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"Twenty Years A-Growing"

The Presidential Address at the One Hundred and Twenty-Eighth Annual Meeting of the Royal Medico-Psychological Association, held in Plymouth, 10 July, 1968

By FRANCIS PILKINGTON

My first duty—and pleasure—is to thank you all most sincerely for the great honour you have done me in choosing me as your new President and to give thanks also for all the congratulations and good wishes I have received.

Many distinguished men have held this office since the founding of our Association by Samuel Hitch one hundred and twenty-seven years ago, but I think none can have felt more unworthy than I.

This will certainly be an important year, and we hope an historic one for British psychiatry, and I am proud that you should judge me fit for the responsibilities of my term of office. Whether or not I acquit myself well, I can assure you I shall do my best. I deeply appreciate your kindness.

Most of our Presidents, until recent years, were Medical Superintendents of mental hospitals; but over the past six years only one—Dr. Skottowe—had held that position, and he had moved to other work before he became President. It seems to me to have been a gracious act on the part of the Association to let the wheel turn round again and have as their President at this particular time a Physician Superintendent, and so make it possible to hold this Annual Meeting in Plymouth. Plymouth has never before had this privilege, though history records that in 1841, the year of our birth, it was proposed that the inaugural meeting be held in Devonport, which now, of course, lies within the boundaries of Plymouth City; in the event Gloucester was chosen for the accouchement. It is proper to remind you that the Association's main objects, as declared by those present at that meeting, were *the improvement in the management of hospitals* for the insane, improvements in *treatment*, and the acquirement of *better knowledge* of insanity.

I should now like to take you across the Irish Sea to a spot off the extreme south-west coast of County Kerry, in the stormy Atlantic. There lies the Great Blasket Island—a few miles long and a bare half mile wide, though rising to a thousand feet in places. The population of the Blasket, entirely Irish-speaking, numbered two hundred in 1904, the year Muiris O'Sullivan was born on the island. It was a closely-knit and happy community, its life almost medieval, a truly remote area. In 1933, Muiris wrote a book for the entertainment of his fellow-islanders; it has since become world-famous and translated into English and several other languages. It tells the story of his youth and growing up, of the rich though limited life on the island, and finally of his departure for the mainland, to work in the big and sophisticated city of Dublin.

Today the old women and the young children are gone. The life he described belongs to the past, and the island is deserted. The village is in ruins and there is silence except for the roar of the sea and the screeching of the sea birds. Yet who knows what the future will bring to the place out of the changes which today are sweeping so rapidly across the world?

O'Sullivan's book is called *Twenty Years A-Growing* and I have borrowed his title for my use today. It may be an odd title for a Presidential Address, yet I feel there are certain things in common between his story and my own: the *remoteness* of the setting, the community he describes, the *changes* which have taken place—in some ways rather sad—yet changes which may herald new and exciting events in years to come.

From that point, though, our ways diverge. Muiris wrote just for the entertainment of his fellow-islanders and had no thought of a wider public. But not for me this cosy intimacy,

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because my words will be printed and sent far and wide. For me a theme is required.

The experience of *remoteness* has moulded me. For twenty years and longer I have been a-growing where the practice and problems of psychiatry have differed greatly from those in the centres of learning. Coming as I did from the academic but stimulating atmosphere of the Maudsley Hospital under that truly great man Professor Mapother, and strictly schooled by Aubrey Lewis, and then more gently fostered by J. R. Rees in army psychiatry, it was, for me, a dramatic change. In the earlier years of my training I had adopted the attitudes about mental hospitals which were then prevalent at the Maudsley. Thus, where so much needed to be done there was often too little attempt at rational treatment; and conditions were generally reported as "terrible". This was the creed I came to believe in. Yet the truth was that all over the country there were doctors who were working hard to introduce reforms. To come here, then, was a dramatic change after the excitements of the Maudsley and the War, because I found myself almost literally at the end of the line and at first I often felt isolated and cut off from the growing points of medicine. But this was my deliberate choice and a challenge to be met.

This month the National Health Service has also been a-growing for twenty years. And I am glad to acknowledge, without any reservations, that regional psychiatric hospitals and hospitals for the subnormal, have benefited more under the National Health Service than almost any other branch, medical, surgical or even Local Authority. In the 1950s especially, as I shall presently describe, very great progress was made. I do not disguise the fact that after leaving the Army in 1945 I was also influenced in my choice by the expectation that once the Health Service was launched there would be much greater opportunities for helping develop the remote areas.

Today, then, I speak about the growth of "front line" psychiatry, especially in terms of the development of a service, over the past twenty years or so, in a remote area more than a hundred miles from the nearest medical school. My story is *not* unique and could certainly be paralleled elsewhere, and for that reason I feel justified in presenting it as an intimate vignette in the history of British psychiatry. It may be a story far removed from distinction in the academic sense, but if the main achievement has been better help for our patients it is worth the telling.

It would be interesting to investigate the field of work of all psychiatrists in this country today, but it would undoubtedly be found that the majority are serving, most of them full-time, in our regional hospitals doing run-of-the-mill psychiatry. And it is also true that almost the entire population is dependent on the resources of their local hospitals when in need of psychiatric help.

I am therefore proud to speak, as a common man, for the ordinary practitioner in psychiatry. Through sheer weight of numbers our type of work must be very important. It may not make the headlines, but in the end it is likely to influence decisively the public's attitude toward our specialty.

In the years after the War, the late 'forties, Moorhaven Hospital, then named the Plymouth Mental Hospital, but often called by the name of the former estate, Blackadon, had room officially for some 550 in-patients (according to Board of Control standards) but actually accommodated nearly 800. Overcrowding was severe. Admissions were under 200 a year from a population of about 180,000. The medical staff varied between three and four. The nursing staff were low in numbers and their training was poor. Although the hospital was officially a Nurse Training School, there was no Tutor and no proper accommodation. (The male nurses, by the way, wore most unsightly uniforms which included a head-dress resembling a wayside station-master's cap!) There was no social work department, and the first P.S.W. was not appointed till 1948. Although the hospital was a "modern" one compared with many, having been opened in 1891, the state of the buildings—wards, departments, the lot—was disgraceful, even dangerous; and tangled masses of coarse grass and evil-smelling weeds grew within the boundary walls of what were still known as the "airing-courts".

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President 1968–9

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In the hospital itself, nearly every ward was locked and there was a depressing series of locked doors set at intervals along the main corridors and between the male and female sides. There were even two hospital shops—one for each sex.

As elsewhere, the Mental Treatment Act of 1930 had been of help, because voluntary patients could emphatically complain, but its provisions were slow to be adopted here.

Outside the hospital, the weekly out-patient session which had been started at the Plymouth General Hospital as long ago as 1928 was doubled in 1945. But there was little other contact with the world outside. Within this closed community there was a deep cleavage between the echelons of the staff, with their traditional hierarchical structure, and the patients who were second-class citizens in this little tin-pot State. The Visiting Committee, who ruled on behalf of the Local Authority, were mostly unknown, even by sight, to patients and staff alike.

Yet this was *not* a hospital which was criticized in any way. There were no complaints—at any rate no openly expressed complaints. The Hospital was simply *ignored*: and the maintenance rate (in 1948) was £2 7s. 10d. a week. (In 1899 it had reached an all-time low of 9s. 11d.—and that included free beer—and (we read) "flannel garments universally supplied"!)

It was always regarded as a hospital with a good standard of nursing, and as far back as 1895 nurses had entered for and passed the R.M.P.A. examinations. The care and skill of the nursing staff was often officially praised, and it was not until 1946 that shortage of nurses became an acute problem. Mechanical restraint has only been used twice in the history of the Hospital, in its first year and in 1914. The standard of psychiatric treatment is more difficult to assess, but though no original methods were evolved there was no undue delay in adopting new ideas. Pre-frontal leucotomies were first performed in 1944, and deep insulin treatment was started three years later.

The public knew nothing of the self-sacrifice and devotion of many of the staff. When I was introduced at a cocktail party, rather apologetically, as the "doctor who looks after the mental hospital at Blackadon" no one ever wanted to know what my work entailed. (As an historical fact, my first job on the first day in my post was to receive the weather report of the preceding 24 hours! Somewhat unnerved by this ritual I routed out the small volume of Hospital Standing Orders and saw to my dismay that no member of the nursing staff was ever allowed to get married without my express permission!)

This, then, was our "closely-knit, almost mediaeval, community", the little world of sinister-sounding Blackadon which I have compared with Blasket in the stormy seas. When opened in 1891 it had the rather doubtful distinction of being the smallest "asylum" in the country and of having the largest Visiting Committee!

1950–1960. The Years of Plenty

We come now to 4 July, 1948, the "appointed day", as it was called. I remember the feeling of satisfaction at being, at last, part of a nation-wide service with the prospect of a steady flow of money from Whitehall, to enable us, perhaps, to develop a service along the lines of Thomas Beaton's in Portsmouth before the war. I remember, too, feeling happy that now, coming into the same administrative structure as the general hospitals, we need no longer be the Cinderellas of medicine. And it soon became clear that the Ministry of Health were really anxious to improve its mental hospitals. Encouraging circulars were received, and their recommendations were backed by financial support.

Morale, in consequence, rose steeply, though this was not the only cause. There was a release of pent-up energy following the years of war-time frustration, and there was noticeably an improved attitude towards psychiatry and the hospitals through the return to civilian life of large numbers of ex-service men and women to become the staff and patients of our service. They had been influenced by the ideas and practices of army psychiatry inspired by J. R. Rees and his colleagues. Hospital Management Committees, too, were receptive to new ideas.

In my own area the benefits of the new deal

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were rapid. The staff were ready for changes, and the public began to evince a growing good will by wishing to come and see us—and learn for themselves. The growth of this enthusiasm was probably influenced by massive changes in war-scarred Plymouth itself which, Phoenix-like, was rising from the ashes.

In taking stock of our position and potentialities at that time it was clear enough that our medical establishment was likely to remain much below what was needed and that there was no prospect of being stimulated by the presence of any medical students. Clearly, therefore, any research programme seemed out of the question. It seemed, rather, that our first duty lay in studying the needs and improving the welfare of our hospital patients as fully as we could. This led, initially, to concentrating on the *nursing staff*, their recruitment, selection and training.

We did all we could to raise their status through mutual consultation and the study of inter-staff relations. Following the lead of St. Luke's Hospital, Middlesbrough, we started a pre-nursing cadet scheme in 1952. This was to encourage recruitment into the hospital service of carefully selected girls and boys, and it facilitated the weeding out of unsatisfactory students unlikely to make good nurses. We were very short of staff, and we believed it to be wise to raise the standard of entry, because the best advertisement is a successful and contented nurse and the worst is the failed student who becomes a virulent anti-recruiting agent in the community. We have now had a total of 170 cadets pass through our hands, 130 of whom became students to give us 60 staff nurses in all: and of these five have become Sisters while nine men have became Charge Nurses or obtained other posts of equivalent status. The establishment of nurses happily being full, the scheme is now being allowed to run down a little. Our nurses' hours of duty had also caused us much concern: each week they were on duty for 12 hours for four consecutive days, a system resulting in exhaustion, lack of continuity of ward control and interruption of patient–staff relationships. The "battle of the long day" was fought and won and reason triumphed.

There was an even worse tradition in the inflexible system of promotion, which was by seniority alone. This brought about a wastage amongst our most promising youngsters, managerial inefficiency at ward level, and a smug "I'm all right, Jack" complacency. We devised a points system for promotion, points being given for ward management, nursing skills and some for seniority. Assessments by a panel of nurses and doctors who really knew the candidates and an interview by an external nurse-assessor were introduced with gratifying success.

In all these three important reforms I pay tribute to the great help given by one of our nursing staff, Claude Bartlett, who for many years was President of the Confederation of Health Service Employees.

All these changes quickly led to improved patient understanding and care. Concurrently, we set about developing a P.S.W. service within the hospital, our need for this being greater than for psychologists or for more occupational therapists. As to our junior medical staff, in addition to seeking to provide for their training and clinical needs, we tried to produce the right atmosphere for them in the wards and through inter-departmental relationships.

I need say nothing about remedying the deplorable state of the wards, departments and engineering services of the hospital. It has been a long, slow, uphill struggle, and is not yet completed. Lack of funds has been the chief obstacle, made more difficult by the established and commendable policy of always putting staff recruitment before building works.

The mid 'fifties saw the introduction of the phenothiazines and the first anti-depressants. These invaluable therapeutic weapons were already in our hands when in 1956 T. P. Rees gave his famous Presidential Address, *Back to Moral Treatment*, which set us thinking about the social structure of the hospital as a "therapeutic community".

Three great advances in treatment were made almost simultaneously, and I believe it to be impossible to assess their merits in isolation. Drugs, the "therapeutic community", and the vastly improved calibre and skills of

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the nursing staff are all essentials in the provision of an acceptable service.

The influence of T. P. Rees was great. He said that patients come to mental hospitals in order to learn to live with other people. The patient, therefore, has a role as an active member of the hospital team. "We, as doctors", he said, "are apt to flatter ourselves by attaching undue importance to specific methods of medical treatment. From the patient's point of view it is the total picture that counts, it is not the daily, weekly, monthly or six-monthly hour he spends with his doctor that matters so much as what happens to him in between these periods." After remarking that one of the main tasks of the Medical Superintendent is to study and improve the relationships existing between the various members of the staff and with the patients he said: "This is the community which provides the atmosphere in which the new patient is treated, the young nurse and the young doctor are trained."

These words were written twelve years ago, and my own hospital is only one of many which has benefited through them. To bring this thinking up to date, may I remind you of Ian Skottowe's comment at an R.M.P.A. meeting three years ago. "In its current context", he said, "a therapeutic community appears to imply a demolition of hierarchical authoritarian staffing, a much freer and more permissive critical exchange of information and opinion among all levels of staff, and the properly controlled inclusion of patients in this self-helping, if not quite self-governing, group." Looking back on the local scene I think that the keystone of our own philosophy has been to respect the patient as an individual, however distorted his personality may have become, and to give him as much responsibility as he can take. This has found expression, for instance, in our Patients' General Committee, which is entirely self-governing, and it was this philosophy which led us to unlock our last ward as long ago as 1956—the same year, incidentally, in which our voluntary patient admission rate reached 97 per cent. of the total.

In a city the size of Plymouth* we have certain positive advantages as compared with the larger centres of population or the more rural areas. We seem to belong to a wider cultural ethos, and it is as easy to meet and mix with solicitors, clergy, teachers and the world of commerce as it is with our own profession. And because our area is self-contained and compact we cannot easily run away from our mistakes or from our awkward and demanding patients. As Longfellow put it:

> "The poor in body and estate
> The sick and the disconsolate
> Must *not* on man's convenience wait."

In short we had long realized we were here to *give a service*. We wished to improve the existing service and to expand it to the extent that it should become truly comprehensive and able to meet all reasonable demands in the area. And so, whilst we were overhauling our in-patient facilities we were simultaneously developing our out-patient clinics (for new and old cases and also for psychotherapy) and increasing our domiciliary consultations and hospital visits. Follow-up clinics for discharged patients soon became a growing commitment. One of the most time-consuming developments was child psychiatry. Though we had started a Child Guidance Clinic as long ago as 1947, it had been in the doldrums from time to time owing to the lack of a clear administrative policy at Ministerial level. It is now flourishing, but we still await a start on our Adolescent Unit project. A Therapeutic Social Club has been running for many years: more recently contacts have been made with the Marriage Guidance Council, the clergy and the Probation Service; from the latter a Forensic Clinic has come into being. The needs of Health Visitors and District Nurses in training are not overlooked, and there is close association with training courses for social workers at the Plymouth College of Technology.

The fostering of good public relations is an important and continuing task. Though open days at the Hospital, which we started in 1952, have been most successful, periodic visits of small groups, and the giving of talks to clubs and societies, are just as useful. The founding

*** The population of the catchment area, which includes parts of S.W. Devon as well as the City of Plymouth, is 205,000.**

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of a devoted League of Friends in 1957 and the abolition of official visiting hours in 1959 should also be mentioned, as should the launching of the Plymouth and District Association for Mental Health a year ago.

In the late 1950s we were beginning to realize the importance of continuity of treatment—whether in hospital or outside—by the *same* physician, social worker or nurse. We also felt the need for much closer relations with the Local Authority and for centralizing the activities pursued outside the hospital. The result was the establishment in 1963 of a community mental health centre (the Plymouth Nuffield Clinic) in the heart of the city. In it there are rooms for doctors' psychotherapy and follow-up clinics, offices for the hospital and local authority social workers, a busy day hospital and the whole of the child psychiatric service. Team work came to be recognized as important, in both extra-mural and in-patient work: the inter-action of hospital social worker and mental welfare officer became a reality, and the nursing aftercare service which we started in 1957 with two part-time nurses steadily grew until there were about 150 former in-patients, mostly with a history of multiple admissions, being regularly visited by five nurses spending half of their working time on this work. Most of these patients are schizophrenics or chronic depressives in the older age groups. Our general hospital out-patient clinics for new consultations and follow-through work continued as before, six days a week.

The years 1950–1960 were "Years of Plenty" in our psychiatric hospitals. They were years of expansion of services—both within and outside the hospitals themselves: years of high morale, of more effective treatment and of greatly improved public relations. A silent revolution had taken place, introducing what seemed a Golden Age.

The Years of Decline

By 1960 the primary aims of the R.M.P.A., mentioned earlier, were coming to be realized. How Samuel Hitch, and his associates from Nottingham, Oxford, Lancaster and York, would have rejoiced!

Yet the Mental Health Act of 1959, implemented in 1960, an Act which was the expression of progressive psychiatric thought and was generally acclaimed, marked the turn of the tide as far as the psychiatric hospital itself was concerned, and ironically ushered in the "Years of Decline", the present decade.

The Act, with its emphasis on community care, even though at first that was more of a phrase than a fact, unwittingly lowered the status of our hospitals, and the growing importance accorded to psychiatric units in general hospitals only revived the idea in people's minds that the psychiatric hospital was a place to be avoided, a last resort for the hopeless case. The hospitals seemed to be in danger of being consumed by the fires of their own success. Though the service was expanding and was becoming ever more comprehensive, there were some cracks in the morale of the staff at the centre. Tooth and Brooke then published their paper (1961) in which they forecast that by the mid 1970s it might very well be that only 50 per cent. of the present number of beds would be needed. The controversy over this prediction is still a live issue, and though the number of in-patients has dropped significantly in some areas, in others there has never been such pressure on beds as at the present time.

Mr. Enoch Powell, then Minister of Health, speaking at a public and widely-reported conference, stated that there was "no future for the mental hospitals" and that they were in fact "doomed". The Hospitals Ten Year Plan, the first edition of which was published in 1962, gave substance to the Minister's speech, and many hospitals were cynically awaiting their fate. He repeated that by the mid 1970s 50 per cent. fewer beds would be required.

The accumulated effects of such statements could not fail to put the psychiatric hospitals on the defensive. It seemed that almost imperceptibly there was emerging a dwindling of enthusiasm on the part of Ministry and of Regional Boards for developing their hospitals, in spite of the circular of 1964 on "Improving the Effectiveness of Mental Hospitals". There was yet another unsettling influence. Some doctors and Committees seemed convinced that psychiatry was just another branch of

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medicine and that psychiatric hospitals could function in the same way as any other hospital. The attack on medical administration was facilitated by this philosophy.

I realize full well that some will regard me as being needlessly pessimistic for venturing to suggest that we are in a period of decline. Let me remind you that I am speaking mainly of the *hospital* part of the service, and not of the development of psychiatry as a whole. Yet, as one who has entered on the last lap of his professional career, I am bound to admit that I do see some threats to our progress amid all the dazzling opportunities of the next twenty years, and I must divest myself of my anxieties.

The first, of which we have already had a taste, is the medical man-power problem. It is safe to assume that the difficulties which the remote areas are now experiencing in obtaining medical staff in the trainee grades is not only because there is an absolute shortage, but because it is an accepted fact that the post-graduate education of a psychiatrist in training has required radical change and improvement, and that a substantial part of it should be at a University Psychiatric Department. We should be living in cloud-cuckoo land if we imagined there would be any improvement in the next few years in the supply of staff to services such as ours.

I should like to quote Sir Denis Hill's very timely remarks at a recent meeting. He said: "The number of psychiatrists has now increased almost to a ceiling which is imposed by the shortage of medical manpower; but the numbers are still too few. In the medium-term future all that can be done will have to be done with existing resources. With an expanding population, expected to increase by 40 per cent. in 25 years, the proportion of the population who in the future can be recruited to the 'caring' professions will be proportionately fewer than at present, and the proportion of the population for whom care will have to be provided will be proportionately greater."

My personal view is that nothing is more likely to retard progress than this situation.

A lowering of clinical standards can creep in alarmingly quickly when the medical establishment is below strength, and it may take years to raise them again. Nevertheless, I would not attribute any decline in standards entirely to having fewer doctors. There seems to have been a gradual shift of interest away from clinical psychiatry, in the classical meaning of that term, to a more widely based but superficial "community psychiatry" in respect of which it has been said that psychiatrists should no longer be "bed-bound clinicians" but should supervise others—for instance Mental Welfare Officers—in helping people. Erwin Stengel, in his Presidential Address in 1966, said that nowadays there is noticeably less emphasis on diagnosis than used to be the case. This surely must be a danger sign.

A remedy for the staff shortage, and it may be a remedy which will also have indirect benefits, is the introduction of our general practitioner colleagues into our staffing structure. Many G.P.s, especially if they have attended psychiatric seminars over a period of time, can be of great value, in both in-patient and out-patient work, and their maturity and relative permanency are not the least of their assets.

An allied problem is in regard to psychiatric social workers. Referring again to Stengel's Address, he said that "social psychiatry can claim to be a new approach . . . and the emergence of the P.S.W. as a member of the team has added a new dimension to clinical work". Yet, if present trends continue, hospital-based social work departments will in a few years have vanished. Joint appointments with Local Authorities might save the situation, but there can only be speculation on this problem until the future organization of this country's social services as a whole has been decided. I am convinced that a good hospital-based (but not hospital-bound) social work service is an essential cog in the machine.

Yet another complex problem is the very future of our psychiatric hospitals and what role they will play if still in existence in, say, fifty years' time. T. P. Rees wondered whimsically whether sometime early in the next century, a coach trip would be arranged at an R.M.P.A. meeting to visit the last of the big mental hospitals before it was converted into a holiday camp. Stengel said that the fact that in this country until recent years psychiatry had been practised almost exclusively in mental hospitals

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was one of the reasons why British psychiatry had for so long led the world in patient care. He commented that the mental hospital is now losing its traditional role and is groping for a new identity.

Ivison Russell, in his far-seeing Presidential Address of 1949, suggested that the integration of psychiatry and general medicine would seem to have been accomplished. Early treatment, he said, was likely to be given increasingly in general hospitals, but it was essential that "those who fail to respond should not be downcast by the suggestion that everything possible has been done and that transfer to a mental hospital is the stamp of chronicity". He feared the growth of a philosophy of saving the patient from the mental hospital. He also spoke of the powerful and evil influence of stigma and wondered if it was not being preserved by the elaborate care we took to avoid it.

Should our psychiatric hospitals be entirely eliminated at the earliest possible moment? There are those who roundly condemn them, who say it is sheer waste of money to modernize, and declare that they do more harm than good. Others venerate them as sacred cows. Emotional bias is not lacking on either side, and has to be reckoned with. Those who, like myself, have spent the major part of their careers in developing comprehensive community services based on their hospitals, cannot avoid the feeling, when their elimination is advocated, that an assault is threatened on the whole fabric of the service.

Yet we must not try to preserve the Establishment, the *status quo*, as unconscious memorials to ourselves. We will, in the event, identify and serve the needs of those we are responsible for. Not long ago Kenneth Robinson said that the day of the hospital as an architectural monument was over. As the ways of society change so do its needs and we must be constantly adapting our tools to suit the new machine.

Psychiatric hospitals have much to offer general hospitals, in atmosphere, in communication and administration. We should not hide our light under a bushel, and we should resist a too hasty absorption into a large impersonal District Hospital which, being less sensitive to psychiatric needs, might be less therapeutic also.

The comprehensive McKeown-style hospital will, I am sure, not be a reality in the lives of any of us, ideal though it is in concept. Changes are bound to be slow because of the cost and magnitude of the task of total rebuilding.

For many years to come, the present Minister's expressed policy of evolution and adaptation of our existing hospitals will be carried out. But whatever final pattern emerges, no effort must be spared to avoid the recrudescence of stigma and a gradual lowering of standards, efficiency and morale. It could so easily happen.

In drawing from the deep well of experience, I have tried to give you a picture of Moorhaven Hospital in its days before nationalization, and then of the service which has been twenty years a-growing: the first decade being Years of Plenty culminating in a Golden Age for hospitals, and then a relative decline as other facilities expand. The *events* described, of course, are *not* unique, even though it has been said that each hospital is a unique institution with its own singular and inimitable pattern of culture. For better or for worse, it seems right and proper that such events should be reviewed.

This, then, is a chapter of psychiatric history, arising out of which I have given you some personal reflections relating to the way ahead. Will the day come when the sun will set on our psychiatric hospitals like the going down of the sun into the ocean beyond the deserted Blasket Isles? Be that as it may, irresistible change will bring new challenges and exciting events in the years to come.

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