

THE JOURNAL OF MENTAL SCIENCE

[*Published by Authority of the
Royal Medico-Psychological Association*]

No. 422

[NEW SERIES
NO. 386.]

JANUARY, 1955

VOL. 101

Original Articles

THE CONTRIBUTION OF PSYCHOLOGICAL MEDICINE TO GENERAL MEDICINE

THE PRESIDENTIAL ADDRESS DELIVERED AT THE ONE HUNDRED AND THIRTEENTH
ANNUAL MEETING OF THE ASSOCIATION ON WEDNESDAY, 14 JULY, 1954

By

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I DEEPLY appreciate the honour that the Royal Medico-Psychological Association has paid me in electing me President for this Year.

It is a tribute to the Middlesex Hospital and to all those who have worked with me, and who are now working with me in the Department of Psychological Medicine.

I shall strive to justify the confidence that the Association has placed in me by making me President, and I shall do my best to uphold the high tradition of my predecessors.

It is a particular pleasure to me to be inducted here at St. Luke's-Woodside, not only because of my close association with this Hospital since 1935, but also because of the part that Physicians connected with St. Luke's in earlier years have played in the history of the Royal Medico-Psychological Association and Psychiatry. I hope that a brief account of this will be of interest, and will explain how St. Luke's-Woodside became the Psychiatric In-patient Wing of the Middlesex Hospital.

Royal Bethlem is the oldest Mental Hospital in England. I believe the second oldest is Bethel Hospital, Norfolk.

On 13 June, 1750 "Six charitable gentlemen of the City of London met in the King's Arms Tavern in Exchange Alley to consider the establishment of a hospital for the care and treatment of poor lunatics". (1) As a result of this meeting, St. Luke's Hospital was opened in 1751. It is of interest that the first physician to St. Luke's was Dr. William Battie, who in 1764 was elected President of the Royal College of Physicians.

At this point I should like to record that in 1766 the Manchester Lunatic Hospital was opened by the Trustees of Manchester Infirmary and this eventually became Cheadle Royal Hospital.

In 1914, when St. Luke's Hospital was still in Old Street, the site was sold to the Bank of England. The old Hospital was finally closed in 1917.

After the first World War the Governors decided not to build another Mental Hospital, but at the suggestion of Dr. R. W. Gilmour, who had been Assistant Medical Officer at St. Luke's, and who was in close consultation with Sir Hubert Bond, one of the Commissioners of the Board of Control and President of the Royal Medico-Psychological Association in 1921, the Board decided to approach the Middlesex Hospital with the idea of starting a Psychiatric Out-patient Clinic there. Not only was this arranged, but provision was also made for the use of six beds in the Neurological Ward of the Middlesex Hospital for suitable psychiatric cases, the cost and maintenance of these beds being borne by St. Luke's. This agreement came into action in 1923, with Dr. R. W. Gilmour responsible both for the Out-patient Clinic and ward cases.

This appears to be the first occasion on which a Teaching Hospital has allocated beds for psychiatric illness, since the closing of the "Lunatic Ward" at Guy's Hospital in 1860.

Soon after this arrangement with The Middlesex, the Board of Governors of St. Luke's considered the question of further building, and in 1930 opened Woodside as a Hospital for functional nervous disorders in the educated classes.

At the outbreak of the second World War Woodside Hospital was allocated by the Government as a Hospital for officers suffering from psychiatric disabilities.

Patients were admitted from any of the allied services. There was accommodation for patients of both sexes so that altogether during the war officers from twenty-five different services were admitted.

With the formation of the national health service, it was decided that the Middlesex Hospital and St. Luke's Ancient Foundation should amalgamate completely, and the Board of Governors of the Middlesex Hospital decided to utilize Woodside, which was re-named St. Luke's-Woodside, as its in-patient psychiatric wing.

You will realize, therefore, that those of us who are fortunate enough to work here not only have the old heritage of St. Luke's Foundation, but also all the advantages of being part of a London teaching hospital.

In view of what has just been said I am sure that you will share with me the pleasure and thrill which I got when I found that this is the Centenary Year of the Presidency of the Royal Medico-Psychological Association, and that the first President elected in 1854 was Dr. A. J. Sutherland, who at that time was medical superintendent of St. Luke's Hospital, in Old Street.

With all this history behind me and considering that this annual meeting is being held in such close association with one of the London teaching hospitals, I felt that there could be no more appropriate theme for this address and annual meeting than that of "The Contribution of Psychological Medicine to General Medicine".

Firstly, I have endeavoured to obtain some factual information in order to show the extent to which the ill-health of the nation is caused by what for brevity I will call psychiatric or psychogenic disturbance. I am indebted to the Ministry of Health, the Board of Control and the Ministry of Pensions and National Insurance for their help in enabling me to obtain the following figures.

On 31 December, 1952 there were a total number of 149,353 patients in mental hospitals suffering from some type of mental disorder. On the same date there were 135,316 people suffering from mental deficiency who were in hospitals, on licence, under guardianship, under statutory supervision or voluntary supervision.

The number of mental hospitals, Section 20 hospitals, registered hospitals, licensed houses and nursing homes taking voluntary and temporary patients came to a total of 357, and in addition there was Broadmoor State Institution.

The number of mental deficiency hospitals, certified institutions, and approved homes, was 184. In addition there were Rampton and Moss Side State Institutions.

The cost to the nation of mental hospitals, state institutions and the Bethlem and Maudsley Hospitals, together with the salaries of specialists in the Mental Hospitals and Mental Deficiency Institutions is approximately £45,661,000 a year.

There are no data, other than those mentioned above, by which we can estimate the cost of upkeep of the numerous clinics, neurosis centres or beds for mental disorder or mental deficiency. It is possible that the cost of these scattered beds and units might amount to a further 5 per cent. of the total already mentioned.

It would appear from the statistics supplied by the Ministry of Pensions and National Insurance (2) that during the year 1950 the number of periods of absence from work for which insurance benefit was paid owing to psychological illness, i.e. the psychoses and neuroses was about 205,000 (involving a loss of something like 10 million days). During any one year the cost to the Nation of sick benefit for such an amount of incapacitating illness is approximately four and a half million pounds, which is about 5½ per cent. of the total paid out during one year in sick benefit for all causes.

In addition to this group (the Psychoses and Psychoneuroses), it is interesting to note some of the other diagnostic labels used in this particular table of statistics. There are, for instance, such headings as:

(a) Allergic disorders:

Asthma
Urticaria
Other allergic disorders.

(b) Diseases of the stomach and duodenum, other than ulcer, cancer, gastritis and duodenitis.

(c) Diseases of menstruation.

(d) Diseases of the skin.

(e) Rheumatism, except rheumatic fever.

Under a main heading "Other unspecified and ill-defined diseases" there are sub-headings indicating symptoms referable to a number of the systems, e.g. cardiovascular, gastrointestinal and the abdomen. Nervousness, debility, and headache form yet another heading.

Remembering that these statistics are compiled from the medical certificates sent in by medical practitioners, it is interesting to conjecture in what percentage of the above groups psychogenic disturbance plays a big or the biggest part in the aetiology of the illness. It is not very popular among patients to have a medical certificate showing that their illness is psychogenic. It is not rash to assume that many of the medical certificates bearing such diagnoses as are covered by the above headings or such an ill-defined diagnosis as fibrositis, myalgia, neuralgia, rheumatism, or even gastritis, really cover an illness that is mainly psychogenic.

The clarification of this point is an eminently worth while piece of research work for someone to undertake.

In order to throw some further light on the incidence of psychogenic disturbance in association with what would appear to be primarily physical illnesses, I have approached the Heads of the Departments of Physical Medicine in the twelve London Teaching Hospitals. It is commonly said that more chronic patients gravitate to the Departments of Physical Medicine and Departments of Psychological Medicine than to any other departments. Even though the evidence that has been obtained from this enquiry is not factual, the experience and impressions of these twelve physicians is surely a definite guide to correct facts. I am most grateful to them for their help. Of the twelve departments, the information gained might be summarized in this form.

- (1) Patients showing considerable psychogenic disturbance are seen in every one.
- (2) Cases of pure psychiatric disorder are the exception.
- (3) Many cases in which there is a physical basis have also associated psychological factors, and this fact it is important to consider.
- (4) It is always important to look for the physical factor and not just to label a patient "functional".
- (5) Assessments of the percentage of patients seen whose illness is mainly psychogenic varies from 10 per cent. to 30 per cent. In one department seeing 2,000 new patients per year 300 are referred to their psychiatric department, and in addition there are probably another 900 who have a very strong psychological element in the aetiology.
- (6) The physician to one department writes "There are many patients who are suffering from misery and not pain" also "Minor organic disturbances become the basis for major anxiety".
- (7) How best to treat the chronic patient, whose numbers ever tend to increase, used to present a real problem. It is very gratifying to learn that this problem is less in those departments in which the psychological sick is taken into account. Close co-operation with the psychiatric department is advised. One department has weekly resettlement conferences.

An interesting fact was brought to light by one observer, who informed me that, when working at one London teaching hospital, he carried out some investigations and found that since the end of the second world war the greatest increase in out-patients had occurred in the Departments of Physical Medicine and Psychiatry.

All this evidence leaves little doubt as to the size of the problem and contradicts the statements made or implied by those who still regard psychological medicine as a comparatively useless adjunct to general medicine.

I have not said much about the sufferings of the patient who is ill with some sort of psychogenic illness. Even today there are many medical people and lay people who are inclined to belittle the severity of psychogenic illness, yet those who have suffered from it, or have seen it daily face to face can have no doubt as to the suffering through which many such patients pass.

Perhaps the greatest contribution that psychological medicine has made, and still can make to general medicine, is by re-iterating the importance of emotion in considering the aetiology and treatment of many physical symptoms. Also the importance when treating a patient of taking into consideration not only the local pathological process, but the patient as an individual and how he reacts to his illness.

The importance of regarding the maintenance of health from many angles

has been steadily increasing. The growth of the study of public health with its many view points has demonstrated this fact. It must not be forgotten that the improvement of general living conditions which has been attained by Public Health Authorities inevitably leads to people enjoying happier lives, and so, less emotional tension.

It has, of course, been known for many years that our physical state is affected by emotion, hence such common expressions as "My hair stood on end with fright". Only in recent years has the truth of these observations been applied in medicine in an attempt to understand more fully the aetiology of the many physical symptoms of which ill people complain, and to which up to the present some completely unsatisfactory diagnostic label has been applied, such as chronic rheumatism, fibrositis, myalgia, disordered action of the heart.

Moreover, the importance of what is perhaps best termed "emotional tension" in the aetiology of physical diseases, such as gastric ulcer, ulcerative colitis, asthma, skin affections of certain types, and some muscular and joint disturbances, is only just beginning to be appreciated.

I think perhaps the clinical experience that made me personally realize more than anything else the significance of emotional disturbance in affecting our physical state was the case in this hospital which was recorded by Dr. Robert Moody (3).

Some of those present may not have read of this case, the outlines of which are as follows:

An army officer of 33 years was admitted in 1943. The main presenting symptom was somnambulism. He was treated by abreactive methods, and on one occasion, after abreacting an incident which had occurred 10 years previously—an occasion when he had been lost in the jungle for some hours at night with his forearms bound tightly together—the complete marks of the ropes reappeared on the forearms. It was possible to repeat this on two further occasions under special conditions, in order to make certain that it was absolutely genuine, and to photograph the marks. Subsequently a number of similar phenomena have been observed in other patients.

How this occurs no one has any idea. It may be through a reactivation of some neuron path from the skin, blood vessels, autonomic nervous system to cerebral tissue, including some hormonal activity.

The importance of studying such a phenomenon seems to lie in the possibility to demonstrate how emotion does affect the physical state. It is usually difficult to allay emotional tension. Certain drugs, such as sodium amytal, have a beneficial effect in a certain percentage of cases, but there are obvious disadvantages of patients going on taking large doses of any drug. Psychotherapy is the most rational form of treatment for the purpose of allaying emotional tension, but it is so often a long process and difficult to arrange, and it is by no means always a certain cure. If, therefore, it were possible to find the exact mechanism whereby emotion did affect the physical state, it might be possible to "block" the path by some means, and so free the patient from many of his most troublesome symptoms. Most of us hesitate to resort to leucotomy or allied surgical procedures unless the condition is very severe.

Admittedly this still leaves the problem, where and how is the emotion generated in the first place, and this calls for more research, and better prophylaxis. How often in psychological medicine one feels that the illness could have been easily prevented, whereas the cure is so hard.

The interesting and important research work being carried out by Professor G. W. Harris at the Maudsley Hospital and mentioned by him in the

inaugural lecture given by him as Fitzmary Professor of Physiology, throws light on this whole problem. For many years it has been unknown how a baby extracts milk from the breast; it is probable that the power of sucking alone is not really sufficient to extract the milk present in the deeper parts of the breast tissue. It has been known that if a mother who is breast feeding her baby has become emotionally upset, the breast milk might appear to dry up so that the baby would not get sufficient.

It has recently been found that the sensory stimuli directly involved in suckling (and probably conditioned stimuli as well) cause the secretion of oxytocic hormone from the posterior pituitary gland which is carried in the bloodstream to the mammary gland, and there it causes contraction of the myoepithelial cells that surround the alveoli and ducts of the mammary gland. The milk is therefore actively expressed from the mother's breast to the child.

Moreover, there is strong evidence that this reflex activation of the posterior pituitary gland by suckling can be interfered with by emotional disturbance. This has been demonstrated by Newton and Newton (4), in the human female, and more recently by Cross (5) in Cambridge working with rabbits.

Further recent research work in Sweden (6) has shown that lactating women from whom their babies have been unable to obtain milk present in the breast tissue, profit by a single injection of oxytocic hormone at the time of suckling. It would seem that one good demonstration to the woman that she can give a large supply of milk to her child, restores her confidence and allays her anxiety so that at future suckling periods the reflex is established and suckling proceeds normally.

Increasing knowledge of electro-physiology, and the very special study of cybernetics may throw light on this whole question. Ashby in his article on "The Application of Cybernetics to Psychiatry" (7) points out that over-stability occurring in some portion of a dynamic system such as the brain, may render the whole action of the system functionally less effective. There is a fundamental law that, when a whole system is composed of a number of sub-systems, the one that tends to dominate is the one that is least stable. This statement is capable of mathematical proof, and holds over all mechanisms—nervous included. A clearer understanding of this fact might explain some of the puzzles concerned with the obsessional neuroses. The obsessional personality does seem to be constitutionally determined. Some of the characteristic features of the obsessional, such as conscientiousness, drive, methodicity, and aim for perfection all go to make for the stable efficiency of the individual, and yet if these characteristics get exaggerated, the cause of which might be some subtle change akin to the over-stability of the machine, the individual as a whole breaks down. This was often seen in the war, when the obsessional could not de-centralize, tried to do everything himself and, of course, wore himself out. Also there is evidence to suggest that it is the obsessional type of personality with repressed aggression who develops certain types of dermatological lesions.

I hope that the data obtained and the views expressed have been sufficiently convincing to leave no doubt in your minds as to the importance of psychological medicine making its contribution to general medicine.

If the best results are to be obtained our brother practitioners must help us by giving us the chance to make that contribution. Constructive criticism is helpful, but not bias, nor prejudiced and often ignorant ridicule.

These observations, then, lead me to the development of the speciality of psychological medicine and its teaching.

In 1808 the Justices of Quarter Sessions were given power to establish asylums. In 1845 this was made compulsory.

In 1888, by the Local Government Act the Councils of Counties and County Boroughs took over the administrative powers of the justices in this respect.

Apart from the asylums, there was little or no provision for beds for psychiatric disabilities, and up to 1930 the asylums were only allowed to admit certified patients. In addition to asylums, there were the colonies for mentally defective patients as well.

There was practically no provision for the treatment of milder psychiatric disorders.

In 1904 the Lady Chichester Hospital was opened for such cases by Dr. Helen Boyle. In 1921 the Cassel Hospital was opened for treatment with Dr. T. A. Ross in charge, and in 1930 Woodside Hospital was opened.

The provisions made for teaching psychological medicine have progressed slowly until recently.

On reference to the General Medical Council, to whom I am much indebted for their help, it was found that prior to 1885 apparently no official instruction had been issued by the General Medical Council that anything concerning mental diseases should be included in the medical curriculum.

On 1 July, 1880 the General Medical Council considered a letter dated 4 August, 1879 from the Hon. General Secretary of the Medico-Psychological Association. At that time the Hon. General Secretary was Dr. Henry Rayner of Hanwell, who later in 1884 became President of the Association. This letter stated that at the Annual General Meeting of the Medico-Psychological Association, under the Presidency of Dr. Lush, M.P., a resolution was passed petitioning the General Medical Council to have mental diseases made a subject of examination for all degrees and licences to practice medicine in the United Kingdom. To this letter the Council replied that mental diseases were already part of regular courses of instruction in medicine, but that they did not deem it expedient at present to ask licensing bodies to have mental diseases made the subject of separate examinations.

Nevertheless, in 1885, when considering recommendations in regard to professional education and examination the Council added mental disease as a separate item in the curriculum, thus making twelve main items, whereas previously there had been eleven.

There is also a further paragraph which reads "Professional examinations should then be so framed as to secure that the knowledge of every practitioner whose name appears in the Medical Register has been tested in all the subjects of professional education which the Council deem essential only".

It seems not out of place at this point to ask how, since 1885 to the present day, examiners have satisfied and do satisfy themselves that candidates have that knowledge, so far as psychological medicine is concerned?

The Royal College of Physicians have also been good enough to look up their records for me, and I am indebted to them for the following information: In 1932 David Forsyth in a paper entitled "The Place of Psychology in the Medical Curriculum" (8) pointed out that the training of medical students in psychology was almost nil. For the most part lectures and demonstrations on insanity were all that was considered necessary, and that was because of the regulations just mentioned. Forsyth also quotes Dr. C. A. Mercier, President of the Royal Medico-Psychological Association in 1908, who pointed out that all the instructions that a medical student got was how to recognize and certify an insane person.

Information concerning the development of psychiatry in the twelve London teaching hospitals had been gathered through the kind collaboration of my colleagues at each of the hospitals in question, and to them I am most grateful. It is, I suppose, obvious that teaching hospitals should exercise the greatest influence in training students in the right attitude of mind towards medicine. The extent to which this has been carried out so far as Psychology and modern concepts of psychological medicine are concerned has been very slight until in recent years.

From about 1850 to approximately 1920 there was only teaching of mental diseases. Charing Cross Hospital appears to have started teaching mental diseases in 1852, when Dr. Conolly was the lecturer. Dr. Conolly was President of the Royal Medico-Psychological Association in the year 1858. There was no department of psychological medicine, by which I mean the appointment of a physician for mental diseases to the staff, until 1902, when Dr. Percy Smith was appointed. Dr. Percy Smith was President of the Royal Medico-Psychological Association in 1904. Some students of St. Thomas's Hospital were sent to Hanwell Lunatic Asylum or Bethlem for instruction in 1849, and subsequent years.

In 1893 Dr. Rayner apparently saw out-patients at St. Thomas's, but he does not appear to have been on the staff.

The first appointment of this kind seems to have been in 1909, when Dr. R. Percy Smith, who in 1905 had resigned his position at Charing Cross in order to come to St. Thomas's, was appointed.

At King's College Hospital a chair in psychological medicine has existed since 1871, and the first Professor was Dr. Sheppard of Colney Hatch Asylum, but apparently his sole duties were teaching. The first physician for psychological medicine was Professor Mapother.

At Westminster Hospital, mental diseases were first taught during the course in forensic medicine in 1872. A Department was first formed in 1939, following a liaison with Springfield Mental Hospital.

At University College Hospital the first physician in mental diseases was Dr. Bernard Hart, who was appointed in 1913.

At St. Bartholomew's Hospital Sir Robert Armstrong-Jones seems to have been the first physician for mental diseases and his department was formed in 1919. Sir Robert Armstrong-Jones was President of the Royal Medico-Psychological Association in 1906.

St. George's Hospital first formed a department of psychological medicine in 1933 when Dr. Desmond Curran was appointed. Before that date there was simply "A Lecturer on Insanity".

At the Royal Free Hospital a department was started in 1943 under Dr. W. D. Nicol. The London Hospital formed a Department in 1942 under Dr. Henry Wilson, though in 1924 Dr. Millais Culpin had been appointed Lecturer in Psychoneuroses.

At Guy's Hospital the first course of lectures was given in the summer session of 1871, by Dr. Thompson Dickson. He was followed by Dr. G. H. Savage, who was appointed to the School in 1874. In 1896 Sir George Savage was appointed to the staff, this being the first staff appointment. Sir George Savage was President of the Royal Medico-Psychological Association in 1886.

The York Clinic, a tribute to the late R. D. Gillespie, was opened in 1944. It was the first Psychiatric Wing to be built in the grounds of an undergraduate teaching hospital. In 1932 Guy's opened their child guidance clinic.

At the Middlesex Hospital the first Lecturer was Dr. Henry Rayner,

appointed in 1873. The department of psychological medicine was first formed in 1937 when I was appointed.

At St. Mary's Hospital the first lecturer appears to have been Dr. Crichton Browne in 1881. The first appointment of a physician for psychological medicine was Dr. Cole in about 1910.

These facts show that teaching on mental disorders for the purpose of diagnosis and disposal of the insane has been going on for many years. On the other hand it is only in recent years that much effort has been made to teach psychology and psychiatry, and to orientate that teaching towards the close connections that exist between general medicine and the numerous psychological factors that enter into the study of aetiology. At the present time, however, every London Teaching Hospital has a department of psychological medicine, progressive teaching is going on, and in several of these hospitals there is an allocation of beds for psychiatric cases.

The importance of the personal relationship between the patient and those who are looking after him in his illness, has been mentioned. It is recognized that many of those, who are engaged in medical and nursing practice, have a natural gift of sympathy and understanding, and that their relationship with their patients is all that can be desired, yet this is by no means always the case. Surely all increase of knowledge should be used and tried out, so is there any justification for not teaching psychology in order to see if it does improve these personal relationships? Psychology should not be regarded as a part of the speciality of psychiatry, but as a basic subject in the medical curriculum as are anatomy and physiology, which should be taught to students in order to enable them to gain the fullest possible knowledge of the human individual. The need for stressing the importance of this personal relationship is particularly strong at present with the advent of the National Health Service and the fears of many that the treasured tradition of the family doctor may be lost.

The importance of understanding the relationship that undoubtedly exists between the physical changes and our emotional life has also been stressed. In order to increase our knowledge concerning this problem, a closer co-operation between all those concerned is essential, and I venture to ask for an even greater change of attitude towards these problems.

Perhaps I may be forgiven for mentioning the Middlesex Hospital where I have been so fortunate in the support of my colleagues. In 1936 lectures in psychology were started to the second and third year medical students during the course on physiology. This was made possible by the foresight and co-operation of Professor Samson Wright, and the approval of the Dean, Sir Harold Boldero. Since that time lectures have been given in applied medical psychology, in the introductory course of the medical unit. For some years lectures on psychology have also been given to nurses and to physiotherapists as well as those to medical students. Since the amalgamation a regular flow of nurse probationers has been sent up from the Middlesex Hospital for a period of three months to nurse at St. Luke's-Woodside, and recently a scheme has been introduced with the official approval of the General Nursing Council, whereby a qualified nurse can put in nine months at St. Luke's-Woodside, followed by nine months at Shenley Hospital, and then take the examination for the mental nursing certificate.

Thus, over a period of eighteen years the teaching of psychology at the Middlesex has been steadily increasing, I feel that this would not have been allowed to continue had it not been for the benefit of all students.

I have been in a particularly fortunate position for observing the results

of teaching to medical and other students. From 1923 to 1935 I was teaching nurses in a county mental hospital. In 1923 there was no sister tutor, and it was necessary to teach not only the subjects required for the nursing certificate, but practical bedside nursing, which meant learning a lot of it oneself if one was to attempt to teach and demonstrate it. This gave one an exceptional opportunity of combining the teaching of medical psychology with the general and mental nursing. I would like to put on record here how magnificently the nurses, both male and female, responded. It certainly showed how nurses will respond if only the medical staff will work with them as a team, and I cannot stress the importance of physician, nurse, occupational therapist, psychiatric social worker, psychologist and others working as a team. If the team spirit is right and the co-operation really close, I believe that nothing but good can come of it. Some critics say that it interferes with the analytical treatment or that professional secrecy is endangered. I believe that if the team spirit is wisely directed, such difficulties can be overcome.

Moreover, I have been closely associated with the teaching of psychological medicine in two other London Teaching Hospitals in addition to the Middlesex. At St. Thomas's Hospital I had the privilege of helping Dr. Henry Yellowlees, from whom I learnt so much and to whom I owe a great deal.

I also took part in the teaching of medical students from Westminster Hospital.

Thus, with all humility, I feel that this experience has given me the opportunity to assess the value of teaching psychology and psychiatry to undergraduates.

Tomorrow we shall hear the best ways in which such teaching should be carried out.

The progress made in teaching along these lines has developed quickly since the war and is still doing so. I was delighted to read in Sir John McNee's Presidential Address to the British Medical Association (9) "The Teaching Hospitals are mainly concerned with the training of our future doctors (and also doctors returning for further experience) but it is often forgotten that doctors are responsible, in part at least, for the training of nurses, almoners, dietitians, physiotherapists, radiographers and laboratory technicians of many kinds". I was grieved, however, to read no mention of the importance of considering the individual's emotional life, and only once in that otherwise excellent address was the word "psychology" mentioned.

The responsibility rests on us who specialize in psychiatry to convince the rest of the profession of the reality of our claims. If we are going to do this successfully, it is essential to make it clear that our knowledge on these matters is still in its infancy, not to claim too much, not to make dogmatic statements which cannot subsequently be justified. We must avoid prejudice and bitter disagreement amongst ourselves. So long as theories and practice are put forward in an honest desire for knowledge and progress, let them be considered fairly, and let this be criticized not only destructively, but constructively.

I hope that the papers which are to be read tomorrow and subsequently will help to carry forward not only progress in our own speciality, but in general medicine as well.

In these days it is necessary not only to have the efforts of the individual but the force of combined operation such as a united society gives. Who better than the Royal Medico-Psychological Association can see to it that this much desired end is attained?

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