AIM AND METHOD IN TREATMENT: TWENTY YEARS OF BRITISH AND AMERICAN PSYCHIATRY*

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THIS Address tonight will mostly concern psychiatric treatment, and it must be quite exceptional, I think, for those of us, still in our late forties, to have lived through such a revolution in treatment as we have seen in the last twenty years in this country. In this revolution I believe we have seen Great Britain emerge as one of the countries now leading the world in the skilled, humane and all-round treatment of her mentally ill patients. There is obviously still very much that needs to be done, yet we must try not to underestimate what has already been achieved recently in this country.

By tradition, the President of this Section is allowed to be reminiscent, and I would like to take advantage of this privilege in my Address so as to be able to look back with you on some of the varied psychiatric treatment happenings of the past twenty years. I think there is much to be learned from them of help to us in the future. Unfortunately, none of us can really hope to get any idea from our past experience, of the kind of *detailed* psychiatric treatments that we may be called upon to practise in the next twenty years. For if the past two decades should have taught us anything at all, it is that we shall never know what exactly is suddenly coming round the corner as a new and important treatment development in our speciality.

I have been very fortunate indeed in all the opportunities that have been given me for exploring the various possible treatment approaches in psychiatry. Starting psychiatric work in a mental hospital with great historical traditions, I had later the chance to train and work under the late Professor Edward Mapother (of whom you will hear so much in this address) at the Maudsley Hospital and to spend nearly fourteen years on the staff of that hospital. I was able to spend all the war years in studying the fascinating special military and civilian treatment problems of those exciting days, working as a member of the staff of the Maudsley Hospital, then evacuated to Sutton Emergency Hospital. For the last eight years it has also been possible to explore the even more varied opportunities for psychiatric treatment and research that occur in the set-up of a London general undergraduate teaching hospital, where a psychiatric in-patient treatment unit and special out-patient treatment department have both been provided, and where such easy and ready access to and contacts with the rest of general medicine and surgery are available.

In this address I shall also want to discuss some special aspects of American psychiatry, so as to compare and contrast them with ours. For there are also important lessons to be learned about our future aims and methods

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from such comparisons. I must stress here that it is only after four separate visits over eighteen years, including two whole years of psychiatric work in the U.S.A. at Harvard and Duke Medical Schools in 1938 and 1947, that I have dared for the first time to talk about this matter.

I was particularly fortunate to have entered psychiatry from general medicine in 1934, when for the next year or so treatment was to be still almost virtually non-existent, as we know it today, for the ordinary run of patients either inside or outside a British mental hospital. Admittedly, Freud, Adler and Jung's specialized psychotherapeutic methods had already been in use in Great Britain for a long time. As early as the first World War one of my predecessors at St. Thomas's—W. H. B. Stoddart—was starting to teach British medical students a new psychiatry based on Freudian dynamics (1). Freud, Jung, and Adler certainly created renewed interest in the detailed working of the mind of man, and also helped to raise to new heights the dignity of and the respect for the sufferer from a mental illness. They also rightly insisted on the need for a most detailed study of the individual patient for treatment purposes, and this has proved just as important for the proper use of the newer physical methods as for the psychological treatments. But unfortunately when I entered psychiatry in 1934 the position was, in general, almost exactly the same as it is today in regard to this group of specialized psychotherapeutic methods. They were proving able to help only comparatively few of the mentally ill in a really concrete and practical manner, and these few could involve so much work, and take up so much of a doctor's time, that the problem of providing for the practical treatment of the mentally ill in hospitals in Great Britain had hardly been touched by their introduction at all.

I entered psychiatry as a locum at Hanwell (now St. Bernard's) Hospital where a hundred years previously Conolly's work had helped to abolish physical restraint in British mental hospitals. Like our modern psychodynamic theorists, Conolly had not only preached the gospel of the importance of love and affection for the mentally ill patients, but he had practised it to some very real purpose. In "moral treatment" he got nearly as far, and possibly even farther than many have reached again today, who are stressing a predominantly psychotherapeutic and social approach. But it is most important to realize that it was obviously very far from being enough. Conolly knew it himself only too well, and was always looking round for new bodily treatments and new physical ways of helping patients (2).

Hanwell in my time still remained a happy hospital with a much beloved superintendent, who was known to and admired by all his patients as a true friend and counsellor. Dr. Daniel seemed to have a real genius for understanding mentally ill patients and establishing good personal relationships with them. But he, too, had learned, and we all learned at that hospital very soon, as Conolly had also learned a hundred years before, that a psychotherapeutic and social approach was not enough in itself to get so many of our patients well. I shall never forget some of the wards then, with their agitated and perpetually suicidal patients, who seemed almost impossible to get at, let alone help by any means then available to us. These patients should always be remembered by those, especially of a younger generation, who wonder how much progress has actually been achieved by using the all-round empirical treatment approach of present-day British psychiatry, which allows every available method to be used regardless of theory or belief—provided only that it helps and does good rather than harm to the patient. In most British mental hospitals, where all modern methods—such as leucotomy, insulin, electric convulsion therapy,

group psychotherapy, the new chemical tranquillizers, occupation therapy, unlocked wards, the admission of voluntary patients and the like—are now available to be used and combined when necessary, these old disturbed wards and these patients have largely disappeared. Furthermore, this broad empirical approach to treatment has now also made possible the opening of so many more of the doors of the old locked wards, often because there are now so many fewer distressed and violent patients in them to try to run away, and this in turn reduces frustration, tension and abnormal behaviour still further in the rest of the mental hospital population not well enough to be discharged.

A little later the late Professor Mapother offered me a locum at the Maudsley and I accepted with renewed hope. He was trying to gather together a team of varied workers, collected from general medicine, who might be interested in research into all the possible physical and psychological approaches to psychiatric treatment that he felt might suddenly develop at any time. His pet obsession, which later also became mine, was that the really workable and practical psychiatric treatments would eventually turn out to be physiological ones, as in the general medicine of today. Insulin, E.C.T. and leucotomy were unknown, and few guessed how many of the hormones and vitamins influencing mental behaviour would so soon be synthesized, or that such a range of modern chemical tranquillizers would be produced so quickly. Mapother was at that time being roundly abused or laughed at by very vocal ideological rivals. Firing their psychological broadsides, these rivals accused Mapother of trying to search for a cause of the neuroses with an ophthalmoscope. How right Mapother was to continue to try to do so at a somewhat discouraging time for him and for us all.

The history of recent psychiatric treatments and the present British aims and methods in psychiatry cannot be understood without knowing more of this truly remarkable man. For the people who were trained by him at the Maudsley now occupy so many of the important posts in British psychiatry and also abroad, that British psychiatry at least has now largely become Mapother's dream come true. His genius lay in a rare capacity, obvious to all, for collecting and keeping around him strong personalities of the most diverse talents and quite differing viewpoints, and so he hoped to build up a permanent staff of clinicians who would eventually make the Maudsley the "Queen Square" of psychiatry. The rapid dispersal of so many of them to other centres after World War II was certainly not among any of his long-term plans. But it has helped to give British psychiatry its present wide, varied and broad basis of treatment.

Mapother felt, after seeing the results of Freudian and other specialized forms of psychotherapy for many years, that these alone held out very little hope of ever solving our enormous treatment commitments in a really practical manner. But he certainly never denied the great importance of psychotherapy as a part of all forms of treatment. He utterly refused to accept as inevitable so much of the suffering of the mentally ill at that time. Mapother expected us to work and continue to work intensively with our individual patients, using all of the few treatment methods we then had at our disposal. He deplored nihilistic attitudes to treatment even then. But effective methods in those days were almost non-existent and somehow we had to hide from ourselves, I think, and from others our real treatment impotence even to shorten the length of an attack of acute recoverable mental illness in most instances.

If I am stressing treatment conditions and results prevailing in those days, it is to counterbalance some recent viewpoints heard both in this country and

in America, that if only one could spend more time on psychotherapy, the need would largely disappear for modern physical treatment methods. Some psychotherapists are now even going so far as to call these merely the newer forms of physical restraint (3). Yet in America today, especially in centres where they are trying to stress psychodynamic and psychotherapeutic approaches to treatment at the expense of the more empirical physical treatment methods, they are openly advocating that two hours a day of personal guidance and help should be given to the young psychiatrist in training to help to tide him over his despair at the lack of any immediate concrete results of his treatment efforts. Certainly we too needed that sort of consolation and support at Hanwell and the Maudsley. But there is certainly no need for it now in British hospitals and psychiatric clinics when all types of new and of older proven methods are being properly and selectively used.

In trying to understand the many problems that the advent of these new physical treatments suddenly created at that time, it is important, I think, to realize that, apart from a few persons like Mapother, psychiatry then seemed relatively unprepared to deal with them in a sensible and practical manner. Many psychiatrists, then as now, were much more philosophers than general doctors in their outlook. They were in obvious rebellion against the materialistic and mechanistic viewpoints of modern medicine, and some wished for a return in our speciality of a better appreciation of philosophical and spiritual attitudes. There were others, too, who wished to emphasize the importance of the non-material mind in psychiatry. But all these more philosophical aspects of mental illness might start to seem very unimportant from a treatment point of view when even a very severe religious melancholia, for instance, cleared miraculously after only a few crude epileptic fits induced by cardiazol, and with so little psychotherapy perhaps being necessary at all.

Only a few persons like Mapother, in fact, seemed to suspect what was coming. When asked what were the qualities needed for a good psychiatrist, he insisted that he really did not know. For they might have to change so rapidly at any moment. Mapother always insisted on having on the staff of the Maudsley, for instance, only those who had obtained the M.R.C.P. For he felt that at any rate he then had a team of potentially good physicians. How right he was in this, looking back on what has happened since in our speciality. A lot of our troubles in the last twenty years have been that too many would-be philosophers have been forced, suddenly and often against their will, to try to use in a skilled manner what are medically and surgically very powerful and potentially very lethal treatment weapons. Because we have not always been the good physicians that Mapother would have had us be first and foremost, we have often also taken up much too violent emotional and philosophical attitudes about them. Such attitudes are very much rarer in general medicine simply because the actual results of treatment are considered much more important than any philosophical theory or belief behind them.

In 1938, just after insulin and cardiazol had been tried and were found to be working so well in selected patients in Great Britain, I was advised and helped by Professor Mapother to go to the U.S.A. on a Rockefeller Fellowship. This was the first of four subsequent visits and two years of work in that great and fascinating country. About that time I think one saw the start of some of the present wide divergencies of emphasis in treatment in British and American psychiatry, still to be seen at the present time. We must accept it now that we are sometimes a very long way apart in some of our general treatment

aims and in the uses we make of all the various treatments now available to us in our speciality. We should try to understand why. Before World War II, Adolf Meyer was well on his way to unifying most aspects of psychiatric thought and practice in both countries. It was also standard procedure for the British as well as the Americans to try to go and sit at the feet of that great man in Johns Hopkins University at Baltimore. At that time, too, the Rockefeller Foundation was starting to pour money into psychiatry, but were looking for a change of approach, which could be more actively therapeutic even if less broadly based than the Meyerian one. The Rockefeller Foundation had also realized, as had Mapother, that to help to mould medical opinion towards psychiatry and create a more favourable atmosphere to its future development, it was the undergraduate medical schools that often mattered far more than the post-graduate ones. New Chairs of psychiatry were therefore being encouraged and supported by the Foundation in the leading undergraduate medical schools in the U.S.A. To help to stimulate such new approaches, physicians or physiologists of acknowledged eminence were sometimes appointed who were particularly interested in the psychoanalytic or "psychodynamic" approach.

During a year spent at Harvard at the Massachusetts General Hospital in 1938–39, at one of the very best of these new Rockefeller endowed units, I was able to watch and discuss the results of treatment with Freudian psychoanalysis, or the briefer forms of psychotherapy largely based on its principles. But I noticed that all the newer physical treatments were being ignored, and it was still the same when I returned there on another visit in 1947. And still the same yet again even in 1954. This meant that many hundreds of Harvard medical students would have meanwhile been taught a restricted viewpoint on treatment; and it was to become just the same in so many other undergraduate medical schools all over the U.S.A. This has now gone on for over fifteen years. Thus psychoanalysis has become the treatment of choice in most academic psychiatric circles. British psychiatry has too often made the mistake of thinking that it is broadly based postgraduate centres and mental hospitals which dictate its future psychiatric policy; but what often matters much more are the undergraduate teaching hospitals. Great Britain could start to go Freudian, or Jungian, or Pavlovian overnight if all the undergraduate teachers got together and decided this was the approach that should be taught to all of the hundreds of medical students each year. This revolution could be effected, probably, quite regardless of what postgraduate psychiatric centres and mental hospitals were thinking at the same time. For mental hospitals and postgraduate clinics have generally in the end to play the tune demanded of them and bow to the views of the rest of the indoctrinated medical profession.

At any rate, I returned from the U.S.A. in 1939, at the outbreak of war, having been given a real opportunity for a year of seeing psychoanalysis and "psychodynamic" psychiatry at its very best in an excellent general teaching hospital atmosphere, and being used under an honest, critical and most inspiring leader. But it became more and more obvious during that year that even by the widespread use of such methods, one could never hope to start to touch even a minute fringe of the large numbers of moderate and severe neuroses and psychoses crying out for urgent help and treatment in both our countries. Other better and more practical methods simply had to be found as speedily as possible. Over the year, too, I had seen many patients doing no better at all than with the more simple and direct psychotherapeutic and physical methods we were using at the Maudsley. Furthermore, only so very few patients could be handled with these more doctrinaire types of psychotherapy. This meant

that most of the psychiatric patients either had to be put on an indefinite psychotherapy waiting list, or be turned away with absolutely no treatment at all. My year, however, was certainly not wasted. Mapother's views on treatment, which had roused so much criticism even in Britain, now seemed to have been amply confirmed.

Mapother, unfortunately, did not live to see the final triumphs of his foresight and planning in England. He died soon after the war started, thinking that its outbreak meant the probable end of all his work, instead of the beginning of a new era in which his views would be so triumphantly vindicated, and his work so effectively carried on in British psychiatry by all those he had inspired.

Present trends in psychiatry in Britain cannot be understood without realizing what happened during World War II. For so many of our preconceived theories about the causation and treatment of neuroses fell to pieces under a very searching test, and in a Britain geared for results in a total war. It was not possible any more to deceive oneself as easily as in peacetime. Also, all that mattered was that as many patients as possible should be got better to serve in the total war effort, and therefore new attitudes to treatment were more quickly able to gain a strong foothold in Great Britain and they have not been dislodged since. Electric convulsion, insulin treatment and leucotomy, front-line sedation and the group therapies became so rapidly and widely used in this country simply because it was found then that they all worked so well in properly selected patients (4).

One of the outstanding developments of the war years, which passed relatively unnoticed then, will undoubtedly prove to be the development of various forms of group therapy. At the beginning of the war, many psychotherapists had entered on it with very high hopes of showing what could be done by the more individual psychotherapeutic approaches. But the first group of really acute Dunkirk neuroses shattered the hopes of many of the pure psychotherapists. Only by using combinations of all treatments, such as "front-line" sedation, continuous sleep, barbiturate abreaction and modified insulin together with psychotherapy, was it often possible to work apparent wonders and at least to avoid much of the terrible chronicity seen during and after World War I. And even with all these additional physiological and environmental aids to psychotherapy, the available psychotherapists also found they could not even start to tackle, let alone help, a tenth of the urgent individual treatment demands being made upon them.

Nothing I say about the value of physiological aids to psychiatric treatment must be allowed to minimize the importance of additional and practical psychotherapeutic approaches. I am only concerned in this address to try to get all such treatment approaches into much better practical perspective. And as religion and politics have shown for so long that psychotherapy can often best be given in groups, it did seem sensible that hard-pressed psychiatrists should at last try to do the same thing, particularly when it was new beliefs, interpretations and better attitudes which we wished to get home to our patients. Furthermore, the formation of groups in British mental hospitals in peacetime has given to such patients a new status and dignity they did not have before.

The end of the war certainly showed a Britain now much more ready to accept all forms of empirical treatment—group therapy had even started to be combined with leucotomy, insulin coma with individual and group psychotherapy. People of different viewpoints, who had worked together during the War, now more happily continued to do so during peacetime, because we had all found something of selective value in the methods being used by the others.

Mental hospitals, too, began to be staffed by persons of all viewpoints. The present era of intensive if empirical psychiatric treatment in Great Britain was, in fact, beginning to dawn.

Shortly after the end of the war, a neutral surviving dictator state sent one of its psychiatrists to report on Britain's new psychiatric approach. He bitterly complained to me that he could not find any typically British approach. Everywhere he went, he said, he was being told something quite different by people of obvious psychiatric authority. I reminded him that we had just fought a long war so as to be allowed as individuals to think and act differently from our colleagues if we so pleased. And this independent treatment attitude has happily grown stronger and stronger in psychiatry in Great Britain ever since. Great Britain seems to be exceptional, in fact, in the very great freedom of psychiatric thought and practice to be seen here at the present time.

I have been privileged to make three further visits to the U.S.A. since the war, and in one of these I spent another very happy year of work there. Adolf Meyer's empire had suddenly crumbled with his retirement during World War II, and so few traces of it remained even by 1948 that it might almost never have existed. A great vacuum was suddenly created, for Meyer had left no real successor to his throne. Into this vacuum entered the strong and growing body of dynamically orientated Freudian psychiatrists, now having very strong general medical and research backing. Certainly by 1948 nobody had much hope of obtaining an important professorial teaching appointment in the U.S.A. north of the Mason-Dixon Line, unless he had finished a personal psychoanalysis and had accepted what is called a "psychodynamic" approach to treatment. And it is still very much the same today. This has naturally had some very serious repercussions on the treatment of the mentally ill in the U.S.A.

For we sometimes tend to forget that no personal or training psychoanalysis is ever really finished till at least the basic tenets of the Freudian psychoanalytic theory have been accepted. In any intellectually honest person, aims and methods of treatment must then of necessity undergo very profound changes. Certainly little encouragement is generally given to the use of the newer physical treatments by persons so trained, since these treatments so often seem to violate important basic tenets both as to the theoretical causation of a mental illness and its proper treatment.

Such viewpoints must not be thought of merely as American ones, for we also see in our own country, for instance, Dr. Winnicott, the present Chairman of the Institute of Psychoanalysis in Great Britain, demanding the right of all mental patients to be allowed to suffer to the point of suicide rather than that their psyches should ever be "violated" by our modern physical methods of treatment (5). The following "psychodynamic" viewpoint, on the proper training of psychiatrists, also reflects some present American attitudes, but actually appeared recently in a letter written by a British doctor (6) to the *British Medical Journal:*

> The practice of good clinical psychiatry is primarily dependent on the ability to develop "empathy" with patients, which can only be done by those whose personalities are sufficiently flexible to accept the insights of analytic psychiatry, whether Freudian, Jungian, Sullivan, etc. Disappointed physicians and neurologists usually possess a resistance to such concepts which could only be overcome by a training analysis . . . Physical methods of treatment, including the latest batch of tranquillizers, are quite secondary in importance to an analytic approach. They are useful, but only as a means of facilitating empathy and psychotherapy in its widest sense. Seven years in psychiatry, including two years in North America, only confirm my opinion that, however valuable an organic approach may be it is no substitute for an approach based on an integration of the great analytic schools and learning theory, whether one's work is in the so-called back wards or in acute neurosis units.

Whether or not this somewhat limited viewpoint can ever really be considered a justifiable one, we must not forget some of the effects it often has on our aims and methods of treatment in the handling of the ordinary psychiatric patient. It does in practice put many patients straight back again to the unhappy treatment conditions prevailing in British mental hospitals twenty years ago when I entered psychiatry and when, as discussed earlier, psychotherapy and sedation were our only available treatments. In America the demands for psychoanalytic treatment now greatly exceed the supply of available practitioners because of the teaching of this approach in so many of its medical schools. Incomes of twenty to thirty thousand dollars a year may now be earned by most psychoanalysts prepared to do this type of treatment in private practice. But this has also meant that the American mental hospitals, where the bulk of the mentally ill are treated, as in Great Britain, have now lost practically every one of their finest clinicians, because they cannot pay anything like the salaries now to be earned from the private practice of psychoanalysis and psychotherapy. And this has happened, unfortunately, just at the time when this whole range of new treatments, both physical and psychological, have emerged which demand that persons of the very highest standards of medical training, and even the higher standards of clinical judgment, should remain working in mental hospitals so as to choose, combine and give all such treatments selectively and skilfully.

The treatment differences now seen in the mental hospitals of both countries can sometimes be very marked indeed at the present time. For instance, let us look at some of the claims being made for the value of the new chemical tranquillizers in some American mental hospitals. Nothing approaching the same results are being obtained in Great Britain partly because all other empirical methods have been and are being so much more widely used, and therefore there are so many fewer chronically agitated and acutely disturbed patients still left to treat now. Hoffman and Konchegul, testing out one of the new chemical tranquillizers as a possible aid to treatment in such mental hospitals, report in a recent paper from St. Elizabeth's Hospital, Washington, that as few as 39 of its noisy and violent patients needed 17,839 hours of seclusion in a period of only seven weeks during the time that nearly half of them were being treated with Serpasil, and this was despite the fact that the half on Serpasil had had their seclusion reduced by over 40 per cent. by a reduction of their extreme agitation (7).* In England today, however, only 6,000 hours of seclusion (and very much less in some of the most active treatment hospitals) may be needed for a whole hospital of two to three thousand mental patients of all types over an entire year. Increased seclusion of patients can be due to many causes but if in Great Britain, for ideological or any other reasons, we had left so many of our agitated and disturbed patients untreated by such empirical methods as insulin, E.C.T. and various types of leucotomy, to concentrate more on psychodynamic approaches, we could never even have started to unlock so many of the doors of our acute and chronic mental hospital wards throughout the country; and this in turn has proved to be most helpful in the proper psychological handling

* In the first six months of 1955, when this article by Hoffmann and Konchegul was published, E.C.T. was reported as used in only 12 out of 7,500 patients in this hospital (8). On a personal visit there in 1954, I also learned that insulin coma and leucotomy had been almost entirely given up, but that psychodynamic treatment viewpoints were strongly held by many of its staff. The hospital is excellently administered and is one of the foremost American psychiatric hospitals.

of many other types of patient not needing these particular physical treatments. We have also certainly not found, as is being claimed in the U.S.A., that the new chemical tranquillizers can in any way replace full or even modified leucotomies in so many of our patients, though they can be very helpful indeed in a carefully selected few.

In Russia, where Pavlov rather than Freud now dominates treatment viewpoints, leucotomy has been totally banned for some years, largely because it was thought to conflict with Pavlovian theoretical concepts. Yet in Great Britain we still go on getting a third of our chronically mentally ill patients out of hospital wherever this method is used; and other patients, remaining in hospital after it, may be relieved of intolerable mental suffering and become able to be transferred from locked disturbed wards to open ones on full parole. Nearly 15,000 full and modified operations have now been performed in Great Britain simply because it does seem to help so many of our otherwise mentally tortured and chronic patients in so practical a manner.

From the patient's point of view, at least, it seems that our present broad empirical approach in Great Britain, tied to no particular ideology or dogma, does certainly improve his chances of being helped both inside and outside of the mental hospital, and to increase greatly his expectation of being able to leave a mental hospital much earlier.

Several obvious facts stand out on looking back over the past twenty years. The most important of these is how few of us, either in England or the U.S.A., guessed from which direction the next really important practical treatment discoveries in psychiatry were going to come. All our future treatment aims and methods in Great Britain must certainly be directed to seeing that no selective approach or dogma is ever propounded or taught again in psychiatry that prevents the rapid use of all new treatment methods. And we should also try to see all new advances as additions rather than as replacements of still valuable older methods.

However much we happen to disagree personally with any particular approach or treatment method, we must in future always allow it the opportunity to show its worth, for the last twenty years have shown how wrong even the experts have generally been in their judgments before new treatments have been properly tried out. It is Britain's great good fortune at the present time that it happens to have no predominant psychiatric approach and so few dominant psychiatric personalities. We are also, I am certain, now providing the essential opportunity and the practical testing ground so necessary for an eventual reconciliation and re-synthesis of so many of the differing dogmas in our speciality to be seen in so many other countries today.

Before the introduction of the N.H.S., for instance, the ultimate goal of promotion in the mental hospitals of Great Britain sometimes involved virtually giving up most of one's clinical work for administrative duties. Now clinical consultants are appointed in mental hospitals at the same rates of pay as the physician-superintendent and a doctor can specialize in the skilled treatment of patients without being penalized for not becoming an administrator as in most other countries. Furthermore, the same special "merit" awards are awarded to the clinicians working in mental hospitals as in other specialties. This enables the really first-class clinicians to remain in mental hospital work instead of being withdrawn by the lure of increased salaries to the psychiatric departments of general hospitals, or into the private practice of psychiatry. Appointment Boards, with the independent assessors provided by the Universities and Royal Colleges, and the compulsory national advertising of all senior posts

in mental hospitals, has helped to stop too many persons of one type of thought staffing a particular hospital, unless there are very special reasons for it. The N.H.S., too, has enabled certain centres like the Tavistock Clinic and the Cassel Hospital, specializing in psychoanalysis, or a centre for special group treatments at Belmont Hospital, to have exactly the same status and financial support as all the other more general psychiatric units and hospitals. All London undergraduate teaching hospitals have now been given strong and quite independent psychiatric departments, and most now have beds of their own, making them much more independent of the mental hospitals and postgraduate centres. New Professors of Psychiatry have been created in most of the provincial medical schools. All this spells ever greater clinical freedom for new ideas to develop, and a greater chance to see them carried out all over the country.

When I was last visiting the U.S.A., in 1954, I was trying to describe the present happy state of British clinical psychiatry under the N.H.S., even if its research aspects still leave so much to be desired. I described it as a pleasant and loosely organized system, which worked so well simply because it had no primary direction or aim except one, and that was the patients' own practical treatment welfare. I learned afterwards that some of the audience felt that such a state of affairs in British psychiatry, even if true, simply could not continue, and that one psychiatric ideology or the other, as in other countries, must inevitably win and dominate all the others. If I have a suitable plea on which to end this Address, it is that we in Britain should go on playing our special type of "all-in" psychiatric game, quite determined that no one side shall ever really win it. The game must also never stop, so that we can always go on learning how to improve our technique of play for our patients' benefit. In all our aims and methods, the patient rather than the belief or the method must continue to come first. We must remain tolerant of all those aims and methods helping even a very small selected group of patients, and perhaps only shortening a particular attack of an illness rather than curing the illness itself. We must also be prepared for all our own personal pet aims and methods to be replaced gradually, or at least to be supplemented by much better ones, as time goes on and our psychiatric knowledge grows. And, above all, let us try to preserve a true sense of psychiatric humility.

Now, as doctors, we do often have to make very important and difficult personal decisions on the choice of particular treatments for our patients, and sometimes have to take calculated risks with their lives, and with their remaining mental health, so as to try and save them from a prolonged and agonized chronicity. Here there is one rule that will help to preserve our humanity, and also keep our determination to do everything possible to help such patients. That rule is that we do nothing, or omit nothing, that we would wish to be done to ourselves or to one of our own family, if we ever happened to be placed in the same unhappy circumstances. Then I think we cannot go very far wrong, either, in any of our own *personal* aims and methods of treatment.

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