MENTAL OUT-PATIENT CLINICS.

A Discussion which took place on July 4, 1930, at the Annual Meeting of the Royal Medico-Psychological Association at Oxford.

Opening Paper.

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I have been asked by the President to open a discussion on out-patient clinics for mental disorders. Although these have existed for many years in some places, it is believed that they ought to be more general, and that one or more should be connected with every mental hospital. Their establishment has now become an urgent duty in view of the passing of the Mental Treatment Act.

It is not the duty of the opener of a discussion to deal with his subject exhaustively. Rather is it his task to touch on its various aspects and to glance at its different problems so as to provoke discussion. I shall deal with the subject under the following heads.

(*a*) The benefits received by the medical officers of mental hospitals.

(*b*) The benefits received by the public.

(*c*) The different ways in which a clinic may be started.

(*d*) The other services that should be associated with fully-organized clinics: social service; bed treatment; teaching.

The medical officers of most mental hospitals in the past confined their energies strictly to work done within the walls of the institution. Their interest in the patient started with his admission as a certified patient, and terminated when the patient was handed over to his relatives on his discharge.

This limited method of dealing with disease, especially with one that is liable to recurrence, was most unpractical and unscientific. Neither experience nor understanding of the earliest symptoms of mental disease was obtained, and no real attempt at prevention

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was made. These deficiencies are made good by the out-patient clinic. It stimulates medical officers to a more active interest in medical science, and the importance and variety of the work make it the most fascinating part of their duties.

Out-patient clinics bring medical officers into closer contact with the domestic life of the poor—a humanizing influence. The public also get into personal touch with the medical officer, and lose much of the suspicion for which the mystery of treatment behind the closed doors of the mental hospital was responsible in the past.

Lastly, the medical officers of mental hospitals have in the past lived too isolated a personal and professional life. By means of out-patient clinics they are brought into relationship with their medical brethren. They learn what problems and difficulties general practitioners have to solve in the management of patients treated at home. It is fitting that these medical officers with their special knowledge should share with family doctors responsibility for the mental health of the communities in which they live.

In the second place, an out-patient clinic benefits those suffering from mental and nervous ailments, for it is difficult for the poor otherwise to get skilled advice in the early phases of these troubles. As a general rule the nervous patient does not suffer from marked physical disability and he is able to hang on and do a certain amount of work. He hangs on too long, and then becoming unable to support himself or attempting to commit suicide, he is sent to a mental hospital. Long before this stage is reached definite symptoms, such as depression, anxiety and insomnia may have existed, and further developments might have been prevented had there been facilities for obtaining skilled advice and treatment. It is well known that simple measures adopted in good time will often ward off a threatened mental breakdown. A *régime* of rest, a change of environment, and the removal of hypochondriacal or other imaginary anxieties by suggestion may be sufficient, or the adoption of simple remedies, such as attention to the bowels and the assurance of regular and good sleep at night by the employment of a simple hypnotic, may be all that is necessary. Although these remedies may be obvious, we know from experience that they are constantly neglected, with disastrous results. The needful stimulus is that a psychiatrist of experience and authority should prescribe them, and then they will be willingly adopted. Such advice would emanate from out-patient clinics.

There is a very large field of minor mental ailments which cause great suffering and have been practically neglected in the past.

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Patients suffering from these received little sympathy even from medical men, who, failing to elicit evidence of physical disease and finding them troublesome, minimized the seriousness of their symptoms and even occasionally suggested that there was nothing wrong. This want of understanding and sympathy often drove these patients into the hands of irregular practitioners, who often benefited the patient by the employment of their nostrums, the active element of which is essentially mental suggestion.

Doctors send patients to these clinics in whose case questions have arisen as to certification or as to whether they are suitable or safe for treatment at home. Children are brought who are backward at school, who have been found difficult to manage at home, or who have repeatedly got into trouble owing to minor delinquencies. Social agencies of various kinds and probation officers of police courts will bring other cases for examination and for advice.

In the third place, what means are to be adopted for starting an out-patient clinic? These, of course, will vary, and will be determined by local conditions. The best form of out-patient clinic is one attached to a general hospital, and many have such a clinic nowadays. These do good work, because every person goes willingly to a general hospital, and he has less hesitation there in seeking advice on a delicate matter, such as mental symptoms, because other forms of disease are also being treated. Such a clinic has this further advantage—that if help be needed, this can be obtained from specialists on the staff of the hospital and from its laboratories.

The clinic should be in charge of an experienced psychiatrist, who has full knowledge of the subject. No doubt pyschiatry is closely connected with neurology, and as neurologists now interest themselves more than formerly in functional disorders of the nervous system, the two services overlap. There must be a certain measure of cooperation.

If a mental hospital be near the general hospital the psychiatrist in charge of the clinic should obviously be one of the medical officers of the mental hospital. Even if the general hospital be some distance away, it is not difficult to make a working arrangement in these days of speedy motor travel.

A second method of establishing a clinic is to have it attached to the mental hospital. There are disadvantages in this method, because patients with nervous or mental symptoms are at present shy of approaching a mental hospital. There are many ways,

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however, by which this difficulty may be minimized. It is usually possible to get simple and inexpensive accommodation, corresponding more or less to a doctor's surgery, for one day a week as a beginning, in a conveniently placed house in the neighbourhood. It may be possible to find a detached building belonging to the mental hospital itself to which out-patients can come without meeting in-patients. If it has a special entrance and a distinctive name, some of the objections to its proximity to the mental hospital are overcome. If successful it will in time develop an independent individuality of its own.

Unfortunately for the purpose of clinics, most mental hospitals are built in the country and are at an inconvenient distance from centres of population. In such cases there is nothing for it but to open the clinic in the nearest large town or towns and in connection with the local hospitals if possible.

It may be added for the information of those about to start such a simple clinic that the maintenance expenses can easily be calculated and are very small. As it expands and as it develops full services its expenses increase, but by that time its value will be recognized by the community. It is important to make a beginning, however small this may be, and to allow the clinic to expand naturally.

A third, but more difficult, method of establishing a clinic is for it to be attached neither to a mental hospital nor to a general hospital, but to be independent and reserved entirely for this purpose alone. There are few such at the present time, but those that exist discharge their functions with great success, and it is probable that with the passing of the Mental Treatment Act other establishments of a similar type will be started. In putting in a plea for the establishment of mental out-patient clinics I do not lay stress on the establishment of superior clinics of this character. No doubt they are valuable, but what is desired in the first place is small clinics that can be managed by the medical officers of our mental hospitals.

In the fourth place there are other services not strictly medical that are of the utmost importance, and should be established if full value is to be obtained from these clinics.

First among these must be placed social services. These are rendered by a social-service worker, or more than one as the clinic expands. She should be present at the clinic and take notes of the history when the patient is being examined for the first time; she should keep records of the name, address, occupation and domestic

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circumstances of the patient; and, if instructed by the physicians, she should visit the patient's home and in a discreet way make observations and inquiries. In this way and in this way only can information in many cases be obtained that throws light on the causation of the symptoms. She also sees that the treatment recommended is being faithfully carried out, or whether indeed it is possible to carry it out at all under the conditions at home.

It has sometimes been found necessary by a service worker to change the environment, and to remove the patient to a new home. In this way has been prevented melancholia that was developing from an isolated life in a gloomy house, and persecutory insanity from the annoyances of undesirable neighbours. It sometimes happens that differences between husband and wife have to be composed or the housewife of poor mentality has to be taught how to arrange a budget on very slender resources, the deficits of which, causing anxiety, were leading to theft and reckless conduct. It is through a service worker that touch can be kept with a patient and cases followed up.

These extra-mural procedures are foreign to the spirit in which we worked in our old mental hospitals. It would have been said in those days, almost brutally, that we were not responsible for what took place outside the hospital, particularly to persons who had never been under our care as in-patients. But surely, as physicians, it is our duty to the poor to treat their mental ailments, to treat these at as early a stage as possible wherever existing, and if possible to prevent serious mental disorders from developing. It is surely our duty even to go out of our way to make these measures effective in the case of persons handicapped by mental trouble and thus unable to help themselves.

In the second place, although most of the patients attending the clinic can receive treatment while carrying on their duties at home or in the workshop, there are others who would receive most benefit by removal from the scene of domestic anxieties and by rest and quietness. The provision of bed treatment is a desirable, if not essential addition to the out-patient clinic.

General hospitals, for whose accommodation there is already too great a demand, are chary about providing beds for mental cases, but a few such beds are available. At the present time it is possible to treat only a few selected cases in general hospitals, and unfortunately cases of mild melancholia, which are otherwise suitable, are not looked upon with favour because of their suicidal tendencies. But under the Mental Treatment Act it is permissible to

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provide special accommodation for early cases. Where advantage is taken of this power, patients from the clinics may possibly be treated in these special wards or institutions.

It would, however, appear that the reception of these cases as voluntary patients into our mental hospitals under the Mental Treatment Act is the most convenient method of obtaining immediate bed treatment. It was our experience in Edinburgh, before the Jordanburn Nerve Hospital was opened, that most of these patients would agree to enter a mental hospital with very little persuasion. The passing of the Act to admit voluntary patients to county mental hospitals in England should be signalized by the opening of out-patient clinics by the medical officers of these hospitals, in order to crown the benefits conferred by this Act by supplying these hospitals with the new class of voluntary patients.

Finally, these clinics are invaluable for the facilities they offer for instruction to medical students. They can, of course, only be used for this purpose where there is a medical school. To see early rather than established cases of mental disorder is much more useful for the student who will afterwards engage in general practice. He also gains valuable experience in coming up against the practical difficulties met in treating such cases at home.

It has been found by experience that the first examination of the out-patient, when systematic inquiries are made into the nature and exact date of the earliest symptoms noticed, and into all the accompanying phenomena, both mental and physical, with a view to discovering the cause and diagnosis, is by far the most instructive clinic the student can attend. It is usually also the longest, but the methods of examining the patient and the material elicited are almost always found interesting and useful. So much now depends on the powers of observation and on the training of the general practitioner for success in our efforts to prevent disease, as Sir James Mackenzie has pointed out, that instruction given in out-patient clinics must have a high value placed on it.

In opening this discussion I have not described our particular experiences at our two out-patient clinics in Edinburgh, namely, at the Royal Infirmary and at the Jordanburn Nerve Hospital, both of which are conducted by the medical officers of the Royal Edinburgh Hospital at Morningside. Nor have I given a detailed account of the symptoms of which the out-patients complain, nor described the nature of the advice, given nor the kinds of treatment that the patients have received, nor the success that has attended these efforts. It may possibly be convenient for

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some of those who follow to speak on these lines of their own personal experience. I have spoken in a general way of the advantages of these clinics. I have also shown how simple and inexpensive this enterprise is, if a beginning be made in a modest way. In short my remarks have been a plea for the extension of out-patient clinics. In my considered opinion, after an experience of nearly fifty years, a mental hospital is not complete and is not doing the good work of which it is capable unless it has one or more clinics connected with it, conducted by its medical officers. To engage in this work is a duty the medical officers of mental hospitals owe to the community in which they live. Finally this has now become an urgent duty in view of the passing of the Mental Treatment Act, which authorizes the establishment of out-patient clinics, and enables early cases of mental disorder seen at these clinics to receive hospital treatment as voluntary patients.

Discussion.

Dr. William Brown (Wilde Reader in Mental Philosophy, Oxford University): Prof. Robertson has covered the ground so completely that my task of following him is simplified, and I am able to concentrate on a single point—is the nature and possible future of an out-patient psychiatric clinic in a big general hospital.

During the last ten years I have acted as Psycho-therapist at King's College Hospital, and perhaps I can be of most help in the discussion if I mention briefly what my experience has been.

Originally a clinical assistant in neurology, I became, in 1924, psycho-therapist at the Hospital. Conditions have been much the same all through those years: patients go first to the neurologist to be " vetted " by him, and if he thinks fit, they come to me for psycho-therapeutic treatment. That is quite an excellent arrangement if you have a neurologist who is interested in the psychological side, and is ready to surrender the psychological treatment to someone else. But if you have a neurologist—however good in his own specialty—who has strong views about this psychological side and thinks his own knowledge of psychology is sufficient for the cases, then, I think, there will be a hold-up; patients will not come for psycho-therapeutic treatment in adequate numbers. My experience has been that patients have been passed on to me in satisfactory quantities, but that nevertheless this neurological gate to the psycho-therapeutic clinic is too narrow and too slow.

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The reason is that psychological disturbance in different forms of illness is not limited to cases which would be originally diagnosed as neurological. Besides the cases of functional nerve disease there are a series which originally reach the other departments of the hospital—functional disturbances of the heart, of the kidneys, and especially of the gastro-intestinal tract and of the endocrine glands, particularly the thyroid and suprarenal glands; these do not necessarily come to one through the neurological department.

So the question arises whether any broader point of view can be taken; and this is a matter for the future. It has not yet been taken, as far as I know, by any of the hospitals. I hope that in the future the authorities of a general hospital will be willing to appoint a psycho-therapist with power to get into touch with, and receive patients from, all parts of the hospital. That means a matter of education and such education is a slow business. One of the tasks is to educate staffs of hospitals on the question of psychology in its relation to medicine. The psycho-therapist should be in touch not only with the neurologist, but also with the physio-therapeutist, cardiologist, etc., so closely in touch that those controlling these departments are ready to show him doubtful cases and ascertain his opinion upon them. At present many members of the staffs of hospitals say they do not know this; they do not know the possibilities of the psychological side. They know the facts as to psychological or functional overlap, and they are educated sufficiently on the medico-psychological side to understand the importance of early treatment of psychotic cases, but they are not adequately instructed in the possibilities of psychological disturbance as influencing the development of physical disease in the different parts of the body. This applies also to surgery. It is so obvious that I almost apologize for mentioning it. A number of patients who are to undergo surgical treatment should have psycho-therapeutic attention before the operation, previous to the administration of the anæsthetic. I have had the opportunity of carrying out such treatment on a number of patients, and of noting what were its effects. I have seen a sufficient number to feel that encouragement to these patients to face their fears, to decide to relax efficiently for the operation and to make use of auto-suggestion in the right way is a great help to them. In the same way obstetric patients are encouraged in the use of auto-suggestion and relaxation before the time comes for the delivery of the child; then the event will be very much less painful to them than it would otherwise

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be. That is still more obvious in the case of disturbances of the endocrine glands, especially in hyperthyroidism. These cases still do not come in a sufficiently large proportion to the neurological section of the hospital, and therefore do not reach the psycho-therapist.

Early treatment by psycho-therapy can be beneficial, though great discrimination is needed, and a correct diagnosis is necessary, because in some cases of toxic hyperthyroidism operation or X-rays are the only justifiable treatments, and time may be wasted by embarking upon prolonged psycho-therapy. There are different kinds of thyroid trouble, and it is the duty of the psycho-therapist to try to understand the differences and to act upon this knowledge.

As to the type of treatment, there is the analytical method, the method of suggestion, and the method of persuasion. Nowadays every psycho-therapist agrees that the scientific method is the analytical, because it is only in that way that the inquirer can know what is going on in the patient's mind, and can get down deep enough into the underlying causes. But we are neglecting the possibilities of the suggestion method. I speak advisedly, because for several years I have seemed to be in a minority of one among psycho-therapists with whom I am in social relations, in practising suggestion and auto-suggestion. Especially in out-patient treatment in a general hospital, suggestion and auto-suggestion are indispensable methods to use. A certain amount of analysis is essential in the first few interviews; but deep analysis cannot be carried out under fifty or sixty hours or more, and such an amount of time cannot, naturally, be devoted to cases in a psycho-therapeutic out-patient clinic. But that does not mean that analysis is to be neglected as a possibility. The knowledge we gain through prolonged analysis enables us to employ it in dealing with our out-patients; that is to say, knowing the general types of complexes and the factors at work, we can guess, in the individual case, what may be wrong, and test out the hypothesis in brief. And we should not forget that in some cases prolonged analysis can be misleading and a mere waste of time. The patient himself may drag out the analysis because he does not wish to get well quickly, and from the analyst who is willing to carry out the work he may withhold important facts. Recently I saw a patient who had been analysed by someone else for a long time and had withheld from that analyst an essential fact which she told me in the first hour. So, even in analysis, the active method of trying to get at the patient's

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mind quickly may stir him up to arguing with you and he may face the present situation boldly; and this is important, for you can do it in an out-patient clinic. In most cases of psychological disturbance there is a present difficulty in that the patient is refusing the leap, but is trying to find a byway instead. And until you can make him take the jump he is stuck and he will regress to more infantile fancies. If he will face that jump, you can employ brief methods of analysis, combined with persuasion and re-education. That is important in out-patient treatment. But, besides that, suggestion has its place. In a whole number of cases you have a functional disturbance which is far greater than the organic trouble justifies, due to the patient's fear and to the general mental and physical tension. And where time restriction does not allow of much analysis one can still train patients in relaxation, and teach them the simple truth which the least intellectual can understand, that so much illness is intensified by bad self-suggestion, through fear, acceptance of certain ideas, dwelling on them in the subconscious and surrendering to them. And it is important to neutralize those bad self-suggestions and to believe that they can be removed by self-suggestion. Patients should realize that they can be helped to help themselves. In many cases suggestion produces permanent benefit. In the past, suggestion was carried out in hypnosis, and was not persisted in to any extent. At present those who practise suggestion are willing to persevere with it for a long time, always being ready to supplement it with other methods.

Returning again to the question of the relation of the psychotherapist to other departments of the hospital, it seems to me that the ideal would be for a medical psychologist to be appointed to a general hospital as a whole-time appointment, just as you have a bacteriologist and a pathologist; and he should visit the hospital every day, so that every member of the staff knows where he can be got at, and the patients can be brought to him. He should have clinical assistants to see and learn the different types of cases; he should have a psychological laboratory, with the latest apparatus for rapid mental testing, for such things as the psycho-galvanic reaction, the testing of memory and of the various physiological concomitants of emotional reaction. Finally, there is the question of teaching. A general hospital is a teaching hospital, and one is supposed to teach students the methods used. But in psycho-therapy I have found a difficulty in that respect. Years ago I began to encourage students to come into my room and look on while I was treating patients. But there was more and

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more grumbling about this among the patients. They objected to telling their troubles to me in the presence of young students who were inexperienced in life. A deputation waited on me asking me to cease the practice and so I gave it up. Lectures to students I realize are not in themselves sufficient. I hope in the future to select my cases, to find out beforehand which patients would not object to onlookers being present, and keep them only for the demonstration clinic, setting aside one afternoon a week for such demonstrations to students, and other times in the week for treatment without students being present; but no prolonged analysis can be carried out in the presence of students.

Dr. HUGH CRICHTON-MILLER (Tavistock Square Clinic): I am sure we have all been very much interested in both Prof. Robertson's and Dr. William Brown's remarks. I do not propose to speak on most of the points that Prof. Robertson raised, but I would like to bring one thought to your mind to which he referred. He talked of minor mental maladies that did not reach a mental hospital in the ordinary way. I think all of us, including the most thoughtful psychiatrists, have to have our eyes opened to what the minor mental maladies of life are, and what is their extent. When one thinks of one fact alone, namely, the number of suicides, successful and unsuccessful, which occur without any relationship to the psychiatric or the mental hospital system of the country, one realizes that there must be an enormous amount of minor mental malady which goes completely unnoticed until the coroner's inquest. We do not realize, as a rule, that somebody attempts his life every hour in this country, and that fact means, I think, that there are many who would be better in mental hospitals. How will they get into mental hospitals? How can they be saved, either from mental hospitals or from suicidal attempts?

Apart from the people who attempt their lives, one can multiply indefinitely the amount of minor mental malady. The clinic for the treatment of these minor mental maladies can serve a great purpose, whether it is in connection with a general hospital, a mental hospital or a neurological hospital, or is independent. I represent one that is independent, and I know that independence has certain advantages and many disadvantages. I have realized some of the advantages and disadvantages of the different systems. I shall not discuss them, but there is much to be said for each system. I think we all tend rather to prefer the system which we start upon ourselves. Prof. Robertson, naturally, feels that the out-patient

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clinic should be connected with a mental hospital; Dr. Brown, just as naturally, thinks it should be in connection with a general hospital; perhaps somebody from the West End Hospital will think it should be conducted under the roof of a neurological hospital; and, again, there are those who represent the idea that the out-patient mental clinic should be more in connection with the educational and scholastic system of the country, because of the central link of child guidance. That is another point, and it is one not to be passed over as altogether absurd, because there is something in it which deserves consideration.

Prof. Robertson was encouraging in reference to the starting of small clinics, saying that the expense was small. It is so, and if you want to see that the expense is small, see that it is kept small. I speak with some feeling on the subject because I have to take part in some begging in an attempt to collect funds from the public for a clinic which has rather outgrown itself in some ways. And with regard to the expenses of a small clinic, Prof. Robertson was a little light-hearted in saying that the expenses were small; I think he was talking only of expenses in £ s. d. But there is one point which should be always emphasized in any talk about out-patient clinics, and that is the question of time; and in that respect, not only in professional time, but in the best professional time, even the smallest out-patient clinic is expensive. That seems to me to be the very essence of the problem.

Dr. Brown made reference to the relation of neurology to psychotherapy. I hope that when Dr. Gillespie speaks he will give us his experience, because most of us know there is a peculiarly happy conjunction of neurological and psychological work at Guy's, which might well be copied by anybody who attempts to form or run a psychological clinic. But, even if only a small proportion of what one hears about some of the other general hospitals and their psychotherapeutic departments is to be believed, the actual working is not the only ineffective thing about them, but matters are even a little worse.

The first point we have to face when we talk of establishing an out-patient clinic on any scale is one of a positive therapeutic ideal. I could not help feeling, in connection with much of the talk which has been going on, both in Parliament and outside it and before the Royal Commission, that there was a certain amount of airiness about the references to mental out-patient clinics, the idea apparently being that if the County Council gave a site and provided a grant for erecting a suitable building, and someone gave leave to

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the staff of the local mental hospital to run it, all was provided for —(Laughter)—and that the mental health of the population would thereupon instantly rise to 100%. I think we have to face the fact that it is very much more complicated than that, and that unless we have a positive therapeutic ideal we really had better not trouble the County Councils to put up the clinics.

There is one dreadful danger—and I speak of this with much feeling, and all who have served in the Army will recognize it—and that is the disposal idea. Some of you may remember the considerable discouragement with which any case was admitted that meant any length of time being spent on it. You got an intelligent person, a soldier who had insight, and began to get down to helping him in a way that seemed promising, and instantly the adjutant or colonel was down upon you, and said, "Surely this fellow is fit to move on?"; and you said "I think he can still be given some benefit," and his reply was "Yes, but we must move him on—we must dispose of him." If the out-patient clinic is to be dominated by the "disposal" idea, I cannot help feeling that we shall risk having that sort of Army situation, in which people were moving round and round, and there was a filling-up of case-sheets, etc., all of which satisfied the people involved. And there is another, rather similar idea which we meet to-day, and that is the out-patient idea in many general hospitals. A friend of mine said to me the other day, "I am in charge of a tuberculosis centre connected with my hospital. A short time ago the treasurer said to me: 'Doctor, there are several of these people whom you are seeing now only once a fortnight, but you used to see them once a week.' I said, 'Yes, once a fortnight is enough.' 'But do you mind seeing them once a week again?' 'Well, perhaps you will tell me why.' He said, 'Well, you see, it makes a difference to our hospital fund returns.'" If any of our clinics are going to be dominated by the "turnover" idea, then it should be realized from the first that it is detrimental to any positive therapeutic ideal. These temptations will always be with us, because of the nature of the material we deal with.

What is the nature of the material? We have, first, what mental hospitals cannot or will not keep any longer, and for them we at the clinics should fulfil a very important function. With cyclothymics there should be the closest relationship between the mental hospital and the clinic, and in this regard I think that much of what Prof. Robertson said is justified. The clinic can do much by thoroughly good psycho-therapy to enable the cyclothymic to

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establish a much better acceptance of his condition, and adjustment between his condition and potential relapses. And if the cyclothymic is being seen with some regularity, the possibility of his being shepherded back to the mental hospital in time, before any serious damage is done to his family or his finances, or anything else, is always a desirable state of things.

Then we have the material from the general hospitals; and in that connection one does share some of Dr. Brown's feelings that there is a good deal of psycho-therapeutic possibility that is ignored. I feel that the general hospitals are always seeing what they can do to people, and when they cannot do anything more, they say so, and we get patients who have received this naïve statement, or on whose behalf it has been made—" There is nothing more we can do for this patient." Sometimes one feels inclined to say, " It is fortunate that you have reached the limit of your active interference." (Laughter.) I saw a patient last week who belonged to a very large factory, a well-conducted factory, near London, where they have very good service with their own medical officer and social workers. She had been ten years employed there, and for seven years she had been in and out of work—in fact in and out of everything. They had moved her from one form of work to another; she had been in and out of hospital, and her last experience had been ten days in a neurological hospital, where apparently they could do nothing for her; and I understood that, as they could do nothing for her, they sent her out, with only this one helpful thought, that the patient seemed to be markedly hysterical, which was assuredly true. During these long seven years of her life during which she had been ineffective, she had been the object of much private charity, and of extraordinarily sympathetic treatment by her employers; she had been the centre of the medical interests of the place. One hospital had curetted her twice, and had shortened her round ligaments once. A dentist had said " It is all her teeth "—that was three years ago—saying that with teeth like those he could believe anything; he proceeded to take out three teeth, and when he had got that length there was a scene, and operations were suspended, and it was suggested that when she got better she might have some more of her teeth out. I was not there, and I did not see the teeth they took out; I only saw one of the teeth they had left, three years later, and it was a very foul and septic affair. A doctor who had charge of her at the works said she was a case of parathyroid deficiency, but he had not, apparently, had the persistence even to prescribe

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parathyroid for her. With all this mass of surgery and convalescent home, dentistry, operations, etc., there was very little room for anything except a little common sense and a pulling of the threads together, and any of us could have done what one did do, and said: If she has got these septic teeth left—which more than one sense inclines me to believe—take them out; and if she has got parathyroid deficiency, which I agree with because her spasms and tremors correspond with that, give her parathyroid, and after that bring her back in a month, and then we will see about her hysteria.

An out-patient clinic for functional nervous disorders and minor mental maladies must necessarily be a scrap-heap and waste-paper basket; it must necessarily be a place where people drift to who are not primarily psychiatric at all. And I do not think this patient was that. Barry wrote a play called "The Old Lady shows her Medals." In 1917, when Asquith was in hot water, *Punch* produced a cartoon in which Asquith was dressed in a cap, and the cartoon bore the title, "The old lady shows her muddles." It is in the nature of things that the psycho-therapeutic out-patient clinic will always be a place where the muddles of our profession tend to gravitate; it will always be that way. Therefore it must be, above all things, a place where the muddles are received without any preconceptions. There must be people who are competent to handle cases which are not necessarily psychological cases, in the first place, at all. We have found this to a large extent, and we have always been sufficiently conscious of our own inadequacy upon physiological lines. We have now two diagnosticians, men of considerable standing (Crookshank is the senior one), who see every case before the psychiatrist is given a chance of interfering. I think that is a sound principle. These are men of considerable clinical experience, and in Dr. Crookshank's case, great clinical experience, and they are men who have a sufficient experience on the psychological side of life not to miss the psycho-therapeutic possibilities. They, as I say, sift the whole of our material for us. Therefore the waiting-list for the last few months is only a waiting-list of those who have been regarded by one of them as suitable for psycho-therapeutic treatment and are waiting for it, other treatment being carried out meanwhile. And I think that is a very desirable and practical system.

We want a positive therapeutic ideal, we want a rational therapy. Dr. Brown complained—and I want to console him instantly—for he thinks he is in a minority of one about suggestion. He cannot be; I am with him, and I think I know many who would

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join him. Suggestion will be of value for this sort of work for all time; nothing will make it useless. Suggestive therapeutics has, however, certain disadvantages. One is that it is used by panacea-mongers. Suggestion is used as magic by people who do not know that it is magic and who think it is science. The moment you get to that position it is very dangerous. But, at the same time, I tell you frankly, we are experimenting with it ourselves. We have a general principle that nobody who has not had sufficient personal experience of analysis should be allowed to use suggestion, and I believe that to be a bed-rock safe line to go on. The only people who can be trusted to use suggestion without getting carried away with their own magic method are people who have had a definite and adequate experience of analysis. But, in spite of that, we, not long ago, made use of a gentleman who has a special method of suggestion which to some of us is apparently mumbo-jumbo; but he himself believes in it with a pathetic earnestness. Provided that a person of that sort of therapeutic attitude is sufficiently carefully caged or tethered, or on the lead, he can be very useful. There always are a certain number of people with a low intelligence quotient for whom magic is essential for a cure. What would any of you do when an Aryan brother appears, greatly distressed and in a highly emotional state, and says that he has "failed his final Law examination for the third time, that he was so overcome with fear that he could not answer the questions?" If you start analysing your Aryan brother with that state of intelligence you are out for trouble, and he will not pass his examination that time, and perhaps not for many times to come. On the other hand, you turn him on to a gentleman who deals in suggestion, just in the crudest and simplest form, who believes in it himself with a passionate faith, and you leave the two of them together for a sufficient number of hours. And the Aryan brother, instead of returning to his country and getting his card printed "Failed LL.B.," will put "LL.B with Honours" instead. And that is an extremely desirable result, and it is a result which is achieved by the controlled and intelligent application of magic to a suitable case.

That is the sort of thing which turns up in one's work and which interests one. On a psycho-therapeutic staff of any size I value enormously people with varying standpoints. We have two perfectly good Freudians on our staff; they are good as far as Freudism can be good; and one of them did what Dr. Brown referred to: with the first case we gave him he "got away with it,"

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and the Freudian transference started. And when I had dealt with him gently but with graduated firmness month after month, I finally said to him, "Miss Jones has had as much of your time and the clinic's time as she is going to have." He said it was impossible to leave her at present as the state of the transference was extremely critical. I have heard a formula like that. I said, "You must take her home; we have several people waiting." He took her home, and he has still got her: is still visiting him with great regularity, and the transference, as Dr. Brown pointed out, is continuing to work out its extraordinarily leisurely way. But he is a wiser man and a more elastic Freudian; and he now says, quite simply, "I am working out an abbreviated technique," and we all say to him, "Good man." We have two very prominent Adlerians, and most of us have a strong penchant for the Adlerian school. But there is more than that in it; when you have a staff which, on the active list, is forty in number, there is room for different people with advantage. We have a devout and intelligent Roman Catholic on the male side, and one on the female side too, and that is enormously valuable, because in the case of some Roman Catholic patients if they were handled by somebody with an analytical outlook who did not share their views, there would be a clash and a scrap, and no good would be done. And we have four married women on the staff, and that I am very glad of, because there are a great many of our patients who make far more rapid and easy contact with married women than with others; such patients appreciate that tremendously, and say, "It made such a difference to me when I knew that the doctor I had to go to was a married woman too."

So we have people with different outlooks and different possibilities of making contact with the patients, and it makes a great deal of difference in the quickness with which one gets through one's work. Some of the men who come as clinical assistants are a little difficult; there are those of the "highbrow" type, who have been taught so much that they have a conscious, or possibly an unconscious feeling that there is nothing more that they can be taught. That makes us welcome the highly-diplomaed and highly-degreed people less than one would have liked to welcome them. We get people who have been a number of years in institutions, four or more years in mental hospitals, and, there again, one is a little critical or doubtful about what their attitude will be towards positive psycho-therapy. Sometimes one finds they have broken away from institutional life as a personal expression of a desire for

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freedom, and sometimes they are very ready to lap up anything that you can offer them. Sometimes, on the other hand, they are extraordinarily infatuated with the fascinating problem of whether a case is an early one of dementia præcox or an early paraphrenia, so that they forget to think out any ætiology or to give attention to any conceivable therapy. But the diagnostic maniacs are, of course useful; one is glad to call them in for some delicate piece of differential diagnosis. But one has to keep an eye on them to see that they are not just satisfied with their diagnosis, and that they are doing something active as well. Our great trouble in the clinic is that, and I think the thing most needed after a rational therapy is a leisured therapy. That is extraordinary difficult. A friend who is supposed to run the psycho-therapeutic department of a large hospital said to me, " I go down to the hospital single-handed on Wednesdays, and at 2.30 I see a waiting-room with 80 people in it, and I know that I have to see each of those 80 people and get away at 5.30, and it is simply a matter of mathematical calculation to know how many moments they each, on the average, can get." And he added, " The solution is one and one only : a cheery manner, valerian and pot. brom." And I agree with him. Unless we can ensure an adequate quotient of leisure in treatment, we shall drop down to this sort of work.

Prof. Robertson referred to the small beginnings. Small beginnings are excellent, but you must remember what it will work out at. After many years we have found that a very stable figure in our work is twelve hours per head; that is to say, that every new patient who comes to the clinic is going to take twelve hours, sooner or later, on the average. That means that there are a large number of patients whom you dismiss straight away, and a certain number whom you see only twice or three times, while there are a few patients who will get fifty or sixty hours of treatment; but the average works out fairly well at twelve hours per patient. And by a process of arithmetic you can realize what you will need in the way of doctors' time in relation to the number of patients you have. And when it does come to 400 or 500 new patients a year, the number of hours of treatment is going to mount up. Our figure last year was 7,500 hours of treatment, and it takes some doing to keep up with that. But if one can keep to a fairly steady ratio, not going over the twelve-hour average per patient, one can still claim for the out-patient psycho-therapeutic clinic that it is serving a really good purpose in keeping, at any rate, some people out of our mental hospitals.

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Dr. HENRY YELLOWLEES (St. Thomas's): I had no idea, Sir, that I was going to be asked to say anything, and therefore I have nothing prepared. But if a short and practical statement of experiences and of what I have done or tried to do in this matter is of interest, I shall be glad to say what I can.

I think that Prof. Robertson's summary of the situation was an admirable one, and I was interested to note that he said, not what Dr. Crichton-Miller attributed to him, that the ideal was association of the clinic with the mental hospital, but the reverse. Prof. Robertson said that the ideal was the association of the clinic with the general hospital. (Prof. ROBERTSON: Yes.) In any case it is a very interesting matter, because, as has been said, you can associate the clinic with the general or with the mental hospital, or it can be an independent one; and there is much that can be said for all three. At Wakefield there is an out-patient clinic, which is a flourishing one, in connection with the mental hospital only, and it will probably do better and even more valuable work after the new Act comes into law. At York I started an out-patient clinic in connection with the general hospital, and we did not make such a success of it as the Wakefield people did of the clinic in connection with the mental hospital there. And the question of title is interesting. We began by covering it up, in deference to the dread of the term "mental hospital," or "asylum," which has been referred to recently, and we called it the "Clinic for Functional Nervous Disorder." But after a year or two we found we did better when we called it what it was, a "Mental Out-Patients' Clinic," and we left it at that. I think that is significant. I am now associated with what was the first general hospital in this country to have a mental out-patient clinic, namely, St. Thomas's, and I will tell you my experiences in the hope that they may be of interest, and perhaps of help to some of you.

The first thing I have to say is that I have not, personally, experienced the least difficulty in relation to the neurological department, such as has been referred to. Prof. Robertson said, quite rightly, that the head of any mental out-patient clinic must be an experienced clinical psychiatrist. I did not quite follow Dr. Brown; I think he made rather too much of psycho-therapy as opposed to psychiatry. The greater includes the less; psycho-therapy I regard as only a branch of psychiatry. And while it is true, as we have heard again this morning, that the psychiatrists are sometimes slow to accept psycho-therapeutic knowledge and teaching

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which is put before them, it is equally true that the pure psycho-therapist is liable to forget that there is more in mental work than psycho-therapy, and sometimes fails to appreciate the breadth of psychiatry. You cannot run a mental out-patient department unless you take a reasonably large view of the word " psychiatry." By my own choice I altered the number of sittings of the clinic from one a week to two, and the second sitting we arranged to fall on the same day on which my neurological colleague has his. We sit in adjacent rooms; and if there is a case which is on the border-line between the two branches or which is of common interest, we step into each other's room, and there is no difficulty or disturb-ance of the procedure in the clinic. The time factor is, of course, the critical thing, and few of us are in the happy position of Dr. Crichton-Miller, with such a magnificent staff as he has. The only thing which occurred to me about his staff is that none of them are allowed to undertake suggestion treatment until they have done enough analysis. (Dr. CRICHTON-MILLER: Had personal experience of analysis.) Does it not, therefore, also follow that none of his staff should do analytical treatment until they have had sufficient personal experience? And if so, how did they get it?

I would much value the opinion of Prof. Robertson as to the presence or otherwise of the social worker in the room. I thought that was a very important point. All of us who have experience of it will agree that the social side of this question is tremendously and increasingly important. I have been in consultation with the Lady Almoner's staff as to how that department can be of the best use, but they have not suggested that the worker should be present at the interview with the patient. I shall be glad if Prof. Robertson will tell us if it works, or if it does not have the effect to which Dr. Brown referred, of cramping the patient's style, as the presence of students does. We also have the difficulty of the presence of students. On one of my two days I welcome students, and on the other day I see the patients alone. And even on the day on which students come, if there is a patient who is seriously troubled by the presence of somebody else in the room I keep him until the end, and ask the students to go before I see him. But I agree it is a difficulty, and one which must be got over.

The importance of having beds is another matter, and only time will work this out for us. At present I and most of my colleagues in other London hospitals have either beds in our own names or the right, by the courtesy of medical colleagues, to take in patients whom we want to admit.

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But we have to be very careful at this stage, because if one takes in a patient in whom there is a risk of suicide or accident, the whole tendency will be crippled, in the eyes of the hospital, for a long time. It is necessary to go slowly and carefully. I think Dr. Crichton-Miller must have been unfortunate in his experience of the "disposal" bogy. As long as one preserves a sense of proportion it is better, I think, than he experienced. I had a long Army experience, and I found it true that they want to get things moving, but if one preserves a sense of proportion one gets reasonably fair play.

And the same is true about one's colleagues in a general hospital. I think the division of patients into "drifters" and "primaries" is exceedingly good. We get the wastage from other departments, cases in which, having tried their best, physicians and surgeons cannot do more. We also get "primaries," and the term "mental department" does not trouble them; they are feeling queer and are glad of the treatment. And that is the great advantage of association with a general hospital; there is felt to be nothing derogatory or stigma-producing, and if people say it is a mental department they do not mind—they come. And it is fair to say that I have been very much impressed by the notes from the young and inexperienced casualty medical officers whose duty it is to sort out the newly-arrived patients who come to the department; this is *à propos* of the wastage question and the ignorant treatment of patients by general physicians. In eight cases out of ten, although made by an inexperienced house physician—a man who does not pretend to have had any training in psychiatry—the notes are extraordinarily good, and again and again I am lost in admiration of the sincere effort of the casualty man to realize the sort of case it is, and to send it to the appropriate department, with conscientious notes about it.

Two things, I think, have emerged from eighteen months' working. The first is, that after all, even with every expedient we can use, what Dr. Crichton-Miller said remains—that the time difficulty is the biggest, the almost fatal drawback to psycho-therapeutic treatment in an out-patient department. It is not suited for that. But, on the other hand, it is remarkable to my mind how clearly it has been shown that a theoretically absurdly small amount of psycho-therapeutic treatment may bring about a marvellous result in the patient; cases that, theoretically, will profit by nothing short of sixty or seventy hours of deep analysis, improve greatly on this shorter treatment. We do the best we can. And, in

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spite of theory to the contrary, they do get better and become reasonably useful members of society. It is fascinating at the present moment to note the various lines along which this is going; the association with the mental and the general hospital and the independent clinic, and I do not think we can say which, ultimately, is the most desirable. But I hope that, in ten to fifteen years' time, it will have become more clear. I have two chief assistants; one is specially interested and skilled in psycho-therapy, and if there is any particular patient to whom we ought to give more than the average time of intensive psycho-therapy, he is handed over to this assistant, who sees him privately in his room and gives him the maximum time possible. I have another assistant who is particularly interested in, and good at, clinical psychiatry, and looks after the cases for whom intensive psycho-therapy is not only impossible, but is undesirable. We all see the new cases together, and allot them amongst ourselves on that scheme, and it works very well indeed.

One word in conclusion. It has been most interesting to me that my psycho-therapeutic colleagues sometimes refer to what one of them called an "intuitive ability" to know what is wrong with a case. It is not any more intuitive ability than all of us have who have clinical psychiatric experience, for the beginning and the end of a satisfactory mental out-patient department is that the man in charge of it shall know mentally sick people when he sees them; and I do not know how any man can acquire that until he has gone through the mill of dealing with the neurotic and the insane, and I do not know where he can go through the mill except in a good mental hospital.

Dr. R. D. Gillespie (Guy's): One of the advantages of coming in towards the end of a discussion is that there is not much left to be said. I was specially interested in what Dr. Crichton-Miller said. Dr. Yellowlees' experience coincides very much with mine in its results. I once tried it on patients who were not insane, and I concluded that on any one day in the year there were about three million possible patients. I feel that the time has come for an extensive development of out-patient therapy.

Dr. Crichton-Miller kindly referred to the arrangement at Guy's, and I might, therefore, mention our organization, with the preliminary remark that the amicable arrangement depends on the insight of my colleague, Dr. C. P. Symonds, who himself has had training in psychiatry. No case comes direct to Dr. Symonds or

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myself; we have clinical assistants of consulting rank; patients are seen by them, and they come to us afterwards. That "seeing" includes physical examination. All of my colleagues have considerable experience in general medicine, and I keep myself in touch by attending Dr. Hurst's courses.

To avoid the muddling which has been referred to, I believe in trying to disseminate knowledge on psycho-therapy throughout the hospital. Besides these two clinical assistants, we have another clinical assistant who confines herself to psycho-therapy, and my chief clinical assistant, after he has seen the patients and sorted them out, devotes himself to cases which I refer back to him. We have a full-time social worker, and we have also other workers. With that equipment we are able to do some follow-up work now which we could not do before, and there is a good deal of visiting done in the homes. My house-physician also assists us when he has time. We meet three half-days a week, one session being devoted to children under sixteen. It is interesting to compare the results of the following-up of children with those of adults.

As to having others present at the interviews, I never exclude anybody whom I think should be admitted. Except in male cases when other questions arise, I have a social worker present, and on one day a week I have one or two social students present. It is surprising how much patients tell you, even in the presence of others, and I have never had a deputation sent to me to protest against the arrangement.

The department itself sees 2,000 new cases a year, and 400 come to the psychological side. With such a load of cases much of my work is advisory. I refer patients back to their doctors with a diagnosis and suggestions for treatment, but where the case requires intensive treatment which he cannot get from his doctor, we try to give it ourselves. But it is only in a small percentage that we can do that. We manage it partly by judicious selection, with a view to spending more time on the cases most likely to benefit.

With regard to suggestion, Dr. Brown said that suggestion could be and often needed to be carried out over a long period of time, so that it is not necessarily a saving method. I reserve it as a rule for those of low intelligence or defective education.

As far as the results are concerned, it is interesting to contrast the after-effects in adults and in children. I recently had 130 cases followed up whom we dealt with two years ago: 70 were adults, 60 were children. Of the adults, 34% showed themselves either cured or considerably improved; in 30% the condition was

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little changed. Ten were, when they came, obvious candidates for a mental hospital, and 7 of those 10 are still there. As to the children, I have a detailed table, but I may tell you, briefly, that 75% are either well or are considerably improved, that is to say, nearly twice as good a result as in the adults. The remainder are, mostly, *in statu quo*. That made me wonder whether there was any necessity for dealing with children in this way at all—whether they would not get better any way. I do find they get better quickly, and on a more stable basis than adults. I am interested in the personality deviations met with in children from the point of view of the prevention of psychoses later on; it is striking what we can do in changing the child's general attitude, and in training the necessary character traits.

Another point is that we have a psychological tester of some experience attached to the clinic who tests all the children and does the performance tests—a very helpful adjunct. It helps one in very important problems in those of school-leaving age, in adolescents and in mental bodily defectives. I suppose the two most important things in life are the work one likes and the wife one loves, and if you can sort children out and give them work which is congenial you will be going a long way in preventing a breakdown later. The aid of the psychological tester is very important, and it is one which can be developed very much in connection with the National Institute, for whose co-operation, some day, we may ask.

Mr. BROCK, *C.B.* (Chairman of the Board of Control): Like Dr. Yellowlees, I did not come with the idea of speaking, but the course of the discussion, to which I have listened with great interest, has emboldened me to take part in it, not because I can teach you, but because I want to do the only thing a layman can do in the presence of doctors, and that is, to ask questions.

The discussion this morning has, naturally, centred on what you can do with the patient when you get him. I want to direct your attention to one or two other questions: How you are going to get the patient, and how you are going to link up your out-patient clinics with the rest of the machinery for the treatment of mental diseases. It is natural that I should look at it from that point of view, because, as an administrator, I am primarily concerned with the machinery side; I am not competent to consider the medical and therapeutic side.

I think there is much truth in the view held by my chief, Sir

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Robert Morant, that if the machine is properly designed it will, in course of time, develop the right type of men and women to work it. That does not mean that any machine, however perfect, will produce Crichton-Millers for all; that is an impracticable ideal. But we have to consider not only what can be accomplished in occasional clinics which are fortunately circumstanced, with an abundance of skilled staff readily available; we have to consider, too, how we can bring some facilities within the reach of the people, wherever they happen to live, for whose care we are in some measure responsible. So far as the population of urban areas is concerned, it is a much simpler problem, but, apart from the people living in big cities, where the establishment of out-patient clinics, given good-will, is not a very difficult matter, we have also got the problem—and this is one of the questions to which I want to direct your attention—of what can be done not only for the people in the rural areas, but also for those in the semi-rural areas and the smaller towns. It has occurred to me to-day whether it might not be worth while to consider the possibility, if you cannot get patients to the clinics, of arranging for men to take the clinic to the patient—arranging for men, at suitable intervals, to visit small centres at which one or more patients could be collected to be dealt with by them. As a means to that end, I think we might find that at any rate the difficulty in regard to premises might be got over by utilizing for this work premises already being used for school clinics. They are not needed in the evenings, and it is in the evening that it is most likely patients will attend these clinics, as, ordinarily, the trouble is not sufficiently bad to compel the man or woman to give up his or her employment. It is well worth while considering whether it might not be possible, by co-operation between general and mental hospitals to organize something of the nature of a travelling clinic, which would bring the initial stage of treatment within the reach of everybody who lives within a reasonable distance, because I visualize the out-patient clinic as only the first link in the chain which we have got to construct. It is true, as the experience of our President has shown, and shown very forcibly in Oxford, and as has been demonstrated elsewhere, that the successful out-patient clinic will save a considerable number of patients from having to come to the mental hospital at all. But, important as that service is, it is almost equally important that the out-patient clinic should be used as a catchment-area to attract voluntary patients. I do not think we shall get patients into mental wards of general hospitals or into mental hospitals unless we can first win

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their confidence in the out-patient clinic, and we must win the confidence of the doctors as well as of the patients. From that point of view the development of clinics, even though they may not be as well staffed as we should like to see them, is very important, because without that I do not think you will get the patients into the mental hospital as early as you should, nor will you get the full value of the new liberty to treat patients on a voluntary basis.

There is another function which the out-patient clinic, as I visualize it, has to fulfil. I look forward to the time when, in addition to the public mental hospitals, there will be in all teaching hospitals—and, I hope, in a large number of non-teaching hospitals—a psychopathic unit, or at any rate wards, for the treatment, not only of definite mental disease, but also of border-line cases, so that those cases who exhibit physical symptoms, or are suspected of being complicated by physical symptoms, can be thoroughly investigated with the resources which are available, and are only available, in the general hospitals. Therefore I look to the out-patient clinic as not only the catchment-area through which you will get your voluntary patient, but also as a sort of sieve which will help you to distinguish between the cases which can best be sent to the psychopathic unit or mental ward of a general hospital, and the cases which can best be sent to the mental hospital. I do not ever want to see all cases of mental disorder, or of suspected mental disorder, sent to the general hospital; it would have a bad psychological effect on the patient, as he would feel, by the time he reached the mental hospital, that he was "done for"—that no good could now be done for him. But I recognize that there are cases which can be better dealt with in the general hospitals, and in the process of selection a well-organized out-patient clinic might be of enormous importance.

There is another thing which I want to see the out-patient clinic do. I am glad previous speakers emphasized the importance of supplementing the medical work of the out-patient clinic by social services. I was struck, last September, when visiting the Rouselle Hospital, in Paris, with the importance they attach to their social services, because of the value of knowledge, not only of the home circumstances of the patient, but also of the antecedent difficulties which may have aggravated his condition; and also because there are many cases in which, when you have done what you can do for your patient, it is vitally important that he should not return to the old harassing, aggravating conditions which started the trouble before. So I want to see the social worker not

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only making the initial inquiries which are so valuable to the physician, but also doing what is possible to see that when the patient goes back the old difficulties have been removed, and that when he has been following an occupation which is bad for him and for which he is not fitted, some new and less harassing occupation shall be found for him. I hope that if in that way we can secure the confidence of patients, they will look to the out-patient clinic as the first place to which they will return if at any time they feel a recurrence of their old symptoms. That is to say, I do not want it to be concerned only with the patient who has never been in hospital before, but with the medical after-care as well. And if that is so, not only the more valuable will it become, but the more rapidly will it secure what is so essential to our success—the confidence of the public and the confidence of the general practitioner.

Dr. Noble (Australia): I have been thinking, Sir, that in such a very interesting discussion as this it might be well that someone outside of Great Britain should have a few words.

I regard this discussion as one of the very best that I have ever attended. The field has been very well covered by the various speakers, and these speeches have shown us that in this country the problem of out-patient treatment is being very widely and very satisfactorily tackled. As a result of this discussion we shall agree that the success of these clinics depends mainly, no matter what method is adopted, on the personality of the workers in that field. The methods suggested by Prof. Robertson—association with a general hospital, or a mental hospital—are very valuable and necessary, and depend on the circumstances and the environment in each case; they are all needed, and all have their place. As far as general hospitals are concerned, it is essential to have beds in association with the clinic. Dr. Yellowlees mentioned the difficulties one has when commencing a clinic. The Council thinks we shall be a nuisance, and say they will give us a few beds to see how we get on. At Sydney we find that when there is trouble in the general hospital it is not on the part of the patients under the psychiatrist, because we have seen those cases and we know which are suitable for being kept in general wards. The difficulties arise in patients belonging to surgeons and physicians. We are reluctant to send patients from the general hospital because we have not a separate block in which to treat them. But in Australia we have succeeded in getting separate buildings in conjunction with general hospitals, and I think that is ideal, and for this reason: all our systems are

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working well, as far as they have gone, but we must look to the future. The field is a tremendous one. We have seen what wonderful buildings they are erecting in America, and we have come back from America knowing that the leaders there complain that though they have excellent equipment they have not the trained psychiatrists in sufficient numbers; in other words, they are deficient in man-power in the specialty. And the same applies here in this country. To get these men one needs association with a general hospital connected with a university. Therefore we must develop along those lines, so that medical students will, during their training, understand that the patients who come before the general practitioner are personalities, not "cases." This necessary work can be done better by the psychiatrist in a general hospital than by any other teacher in the hospital. Therefore I say it is most important that we should have these clinics in assocation with a general hospital at a university centre, so that we can attract the undergraduate and induce him to take an interest in our subject. Then house physicians and house surgeons can attend our department, and we do find that a number of them take an interest in the subject. In that way we can build up a team of useful workers.

Another aspect of importance is the child-guidance clinic, and there again it is difficult to organize that work apart from the general hospital. It succeeds in America largely, but in our smaller communities we get children better by working in children's and general hospitals than by separate agencies.

Mr. Brock mentioned the difficulty in rural areas. In New South Wales we have, in conjunction with the educational system, a travelling clinic which goes through the country. On that clinic are several psychiatrists. It is a good system, because by it, children the subjects of psychological difficulty are secured early, and it is a good method for following up.

Another aspect of the work which would be a great help, but has not been mentioned, is that of mental hygiene in the universities themselves. In Oxford and Cambridge you have excellent fields for that work, and much useful work of that kind is being done elsewhere. Some undergraduates have problems peculiar to themselves, as well as like problems to the rest of the community. The recent tragedy at Cambridge would be a good text for such bodies as this to have facilities for helping undergraduates. It has already been well exploited in Canada and the United States, and it should be considered carefully here, because not only will you thereby help the students, but you will teach intelligent men and women about

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our subject, and so get a wider sympathy with psychological medicine throughout the community, and that is a necessary thing to do.

I thank you, as a member of the Association who lives far away, for the benefit of having had the opportunity of hearing such an excellent discussion.

Dr. D. SLIGHT (McGill University, Montreal): It has been of great interest to me to be present and hear the various view-points. I myself have an appointment in a general hospital. One thing which has been touched on to-day is the need for taking a general view-point on the part of the psychiatrist. We have heard discussed the relation of medicine to psychiatry. Frequently men say, "Should not I be a neurologist?" I say, "Yes, and after that go and learn to be a general physician." I think it is pathetic to imagine that the only way for psychiatrists to see cases is through a special clinic. We psychiatrists who are connected with general hospitals and medical schools and are teaching students are using this subject as an introduction to the general study of medicine. I am fortunate in the co-operation I receive from my colleagues. I receive my cases from the other departments in hospital, and refer cases back to them. We are called "psychologists"; it is a joke; but we have to sell the subject to them on their own terms. We have got to be prepared to talk some amount of surgery with the surgeon, some medicine with the physician, and so on, and I plead that we psychiatrists will be in a more fortunate position if we are to take our place as reputable men in the general medical field if we take a broader view. It is unfortunate if we allow ourselves to be looked upon as pure psychiatric experts, or as "neuro-psychiatrists"—an unfortunate term. We should be very careful, otherwise we shall get into trouble and bring the subject into grave disrepute.

Sir HUBERT BOND said the subject was a very important one. He would, as time was short, avail himself of the invitation to contribute his quota to the discussion in writing. It must be a great delight to the President, who had devoted something like twelve years of intensive work to this particular subject, to see how it had grown, and was still growing in the minds of those in this department. It would dominate the method of approach as soon as the Mental Treatment Act began to have its way. One point which had been missed was the connection of the mental with the physical

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examination of the patients. What was to be done in that regard, and which was to have the prominence? Were the two to proceed *pari passu*, or was one to have precedence of the other?

Prof. Robertson, in reply, said: I cannot, at this late hour, Sir, enter into a reply on all the details of this discussion. But I may say I think there is little doubt that we have come to a critical point in the history of psychiatry in this country, and that a great deal depends on this question of opening out-patient clinics. We are not concerned with the development of magnificent institutions, such as Dr. Crichton-Miller's; what we have to do is to raise the standard of clinics and introduce them into those parts of the country where they do not at present exist. I agree with Mr. Brock that this is going to be one of the means by which the ideas of physicians in mental hospitals will be brought into contact with the public and with general practitioners, so that the treatment of our patients will no longer be confined to the mental hospitals. Our work must be extended in all directions among the community. Even the starting of out-patient clinics in a modest way is the thin end of the wedge, for before long the practice will extend; and in this way we shall be able to get the full benefit of the Mental Treatment Act.

As Mr. Brock said, How are we to get voluntary patients into our mental hospitals? This is one of the methods by which it can be done. And there will be two other effects. There will be earlier and preventive treatment, and ideas that the mental hospital is a place of stigma will be greatly minimized. The second is, that you will educate the general practitioners of the country. One of the difficulties at the present time is that the general practitioner, and even the eminent consulting physician, does not realize when he comes up against a mental case. I know this in connection with my former position in Edinburgh. Any physician in the hospital could ask me to see any case in his ward with which he had a difficulty from the mental point of view. Some physicians asked me to see them every fortnight, but other physicians never asked me to come into their wards, and when I hinted that they must have such cases, they told me they had not. I know such cases exist, but some physicians do not realize their existence and what can be done for them by calling in mental specialists. Too often, as Dr. Crichton-Miller and Dr. Yellowlees said, it is only when they find they cannot do anything more for the patient, who has been first a medical case,

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then a surgical one, that they send him along to the mental out-patient department, to see what the psychiatrist can do.

Another problem that has arisen in the discussion is the teaching of the medical student. The out-patient clinic is a very good place for the medical student to see these cases, and I think more importance should be attached to the teaching of psychiatry and psychology in the medical curriculum than at the present time.

All these things are connected together, and the subject extends in so many directions and involves so much in connection with social life, education and medicine that I hope all will put their minds to this question and help with the solution.

[A contribution to the subject by Dr. LORD will appear in our next number.—EDS.]

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