the apparently contrasting roles of physician with that of therapeutic participant or mediator. On the one hand he is the objective observer and investigator using scientific knowledge and skills, and on the other he is involved as a subjective participant in the patient's distress, including intuitive and empathic methods of thought and feeling.

The report of the Conference (1970) was concerned with educational objectives, and a great deal of time was spent in arguing the case of whether it is wise or legitimate for teachers to attempt consciously to alter the attitudes of their students. There was no consensus on this, but the Conference deplored the polarization of attitudes towards the so-called medical model and the psychosocial models of mental illness, either of which if held exclusively produces serious limitations on the skills of the psychia-

trist. There was less certainty as to how to overcome the difficulty. Some suggested that sensitivity training is helpful—an increased self-awareness of one's own motivations, one's own needs, normal or neurotic, and the extent to which these influence or interfere with relationships with patients. There are some who seem to have these necessary positive qualities of personality; but for many, given suitable exposure to appropriate experience, they can be acquired. There are, of course, a few in our profession who suffer from personality defects of a serious nature which render them always a potential danger to patients. I believe it is the duty of educators to steer such people away from a career involving the personal care of patients.

Clinical Maturity

Clinical maturity is a characteristic of the good psychiatrist. It was Laurence Kubie who pointed out that to *learn* about psychiatry was not to *become* a psychiatrist (1971). Scholarship is not enough, only long and painful exposure to the ongoing care of sufficient and varied types of patient will allow the doctor to become a psychiatrist. Kubie wrote (1971) that there is one setting in which it is impossible for the student of psychiatry to become a psychiatrist. 'This is the setting which uses only an assembly line approach to patients, and where the official attitude is to scorn sustained individual interaction, and to take pride in brief interviews and a rapid turnover'.

What then are the characteristics of clinical maturity? I think these are: personal and emotional maturity, which mean freedom from personal neurotic nostalgia with one's own past; protection of the patient from the negative aggressive aspect of one's self, but ability to acknowledge to oneself when one does not like a patient; the capacity to empathize with the mentally ill, but to remain objective about the significance and meaning of the various manifestations of illness; to be kind but not to indulge oneself or the patient in excessive compassion.

Most difficult of all, and perhaps the hallmark of clinical maturity, is the capacity to combine effectively the roles of objective observer of the patient himself and of his interpersonal and intrafamily relationships with that of participant-observer or mediator in the therapeutic process. David Shakow (1972), the distinguished American psychologist, has divided the functions of the psychiatrist as observer into four—objective, participant, empathic and self-observing. They are used by all physicians, but they are most highly developed in the psychiatrist and constitute the core of his clinical skills. All those working in the mental health field need them. It need hardly be said that the clinically mature are skilled in objective observation, in the capacity to take the relevant comprehensive history, and to examine the mental state of the patient, if necessary in great depth without upsetting him. Great psychiatrists like Laurence Kubie and Manfred Bleuler have always insisted on maintaining a personal continuing care of at least a small group of patients. Ultimately, as John Romano has written (1972), it is the patients who teach us most, and the clinically mature psychiatrist knows that throughout his career he will continue to learn.

What then are the consequences which flow from these attributes? To know when to treat and when not to treat, but always how to manage. To know whom to treat oneself, and to make time to do it. To know who should treat, and not to involve onself excessively in a relationship on which the patient will come to depend if one is not the best person, nor the appropriate person, nor the person capable of providing that continuing care which all patients, for a short or a long time need. This colleague, as we now realize, may be a nurse, a social worker or a psychologist. Delegation of responsibility, however, does not absolve one from it.

Today increasing numbers of senior nurses and social workers are involving themselves in therapeutic activities, including psychotherapy, for which they have had little or no training. In time many will become experienced and sophisticated in this work. The clinically mature psychiatrist will want to teach and will obtain great rewards from doing it. If he must, as indeed he must, restrict the field of his extramural work, he should give the highest priority

to the role of helping his professional colleagues *within his team* who share with him the burden of care of so many patients.

Hazards to Good Practice

The opinion has been firmly expressed that the psychiatrist is a clinician, a special sort of physician, and that his primary responsibility first and last is to the care of his patients. There are special problems here for the psychiatrist who follows an academic career or who is a clinical scientist or primarily a clinical research worker. There are many such who are expert clinicians, but the problems which they face in the context of the present theme cannot be examined here.

Two further aspects of the psychiatrist's work deserve attention. First there are hazards which can arise both for patients and doctors from the doctor's own personality. Second, there are the temptations which are put in the psychiatrist's way to avoid his clinical commitment.

Many of the hazards to patients which can arise from the psychiatrist's own personality can be traced to his inadequate or biased training. Briefly, there are the well-known risks of excessive identification with the patient and neglect of the phenomena of transference and counter-transference inherent in every doctor-patient relationship. Ignorance and neglect of this can bring pain and damage to both. Mention has already been made of the limitations on psychiatric skills which result from total acceptance of one ideology—one type of explanation for mental illness. There is the serious hazard for patients which occasionally arises from this when the psychiatrist is intensely motivated to cure at all costs, when he has a passionate and excessive zeal to treat, and an unfortunate inability to accept that in the present state of knowledge we are not infrequently therapeutically impotent. Out of this attitude has come some of the abuses of psychiatry—the excessive use of ECT, multiple leucotomy operations, excessive use of drugs, and worst of all the use of legal methods of restraint, which under the present Act allow the psychiatrist, acting of course honestly although ignorantly, to impose excessive treatment.

Despite all the difficulties, administrative, practical and social which afflict the subject at the present time, a career in psychiatry can still be one of the most rewarding in the whole of medicine. It provides, almost uniquely, the opportunity for the continued personal growth of the psychiatrist himself. The rewards of helping patients to get well and learning oneself from the process are very special to our profession. There are, however, many temptations and avenues open to the clinician who wishes to avoid his clinical responsibility. There are many activities, honourable and desirable in themsevles, which now more than ever beckon the consultant away from his clinical commitments. Indeed official advice would seem to make it desirable for him to be persuaded.

The difficulties should not be belittled, the great demands which are being made on all psychiatrists operating hospital-community services. Moreover, the concept of the psychiatric team of different professionals has proved a great advance, but the psychiatrist must be the leader of that team. There can be no place for consensus diagnosis or consensus treatment, although the psychiatrist could not sustain leadership and would be a poor clinician if he did not listen to and take advice from every member of his team. Each has his own expertise to contribute. Ultimately, however, responsibility must rest with the consultant psychiatrist.

It is a function of self-observation to examine repeatedly what one does and how effective it is. This can help determine the quality of the care the patient receives. As McKeown (1976) has pointed out, we can examine the quality of care by asking three questions. How well do I do what I am doing (the standard)? Is what I am doing worth doing (the effectiveness), and finally, whether what I do makes better use of resources than the available alternatives?

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