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SUPPLEMENT

MAY—JULY, 1938.

THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION.

QUARTERLY GENERAL MEETING.

THE Quarterly General Meeting was held at 11, Chandos Street, Cavendish Square, London, W. 1, on Friday, May 20, 1938, under the presidency of Dr. Douglas McRae.

The Minutes of the previous meeting were taken as read and confirmed.

OBITUARY.

The PRESIDENT said that the Association had lost two members since the last meeting. One of them was Dr. Andrew Davidson, of Sydney. He qualified at Aberdeen with honours in 1892 and took his M.D. in 1899. He had been a member since 1896. In Sydney he was Lecturer in Psychological Medicine at the University, and Superintendent of the Institute for the Insane at Callan Park. A paper of his entitled "Nervous Diseases Associated with Tabes Dorsalis" was published in the Journal in 1897. He held a high position in psychiatry in Australia, and enjoyed the respect of all those with whom he came in contact.

The other member who was lost to them was Dr. A. W. Neill, of The Warneford, a member of the Association since 1910. He was very largely instrumental in making the 1930 Oxford meeting the success it was. He, the President, had always been very much struck by his zest in his work, and the admirable arrangement of the institution he controlled. He took an active interest in the Association for many years and was a most useful member.

The members, by rising in their places, signified their regret at the death of these colleagues, and their desire that a vote of condolence should be forwarded to the relatives.

MATTERS ARISING FROM THE COUNCIL MEETING.

The PRESIDENT said that the Observation Visit to Hortham Colony had been a great success. Seventy members attended and the arrangements made by Dr. Lyons were admirable.

The Committee appointed by the Council in February to consider (1) correspondence from Mr. Claud Mullins, magistrate, on the question of child witnesses giving evidence in criminal courts and (2) Dr. Boyle's resolution "That it be a recommendation to the Home Secretary that every first offender be offered the opportunity of examination by a psychiatrist" had met, and Dr. Macfarlane, Secretary, reported that questions on (1) were being asked in the House of Commons. It had also been proposed that a letter be sent to the *Times* signed by prominent members of the Association, and that the matter be brought to the notice of the Home Secretary. In regard to Dr. Boyle's resolution it was recommended that no juvenile

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offender be deprived of his/her liberty without the opportunity of being examined by a psychiatrist.

The Minister of Health had appointed a Sub-Committee of the Inter-Departmental Committee on the Recruitment and Training of Nurses to consider the problems of the mental nursing service. Dr. Masefield had been co-opted as the Association's representative on this Sub-Committee. Drs. Petrie, Drury, Thomas, Good, Fleming and Masefield were representing the Association on the Joint Committee of Representatives of the Mental Hospitals Association, the Mental Hospital and Institutions Workers' Union and the R.M.P.A. These representatives, with power to co-opt other members of the Association, would draw up a separate Memorandum which would be presented to the Council for their approval.

The Study Tours Sub-Committee were organizing a Tour of the Swiss Mental Hospitals in October.

A letter had been received from Dr. Banarsi Das enclosing the preliminary notice of the first meeting of the Indian Division.

The County Councils Association had written asking whether, under the Matrimonial Causes Act, medical superintendents would give certificates with or without fees to spouses seeking divorce as Poor Persons. The Council agreed that in every case a guardian *ad litem* should be appointed and to him might be sent any report or certificate in the case of the defendant.

Election of Members.

The following, after ballot, were elected Ordinary Members of the Association:

Carlyle-Gall, Carlyle Marchant, M.R.C.S., L.R.C.P., D.P.M., Medical Officer, Royal Air Force; Parkley, Crumlin, co. Antrim.

MacMahon, James Francis, M.A., M.D., D.P.M., Deputy Medical Superintendent, Leavesden Hospital, Abbot's Langley, Watford, Herts.

Spiridion, Jan Tadeusz, M.A., M.B., B.Ch.Camb., M.R.C.S., L.R.C.P., D.P.M., Assistant Medical Officer, Springfield Hospital, London, S.W. 17.

The President remarked that he had been very much impressed by the number of new members now joining through the Divisions. He wished especially to call attention to what had been done in India. Dr. Das was doing extremely good work in connection with the formation of an Indian Division, and the members generally would endorse the action of the Council in tendering to him their congratulations.

Discussion.

"The Alleged Inadequacy in Numbers of Medical Officers in Mental Hospitals."

Dr. J. A. F. Denyssen (Banstead), in opening the discussion, said: I would first like to thank you for the opportunity of reading this paper. It is the result of much thought on the subject, many talks on the various aspects of the problem with my colleagues, and—I need not tell you—of our practical experience of this work.

I find there is complete agreement on the main point, which is, in brief, that in mental hospitals generally, insufficient individual attention is being given to patients who clearly need it.

This is due to inadequate medical staffing, which is aggravated by an increasing amount of what is labelled as "routine work".

The net result is that recent considerable advances in psychological medicine are not being made available to mental hospital patients. In this respect they are hardly better off than they were twenty years ago. Improvement in their standard of mental treatment is quite incommensurate with progress in psychological treatment.

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It is to be noted that friends of patients, who show appreciation of the generally high standard of physical treatment, make frequent complaints of a lack of individual attention to the patients " personal problems ".

The feeling of hopelessness and lack of progress engendered in this manner in the minds of the friends and relatives of patients, must react unfavourably on the patient. On the other hand, the stimulating effect on a patient's friends of the improvement following some new treatment must have reactions on the patient that will tend to accelerate his recovery.

As cardiazol therapy is being tested in several mental hospitals it is perhaps not irrelevant to quote a brief extract of an article by the originator in the *Psychiatrisch-Neurologische Wochenschrift*, 1938, Nos. 8 and 9, in which Dr. Meduna states :

" With regard to the psychic part of the treatment, which must keep step with the cardiazol treatment, and which, so far, has been surprisingly neglected in the literature, I am nowadays guided by the axiom that there can be no question of a full remission unless a patient has been brought to a full understanding of his condition ; unless he exhibits no critical attitude to his pathological experiences and unless he has been able intellectually to digest the character of his illness. This psychic unfolding must be the aim of the psychic treatment accompanying the cardiazol therapy."

What I have referred to as routine work includes such activities as ward visits and rounds ; statutory mental and physical examinations ; care of the physically sick ; reports, letters and interviews with relatives ; lectures to nurses ; participation in social and athletic functions ; coping with the everyday problems and minor emergencies of the hospital population.

This " routine work " is being continually augmented by the increasing number of operations performed in mental hospitals and the assistance and co-operation given to surgeons, gynæcologists and other consultants ; and by the fact that on account of holiday leave, the hospital staff is below strength for a considerable part of the year.

For further information on these points, it is of interest to refer to an editorial on " Medical Staffing of Mental Hospitals ", by the Chairman of the Board of Control, in the *Lancet* of July 18, 1936.

More adequate staffing of mental hospitals would enable medical officers to provide their patients with more individual attention and with psychological treatment—more commensurate with modern knowledge—of which they are now deprived.

It would enable them to give more adequate attention to the important question of occupational therapy. There must be thousands of mentally disordered people clinging on to life in the outside world on account of some small occupation by means of which they prove useful to society. When the link is broken they may soon find themselves in mental hospitals. If they do not respond within three to six months they easily move towards more chronic wards where they still continue to show those minor psychological changes which could be used to turn their attitude towards life into more normal channels. But to do this there must be a medical officer available who has the time to pay attention to these minor but very important phases. For want of this provision of skilled and timely observation, they are apt to remain for long periods at the industrial occupation to which they have been assigned, become in many cases efficient workers, but frequently sink into apathetic acceptance of the situation. Some of these from time to time, on account of organic symptoms, improve or recover in their passage through an infirmary ward for no apparent reason other than that they have more individual attention

Adequate staffing would facilitate the proper carrying out of the increasing amount of pathological, post-mortem, laboratory and research work which is now being required.

It would incidentally relieve the mental hospital officers—on whom the present and future welfare of the mentally ill depends—of the sterilizing and deadening effects of excessive " routine work ". As the Chairman of the Board of Control rightly points out, " A quantitative inadequacy breeds a qualitative inadequacy ".

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A doctor whose time is filled with routine work has not much energy, and ultimately not much desire, to give the individual attention to the patients who clearly need it and are entitled to it.

It would give more leisure time, which could be utilized in keeping his knowledge up-to-date by attending meetings, clinics, hospitals, lectures and refresher courses.

The subject would be incomplete without saying a few words about atmosphere. It is largely that of a segregating mechanism. Increased staffing, equipment, rules and regulations would still yield rather indifferent results at first if a genuine attempt is not made in cultivating the right attitude of the medical staff.

It is not difficult to gauge the atmosphere in a mental hospital where the medical superintendent complains that little time is spent by the existing staff in doing the essential work of the hospital. The work suffers because the medical officers have lost interest in the service and some are already in the process of obtaining appointments outside. A good many of these men are by no means lacking in ability, as evidenced by their achievements in outside appointments.

Although advantageous, it is not essential to import men of exceptional brilliance into the service. There are a good many average men who could do most useful work under suitable conditions.

In mental disorders we are dealing with reactions that are so subtle and many-sided that it is difficult to know where to begin. We are studying mental disorders mostly on a descriptive level. Because of this, all investigation efforts have been built around isolated variables. In psychiatry co-operative investigation is almost a necessity. A massed attack is more likely to bring a better understanding of the causation.

The clinical material in mental hospitals should be an important factor in attracting research workers, where there is a large population living under control conditions for long periods; where co-ordinated attack saves duplicating effort and waste of money.

The medical officer should feel that it is expected of him to produce results, not necessarily in getting his patients discharged, but in recording observations or special investigations, elaborating approved methods, and testing new therapies. Such an atmosphere would undoubtedly make itself felt outside the hospital, dependent to a large extent on outside contacts, and better liaison with outside hospitals, clinics and teaching schools.

The staff should be encouraged to be non-resident. Here I should like to quote Dr. Bryan's book on *Administrative Psychiatry*, in which he states: "Wherever possible, professional men and their families should live in the community. Even if houses are provided, there is a constant temptation to narrow the field of interest to the hospital group. A cloistered existence of this kind is not mentally healthy. To live a contented home life one should be reasonably free from dictation in social and family relationships. This is not always possible in the close knit hospital community.

Living outside the institution, the right kind of professional staff, through their social contacts would add immeasurably to the prestige of the hospital."

To draw the right type the service should be looked upon as a career. Remuneration and prospects of promotion should be made reasonably attractive.

At the present the higher appointments are purely administrative, with no alternative prospects of higher clinical posts.

The services of promising clinical and research workers are, to a large extent, lost on account of their absorption with administrative problems in the higher ranks.

The increments stop in various grades, irrespective of the fact that higher appointments are not available or that the individuals are doing satisfactory work. It still costs a thousand pounds to give one's child a medical career. Under present conditions this privilege is limited to but a few.

It is our duty as medical men to initiate progressive steps rather than complacently wait for evolutionary processes to solve our problems, or to hope that in

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time the public will stimulate us. Education of the public is necessary to get the financial support we require.

The superintendents are in a strategically favourable position in this respect on account of their closer contact with lay officials and committees.

Although initially more expensive, increased staff will eventually pave the way for substantially diminishing the period of detention of patients. Large business concerns do not hesitate to put their money into research, knowing that they will save money in the long run.

Hence the importance of thorough ventilation of the subject at this meeting, and I am most grateful to you for the opportunity you have given me.

Dr. A. G. DUNCAN (Severalls) said: In July, 1937, the Chairman of the Board of Control made some observations on the "frankly depressing" steadiness of the recovery-rate in mental hospitals, referring particularly to the fact that in this work we have not got enough doctors. It is felt that the question of adequate medical staff and the reasons for any insufficiency are better discussed at a general meeting of this Association than in Council or Committee. The subject is one on which it is very difficult for one voice to represent the opinion of many, and the value of to-days' debate will depend on the readiness of medical officers, especially assistant medical officers, to express their individual views. I must emphasize also that this communication is not intended as a basis for discussion, but only as my own contribution to it, and the only excuse I have for making this contribution is that I have been requested to amplify the comments I made when the subject was considered by representatives of the Royal Medico-Psychological Association and the Mental Hospitals Association.

Sir Laurence Brock deplores the fact that one doctor to 350 patients is quite a normal proportion in this country, and that one to over 450 or even 500 is by no means unknown; he mentions continental hospitals in which the proportion is one to 160 and even higher, though he does not say whether their recovery-rates are any better than ours. I see little value in any attempt to estimate the minimum adequate number of medical officers on such a basis of simple proportion. It ignores the fact that the amount of work to be done is very much influenced by the admission rate. Obviously hospital A, dealing with 650 new patients in a year requires more doctors than hospital B, of similar size but with an admission rate of 350. (All the figures I quote in illustration are taken from the reports for 1936.) The formula I have proposed considers both the size of the hospital and the admission rate, in estimating the number of assistant medical officers required: one for every 500 patients, plus one for every 150 in the admission rate, plus one if the hospital has more than 2000 beds. (This does not, of course, suggest a method of distributing the work.) Arithmetically, the medical superintendent does not count; whatever the amount of clinical work he does, it will not lessen that to be done by his assistants; however long the medical superintendent spends at the admission villa in the morning, it will not reduce the time I must be there in the afternoon. (More likely it will increase it.) The additional one assistant medical officer in the large hospital is on account of the extra work of a semi-administrative type devolving on the senior assistants, which in the small hospital is done by the medical superintendent. The admission rate should be the average of two years, unless it is rising quickly, when this factor should be weighted accordingly. Fractions of a half may appear in the sum, and in the total a half should count as one. I have selected the figures arbitrarily; doubtless others would vary them, without altering the totals very much.

On this basis, a hospital of 1,060 beds and admission rate 245 requires a minimum of four assistant medical officers; one of 1,900 beds and 360 admissions, seven assistant medical officers; for a size of 2,550 and 400 admissions, nine assistant medical officers. Without implying that the results are anything more than an expression of opinion, it may be of interest to apply the test to the adequacy of medical staffing of a number of hospitals. In 1936, of forty-two county and borough mental hospitals whose statistics I have, twelve would appear to have the minimum

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number of doctors; in nineteen there is one less than the minimum, in four there are two less, and seven hospitals are more than two assistant medical officers short.

But it does not require the application of any formula to demonstrate that some hospitals are seriously under-staffed. The Chairman of the Board of Control concludes that this is due to want of imagination on the part of the Visiting Committees. Whether this is generally so I am unable to judge; perhaps the medical superintendents, who doubtless influence the Committees in deciding whether a hospital is adequately staffed, can express an opinion. We do know, however, that it is by no means easy to secure and retain in mental hospital work doctors of the standard and qualifications desired. With some difficulty, temporary medical officers can be obtained; some of them one would not wish to keep. Others show keenness and ability, but will not stay; why do they go, is a question which assistant medical officers can best answer.

No doubt there are many reasons, and it is to be hoped that they will be put forward to-day, not as complaints, but as helpful suggestions. I shall touch on only one. For a junior medical officer the routine work of a mental hospital ward is often uninteresting and uninspiring; unless he has time and facilities to exercise some interest outside the actual ward work which must be done, he runs the risk of intellectual stagnation. Such interest need not necessarily be dignified by the term "research", and the laboratory is by no means the only place where it can be indulged; indeed the wards and the records office provide a far larger scope. But if the ward has no clinical room in which investigations can be undertaken, if the laboratory is already over-crowded, if there is, in the records office, no freedom from interruption, if there is no time for anything but the necessary routine work, the result is inevitable. The interest which the new assistant medical officer nearly always has on arrival is rapidly extinguished. He deteriorates to a mere wheel in the machine, or departs in search of a less restricted field.

The successful end to therapeutic effort—for many a most important reward in professional life—is less common in county and borough mental hospital work than in any other branch of medicine or surgery; we do not at present know how to rectify this deficiency, but we should recognize that it is in part responsible when the recent entrant into psychiatry finds the work too dull. I believe, from experience of a number of temporary colleagues, that the doctor who has just started on a psychiatric career often fails to realize why his work is dull, and what he can do to make it interesting.

Sir Laurence Brock complains that there is not a great deal going on which can really be called research in its true sense. I do not think the restriction he places on the term—"a very highly specialized work needing a particular type of mind and a specialized training"—is at all helpful to psychiatry or to mental hospital doctors. This Association knows that there is a great deal of research being carried out in far more than the few hospitals Sir Laurence Brock mentions, and it would be most unfortunate if our younger medical officers were given the impression that the elucidation of psychiatric problems is no concern of theirs. Every assistant medical officer should, for his own sake, be a research worker in the way I have endeavoured to outline. Spectacular results are not the main object. We are asked why we have produced no men like Freud, Jung, Adler, Janet, and some half-dozen others who have "found new ways of approach to problems of mental medicine". Perhaps it is of some significance that only in the case of one or two of the Continental psychiatrists held up to us as examples has their work been such as to have any influence on the recovery-rate of psychotics.

Perhaps it is not out of place for an assistant medical officer to refer to Sir Laurence Brock's comment that in the mental hospital service far too many prizes go to the successful administrator, and his differentiation of medical superintendents by their relative concern with medicine and with what he calls hotel-keeping. The distinction is as unfortunate as it is unreal, and I mention it because it has been used to support the suggestion that the insufficiency of doctors might be met by the appointment of non-professional administrators, liberating the medical superintendent for more clinical work. I believe such a policy would be impracticable;

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it certainly would not be welcomed by assistant medical officers. We cannot be held responsible to two individuals; to borrow our President's metaphor, better the devil we know than the devil we do not know.

Discussion.

The President complimented Dr. Denyssen and Dr. Duncan upon the clear and direct character of their papers. Those members who were medical superintendents had all been assistant medical officers, some of them for many years, others making more rapid progress. As a former assistant medical officer himself he recalled a long period of hard work at a low salary. At that time no assistant medical officer was allowed to get married. His whole object was to become a medical superintendent, when the opportunity of marrying and settling down would present itself. But he was very glad of his experience as an assistant medical officer under Bevan-Lewis and Clouston and he was singularly fortunate in his association for ten years with Ford Robertson, who was a research genius.

He was inclined to blame the Board of Control for the imposition of a great deal of useless routine work. There were a number of things they were asked to do which had no point or purpose. As for leisure to attend meetings and carry out research, well, in his day, there was no such thing as leisure. To-day the demand for leisure had grown very considerably, and he had known medical officers whose whole time even on duty was spent in wondering what to do with their leisure. He had any amount of research facilities, but he had experienced difficulty in getting men to "roll up their sleeves" and tackle things. He had had one or two who rather suggested that they expected him to provide all the ideas and devise the work, and they were disappointed because he was not constantly feeding them with ideas. Undoubtedly there was a very large amount of valuable material for research that "went down the sink" in asylums because there were not the men to take an interest in it. If there were scientifically minded men in sufficient numbers, then the material was available at a mental hospital without any question. He was forcibly reminded of a remark of the late Lord Haldane, that of the research scholars who got honours at universities only about 1% ever finished up by doing anything that was a solid contribution to knowledge. If that was so, he wanted to suggest that it was not easy to pick up suitable men. He was far from saying that if they did pick up suitable men they should not give them every encouragement. There was not a superintendent in Great Britain who would not be greatly pleased to get a man of that type and give him every encouragement.

With regard to the recovery-rate in mental hospitals, this had gone down because so many cases were now being treated in a variety of ways outside. Another point was that in mental hospital practice they were not getting the same proportion of recoveries as they did in general medicine and surgery. But the difference between the two spheres of practice must be remembered. Did a surgeon, for example, keep in hospital to cumber his accommodation a patient on whom he had carried out an amputation? What cases of chronic nephritis and chronic rheumatism remained in the general hospitals? On the other hand, in the mental hospitals they got "cluttered up with their failures". In psychiatry they got as good results as in ordinary medicine and surgery, only they had to keep their failures. He considered it rather a slur to suggest that not as good results were forthcoming in psychiatry. But what bootmaker was going to mend a pair of boots when not only the sole but the uppers were gone? They were accustomed to admit cases which were frankly hopeless. He had had many cases which had been three, four, or five times in other hospitals as voluntary patients, and they arrived as certified patients, obviously quite demented.

Dr. E. J. Fitzgerald (Witham) said that in 1914 the Royal Medico-Psychological Association had a committee sitting on this very subject, which issued a report, and he had expected this to be mentioned in one of the two opening papers.

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A gentleman who afterwards became a Commissioner of the Board of Control was chairman of that committee, and the report of the committee might very well be read to-day. One thing that to him was of extreme interest was that in the Irish service all medical officers had to be married, whereas in the English service no assistant medical officer was allowed to be married—the reverse of what obtained in the case of the clergy of the two countries, and rather an interesting psychological phenomenon. To-day we were a little more up-to-date in this country. But surely the question that had to be faced by medical officers in mental institutions was that if in a hospital there were nine or ten officers, it was evident that only one or two had a chance of becoming medical superintendent and getting a " living wage " on which they could bring up a family. The others would have to live in the genteel poverty in which curates used to exist. In the report he had mentioned it was suggested that the conditions under which many assistant medical officers laboured were due solely to the medical superintendents who, like colonels in the army who had been through the mill, were apt to say, " These youngsters that are coming up must go through the mill just the same as I did ". If his children thought of becoming medical officers in the public service—and he was a son of a medical superintendent himself—he would tell them to keep out of the mental hospital service. On entering it one might sometimes have the good fortune to come under an enlightened medical superintendent, but at other times one did not. He knew medical officers who had themselves to buy apparatus to do their research work, paying for it out of their own pockets, and he knew of one man who was absolutely forbidden to attempt hypnosis on penalty of dismissal.

Dr. J. J. B. MARTIN (Bristol) said that he might be able to give, not so much of his own ideas, as the criticisms and suggestions which had been given to him from outside. In other words, he might be able to let them see themselves as others saw them. He had a new hospital and required a considerable addition to his medical staff. He had naturally approached his committee and his committee had seen fit to take advice outside the hospital. He thought they were quite right in so doing. They had, for instance, discussed this matter with the director of public assistance. This was a man of sound common sense, and he said to him, " Well, Mr. Superintendent, you have yourself and four other medical officers for 1,200 patients. Are they actually necessary now ? " He was assured that they were, and he went on to say, " Well, I have an institution with 900 patients, very similar to yours, and I have got one medical officer only, but that medical officer does exactly 32 hours per week; he looks after just about the same number of new admissions. He sees all the cases under Section 20, and as far as I know that institution is run on perfectly good lines, the patients get a good showing, the chronic patients are well looked after, and my recovery-rate is very much higher than yours ". That remark set him thinking. He had himself thought rather on the same lines. He had been an assistant medical officer and he had been in general practice. There was no question to his mind that the work in general practice was very much heavier. Quite frankly, the work in hospital did not compare in physical strain with that which was imposed on one in general practice. He remembered two hospitals with about 800 patients and an out-patient clinic. On two occasions he had been left with the sole charge of such a hospital, owing to the sickness of other members of the staff, and on both occasions he did the work of the whole hospital, and found that his day's work then compared favourably with that of a full day in general practice.

The director of public assistance whom he had quoted said, " I do not believe the medical officers are necessary at all. You cannot tell me that all your new treatments have influenced by a fraction the recovery-rate. There is plenty of work in the mental hospitals for good nurses, but not for efficient doctors ". At that he began to tell him what the doctors actually did. He had watched his medical officers and seen exactly how they went about their work. They were quite a busy crowd. Their hours of work did not compare with those of the

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ordinary practitioner. They spent most of their time in compiling utterly useless statutory notes, and they seemed to think that was the main thing. They had got these notes and medical registers and so forth, and they were thoroughly tired of doing it. They realized that all these records were relegated eventually to the cellar. He had to say, frankly, that his committee had got very much the same views as this director of public assistance. They had queried the whole system from top to bottom, and they had said, " We are not going to pay medical men to write these notes. If they are no good, why should we pay from £600 to £900 a year for work which a clerk can do at £150 a year ? " They told him quite rightly that 80% of his recoveries occurred among the first-year admissions. They also said that they would give him as much money as he wanted for research, and they asked why there was not any research done in the hospital. He had taken a certain interest in pathology all his life, and they had the usual laboratory and so on, and yet one could say that apart from a few minor things, nothing useful had emerged. Actually there had been no real contribution to medical science—he was not referring to anything startling, but to the kind of contribution which would stand the test. The same thing applied, of course, to the average work of mental hospitals. Much of the research published, even in their own journal, was repetitive in character. It was a re-hash of what other men had already done. He had always set his face against that, and he hoped none of his own medical officers ever did it, because it was sheer publicity. But these lay committees were apt to feel that the matter had not been properly tackled, and they were prepared to pay for the treatment of the very earliest cases in the out-patient clinics. They did not care twopence about the chronic patient. They said that so far as the chronic patient was concerned it was a matter of nursing, but as regards out-patient clinics, research, and admission hospitals, they were prepared to pay for medical officers.

Talking it over with them they had arrived at this conclusion amongst themselves—that the actual work outside the hospital was much more valuable than the work inside. In other words, it was felt that the extra-mural activities of the mental hospitals should be very largely extended. Then the complaint of the medical officer that he had nothing to do or nothing worth doing would pass away. His own happiest time was in his out-patient clinic, where he felt occasionally that he could do some good. He hoped that he had shown those present what some others were thinking on this subject, and if in the course of the discussion some of the criticisms he had repeated could be answered and he could be given some idea as to how to persuade his committee to the contrary, he would be delighted.

Dr. K. C. Bailey said that the introduction of such treatments as insulin and cardiazol was an additional factor for supporting extra medical officers, but one thing to bear in mind was the difficulty of attending cases. He thought additional medical officers were necessary for increased clinical activities. The routine work had to go on until such time as alterations were made, and meanwhile extra medical officers were needed in order to get into touch with early psychotic cases outside and be able to treat them in the early stages. He was in Switzerland in the early part of the present year, and there he found in a hospital of approximately 1,000 patients nine resident doctors. In discussing matters with the senior medical officer he asked what they could find to do, because actually there was very little research going on at all, and there was just the ordinary routine work, which, by the way, was far less than was actually done in this country. But the work which these officers did was mainly on therapeutic lines, and he did not think a mental hospital in this country which did any real psychotherapy could do with a small medical staff. He believed that psychotherapy was very useful, and for that reason an added staff was needed.

Finally, there was the atmosphere of the mental hospital to be considered. The atmosphere was largely the result of the attitude of the medical superintendent. One of the reasons why so many young medical officers went astray and ceased to continue in the service was the lack of enthusiasm on the part of the medical

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superintendent. He added that personally he was in a mental hospital which was very happily situated in this respect.

Dr. DONALD BLAIR (Banstead) said that he was encouraged by the President's remarks to say a few words as one who had been a comparatively short time in the mental hospital service. As far as he could see, the increase of staff could only be warranted by the production of better results—that is to say, a better discharge rate, if that could be obtained. One of the important things was the question of psychotherapy. In mental hospitals they were dealing with psychotic cases. Psychotherapy played an important part in the recovery of patients with schizophrenia. He had seen a certain amount of cardiazol and insulin treatment, and he had no hesitation in saying that that was a definitely important factor, and in a large mental hospital where, incidentally, most cases were now treated with cardiazol and very few with insulin, there was very little time for an assistant medical officer having 500 patients to give much individual attention to each beyond actually administering the cardiazol and insulin.

A certain amount of comment had been made as to why medical officers lost interest. Before he entered the mental hospital service he had had five hospital appointments, but the mental hospital service astonished him on account of the amount of routine work—the mass of notes which had to be written about patients. These notes took a very large amount of time and attention, and certainly discouraged him and detracted from his interest. He had noticed in the *British Medical Journal* every now and then an advertisement for a house physician in a mental hospital. He thought that was an excellent idea. It was what ought to be done. Just as there were house physicians and house surgeons in ordinary hospitals, so there ought to be mental house physicians. Then when people went into outside practice they would know something about it, and this would react on the hospital, which would get patients earlier.

Why should not medical officers from mental hospitals be used in outside clinics? He was fortunate enough to work for some time as clinical assistant at the West End Hospital, and he found it very stimulating and helpful to see the type of patient encountered there. On the question of research, one county hospital, on considering one's application for appointment, asked what research one had done. The greater part of research was difficult to do well. There was much talk about research, but most of it was of no account. In American journals it would be found that the articles dealing with research had appended to them not one name, but four or five. They represented a good piece of co-operation. When four or five people worked together the names of all of them should appear at the top of the article. In certain counties where there were more than one county hospital the work which might be done in the way of co-operation was colossal. Take schizophrenia; they were hearing of the wonderful things done by insulin and cardiazol, but the claims were doubtful. This was because they did not know anything about the admission-and discharge- rates of ordinary schizophrenia. Why should not one of these places produce figures on which reliance could be placed? Any of the big services could do it.

Dr. W. J. T. KIMBER (Hill End, St. Albans) spoke as superintendent of a hospital where at the present time Dr. Duncan's formula was not only met but exceeded. He desired to draw attention to the fact that what they were aiming at was not a Utopian dream, but quite a practical proposition. According to the formula given them his admission-rate was 350 a year, which should give him 2·3 medical officers. The total number of patients was 1,100, which, again according to Dr. Duncan's formula, gave him 2·2. This added together to 4·5, and the proportion of medical staff he had was about that. Personally he did not find it any too many, and his committee was satisfied with what was going on.

He did not quite like the suggestion that there was not a great deal of clinical work to be done in mental hospitals. Actually, in his view, there was a great deal. They were apt not to put much value on attending social functions at

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mental hospitals, taking part in recreation and so forth; nevertheless, these were occasions on which medical officers and patients could actually make a very great advance in their relationships and their chances of approach. He did not think that this should be disregarded. In addition to the staff he had already mentioned, he had six visiting psychotherapists for the out-patient clinic, that is to say, practitioners specializing in treatment of mental disorders by psychotherapy, largely to the exclusion of more physical means. The junior medical officers on the staff received instruction from and worked under these specialists.

With regard to the house physician, if he stayed for twelve months they endeavoured to give him the groundwork of a knowledge of practical psychotherapy. This had been going on for some years, and therefore he rather resented the suggestion that there was no mental hospital in this country where real psychotherapy was going forward. The officers who were keen and interested should have a chance of understanding the possibilities of the treatment and learning something about it. These were the things that were going to attract medical officers and give life to the institution. He would be sorry to think his own medical officers were working as hard as the average man in general practice, because he did not think the average man in general practice had a chance of approaching his patients for the most part in the way that they as psychiatrists must approach them.

Dr. A. A. W. PETRIE (Banstead) said that in the discussion so far not many constructive suggestions had been made as to how more medical officers were to be employed. To provide so many medical officers to do routine work was obviously foolish. It was common ground that 1 : 350, compared at any rate with Germany and the United States, was a very small proportion. Generally speaking, the continental hospitals and clinics had a larger proportion of medical officers. He was one of those who believed in the establishment of psychiatric units for teams of workers to carry out work on the various problems, but quite apart from that there was one way in which stimulation could be given to the medical staffs of hospitals. The whole staff should all do some special work apart from their routine work. He personally thought it would be a great advantage for the medical superintendent to undertake clinical problems for a period as opposed to administrative work, and the same idea could be applied to the subordinate medical staff.

Prof. D. K. HENDERSON (Edinburgh) said that he found, when he got assistant physicians now, that most of them were studying in the first place for the diploma in psychiatry. A great many of them wished to take their degree, and in consequence these assistant physicians, in the time they were not occupied in their mental hospital work, were studying for degrees. He was not impressed at all by the pessimistic outlook of the director of public assistance who had been quoted by a previous speaker. He quite agreed that there was need for out-patient departments and psychiatric clinics to be developed, as well as special organizations for dealing with early cases. It was only under these conditions that the early cases would be obtained. But irrespective of that fact, he maintained that the bulk of psychiatric work had to be done in mental hospitals, and would always be done there. Patients in mental hospitals should not be looked upon as pathological specimens, but as biologically faulty adaptations. If one could get one's assistant physicians imbued with these ideas, the fact that they were dealing with living people, no matter how badly adjusted, would give them the proper stimulus and enable them to do their best work.

He thought it had always been true, and was far too true to-day, that the superintendent and the senior members of the staff did not take that part in the clinical work of their hospital as they should. But one very simple and very easy way to get over that difficulty, which he recommended to all superintendents and all mental hospitals, was the institution of clinical staff meetings. There was nothing more stimulating or instructive so far as the junior physicians were concerned than to have constant staff meetings in relation to every new

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admission into the mental hospital. At these staff meetings it would be the duty of the assistant physician to present the case to his staff and to his seniors, and it was important for the superintendent to help in the valuation of the case-material. This brought the members of the staff into association with one another. It was anomalous to him to think of the superintendent as a pure administrator. He believed that was a totally false idea on the part of the assistant medical officer. No medical superintendent worthy of the name was a pure administrator. He might not be able to contribute the last word to the newest forms of treatment, but by his broad outlook and experience and training, which accounted for so much, he was able to influence the actual clinical work done. One of the ways of getting the staff to work harmoniously was to institute regular staff meetings in every mental hospital throughout the country.

Sir LAURENCE BROCK (Chairman, Board of Control) asked to be allowed to intervene briefly in the discussion. When he quoted the figures in the speech he made to the Mental Hospitals Association, he never suggested that the proper proportion of medical staff to patients could be reduced to a mathematical formula. He did not think it could. The only scientific way to approach it was to take the hospital ward by ward and consider how many wards a medical officer could undertake. He did not think one could arrive at a formula even if one loaded it with extra weight in the shape of new admissions. The proportion of new admissions must affect very directly the number of medical officers required, but he hoped that that suggestion did not carry with it an implication, which he would deprecate, that it was only the out-patients and the new admissions who required psychiatric treatment. There was a great deal of psychiatric work which could and ought to be done amongst those patients whom they mechanically and complacently labelled "chronic".

He had hoped that in the course of that discussion he might have heard more of the possibility of relieving the situation by the employment of part-time medical officers, particularly in clinics, because they all knew that the development of the out-patient clinic had very greatly increased the strain on the medical officer. It had given the medical officer a great deal of extra work to do, often of a very exhausting and exacting nature, which committees did not always recognize. While it was most essential that some of the whole-time officers should be associated with the clinics, he wondered whether there was not room for part-time officers doing clinic work only. This might do something to meet the criticism that a good many of their out-patient clinics, useful as they were, were mainly diagnostic, and that many of them were not doing anything worth speaking about in the way of continuous scientific treatment. This was a suggestion he ventured to throw out in the hope that those who followed in the discussion might discuss it more at length. Committees might be a little more ready to agree to the appointment of part-time men whose appointment would not carry with it ultimate pension obligations. It would have an advantage in another direction. At present it could hardly be denied that they were suffering in this country from a grave lack of psychiatrists in private practice. Outside London, Edinburgh and a few other big centres, there were really very few competent psychiatrists engaged in private practice. This meant that the general practitioner, who knew lamentably little of psychological medicine, was not in a position to get the expert assistance he must often want unless he happened to be somewhere within the range of London, Edinburgh, Cambridge, or the very few other centres where men in private practice were to be found. If there were more of these part-time posts, then it might give the ambitious and adventurous man just that opportunity of getting over the first few years while he was endeavouring to build up a practice. It would not give him an adequate living, but it would be sufficient to provide him with bread and butter for a start. Thus there could be gradually built up a network of practitioners in private practice who would be available to help the ordinary general practitioner. It would be valuable from the point of view of patients and of the men in general practice alike, and he might with some hesitation

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venture to say that it would be valuable also from the point of view of their own speciality, because he could not help feeling sometimes that the rest of the medical profession was a little bit inclined to look on the psychiatrist with that sort of tolerant contempt—perhaps "contempt" was too strong a word—with which men in safe occupations were always regarded. Being himself in a safe occupation he could understand the feeling. The Civil Service had never attracted the adventurous, but there was room for a more adventurous spirit in psychiatric medicine than had been manifest hitherto.

Dr. DONALD ROSS (Lochgilphead) said that he was very glad to hear Prof. Henderson say what he did. Dr. Denyssen had mentioned that large business concerns did not hesitate to put good money into research. He himself had been very well served in some ways, and had had assistants who pleased him very well. Taking the post-war period, one of his assistants was now a superintendent of a much bigger institution than his own, two others were deputy superintendents, and three or four more had gone as assistants elsewhere, while some were in general practice. In Scotland he had never experienced the drawbacks which had been mentioned in the course of the discussion. One or two of Sir Laurence Brock's remarks seemed to be at variance with what was stated in the Annual Report of the Board of Control last year, where a caveat was entered with regard to observation wards, and it was suggested that patients should be got out of the observation wards into hospital as soon as possible. In his own district he was sometimes asked to go out in consultation with colleagues—more often than not it was without a fee, but he was allowed to keep the fees he earned. One of his assistants who left him last June had not been replaced. The first advertisement brought no applications; the second advertisement one application, which was not suitable. One of his colleagues had advertised two or three times, and eventually got one applicant who was appointed to the position. Why was it that the younger men were not applying for some of these posts? Was it a question of insufficient salary?

Dr. DONALD BLAIR, speaking a second time, said that the question related not only to the number but to the quality of medical men. Something had been said about the M.R.C.P. and the M.D. He himself had been faced with an ultimatum that without the M.R.C.P. he could not get any further. He would be delighted to take the M.R.C.P., but of course there was the financial consideration and the demand on one's time. He had obtained a certain amount of qualification for carrying out cardiazol and insulin treatment, and now if he was to take the M.R.C.P. he would have to throw this up. How much insulin treatment was being carried out in the L.C.C. mental hospitals? Very little. It was being done at St. Bernard's and to some extent at the Maudsley, but elsewhere among the new patients who were supposed to be good material for this treatment there were no cases in which insulin was being given. It seemed a pity, therefore, that he should have to turn his interests all round the other way. In his view the London M.D. in Psychological Medicine ought to be given consideration. He wished to get the M.R.C.P. and intended to do so, but he wanted to point out what it meant.

Dr. C. J. C. EARL (Caterham) said that Dr. Petrie had made a very constructive suggestion. The question was, when a young man entered the service under present conditions who was going to teach him? The medical superintendent was an administrator, and could not find time to do clinical work. He had to prepare committee reports, Board of Control reports and so on. The deputy medical superintendent also had quite a number of things to do which might quite easily be done by someone with no special qualification at all. He did not feel that the outlook in front of the young man was entirely satisfactory. Many people thought that the medical superintendent was more of a farmer than a doctor. The whole of the senior medical staff were devoted to the machine. If

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one looked back through the research carried out by the mental hospital service in this country, it would be found that most of it was pathological work—histology and bacteriology principally. This was because the enthusiastic junior could get hold of microtome and incubator and go down to the laboratory and stay there without interfering with the machine. But if he started trying to treat the patients he got into trouble. That was why so little psychiatric work had been done.

Dr. J. B. S. Lewis (St. Bernard's Hospital, Southall) said that it seemed to him that a number of recent speakers had rather wandered from the point. He desired to speak only on the alleged inadequacy in numbers of medical officers in mental hospitals. It was his personal conviction that the number of such officers was inadequate. This inadequacy was not "alleged", but real. When he was at school he was rather interested in mathematics, but not sufficiently so to impress the mathematics master, who stigmatized him as an armchair mathematician. He wanted to draw a slight parallel between that and psychiatry. He thought that the important thing in psychiatry was to be an armchair psychiatrist in this sense, and a very important sense, that adequate time could not be given to each patient individually under present conditions. Every mental hospital with a thousand patients, he believed, had enough work for a psychiatrist doing full-time psychotherapy and nothing else. He was continually coming across chronic neurotics who had been labelled "psychotics"—but he would not go into that. The chronic patients too, as a number of speakers had suggested, did not have enough time spent upon them, not from the point of therapy, but from the point of understanding their every-day problems. They simply came in for the purpose of note taking, the interview took a minute-and-a-half, the writing of the note perhaps took three minutes, and the time spent on the patient was wholly inadequate, and the patient's problems remained unascertained. He had had an example before him of the kind of errors that were possible. He discovered that a man was supposed to have a delusion that he had £200 in the bank. By studying his case he ascertained that it was a fact and not a delusion, and the man actually had £200 in the bank, and he was instrumental in getting the money out of the bank for that patient. There should be opportunity for armchair psychiatrists to do their real work, instead of having to race around over their notetaking. He admitted that a number of assistant medical officers would not be up to this particular requirement. But in every profession and walk of life there were a certain number of individuals who were dead losses, and this had to be faced. When the call for economy came in 1931 they were asked what they could do without, and the reply was, "We could do without one of our assistant medical officers".

Sir Hubert Bond (Senior Commissioner, Board of Control) said that having been a resident physician in six mental hospitals, and afterwards becoming a member of the Board of Control and able to regard the work of others dispassionately, but always with intense interest, he felt that some little contribution from himself was called for at that meeting, but it must be brief. He believed that there was hardly any other subject to which this Association could address itself with more utility, and so far as the discussion had gone it had been most valuable. He thought it could go a great deal further. Two things had emerged. Some speakers had mentioned an extraordinary paucity of medical staff, stating that they could not get those to whom they had an undisputed right. If that was so, why was it? That alone deserved very close inquiry. One could suggest quite a number of reasons, and it was really a matter worth while looking into. Secondly, there was the point of view of those who were not faced with that difficulty, but were they facing also a shortage in view of the duties which were really required? He was glad to find that practically there was a unanimous opinion that there was a shortage. He would rather beg his friends not to dwell so much on this question of routine work. If they did want to labour it, they should be prepared to say precisely what they called routine work, and then be equally prepared to meet

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somebody whose whole life had been spent in the work, and whose interest in the patients was the first thing in his thoughts. How could one speak of the work as a mere routine if it was something that affected vitally the happiness and welfare of the patient? As for records, the President and himself were brought up in a hard school, in which they were taught to be ashamed if they did not record their examination of patients. That was all they were required to do, and he could not understand the physician who, face to face with his patient, did not want to make some record. The record was actually part of his next step in the treatment. He was not quite sure what it was that was so hampering about this record-making. There used to be four notes a year asked for with regard to each patient. That was said by some to be "too much routine", and that it would be far better to cut the number down to two. It was the medical officers themselves who asked for the two notes a year; it was not something imposed upon them by the "powers that be". He had seen some of these notes; some were extremely full and valuable, others were no longer than one of the old quarterly notes used to be. And what were four notes a year in regard to a patient under one's care? Sir Laurence Brock had said that he did not think it was possible to estimate these notes in terms of numbers. He supposed he was really right. The questions to be faced were whether there was any difficulty in getting medical officers at some places, and secondly, whether a considerably greater number of medical officers were not wanted in order to carry out the work as it should be done.

Dr. L. W. Russell (St. Bernard's) said that he had approached the problem of personal contact with patients, which Dr. Lewis had mentioned, from the other end. As an assistant medical officer he found himself with something like 450 patients to look after. He could look after the whole of them superficially, doing occasional notes—two notes a year—which soon became a matter of routine with him. But he decided that this routine work was not fair to the patients, and the only alternative was to take a certain number of patients, and treat them individually and carefully. They became known as his protégés. That seemed to him a direct argument for the employment of more medical officers. If he had not done that he would have become a routine officer doing his statutory notes with little interest in his patients.

Dr. R. Pakenham-Walsh (Lancaster) stressed the importance of records for research purposes; this particularly referred to schizophrenia. In order to find out about the spontaneous remissions, it would be necessary to go through the whole notes of untreated cases. As it was so important to keep these records carefully, and many medical officers had difficulty in finding the time while doing routine work, he thought that more medical officers were necessary. He had found the notes of many cases largely inadequate.

A Member pointed out the extra demands upon the time of the medical officer made by the advent of voluntary and temporary cases.

Dr. J. Ivison Russell (York) said that he was rather disappointed to hear from some assistant medical officers that they felt to-day very much the same as he felt about 1912, though he had innocently supposed that there had been an improvement. But he felt that his assistants had not got too much spare time. There were three assistants for 1,000 patients. At the present time one man started work at half-past seven in the morning giving insulin, and did not leave the ward until about half-past twelve. During that time he had a series of cases coming in from other wards, which were undergoing quite searching tests to establish whether or not they would be found suitable for the treatment. It involved a very careful physical examination. If there was any spare time during those five hours he had other cases coming in for examination for what were called statutory notes. He suggested that the work of the assistant medical officer under present

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conditions was quite as strenuous as that of the average man in general practice—one, say, with a reasonably sized practice bringing him in £3,000 a year.

One constructive idea was that medical superintendents should be encouraged to do work outside the hospital. It would keep them alert, and he believed individual practitioners would welcome such consultation. But there were difficulties and discouragements on both sides, from the British Medical Association and from their own body. Sir Laurence Brock had suggested that in order to keep contact with the outside world outside men should be brought in to do the work. But surely the other thing should obtain—medical officers should go out into the outside world. There seemed to be a view that some big change took place in an assistant medical officer on his appointment to be a superintendent—that he became an administrator pure and simple. Personally he himself had found administrative work a relaxation, but there was no excuse for officers not doing a considerable amount of clinical work.

Dr. J. H. MacDonald (Glasgow) maintained that many asylums were too large. The ideal institution would not have more than 700 beds. Instead of adding to the large institutions, small ones should be built, and this would offer more posts for superintendents, and there would be more encouragement for the younger men in the service. It was of no use complaining about lack of research in institutions unless research directors were provided. The research worker needed guidance all the time, as well as technical assistance. He knew, speaking from his own experience, what an encouragement Dr. Ford Robertson, had been in Glasgow in this respect. If advance in research was desired it must be paid for; there should be a number of research institutes, whose directors should be paid as well as any administrator in the country.

The President said that this had been one of the most interesting debates the Association had ever held. Men had stood up and said what they thought, irrespective of any effect it might have on their promotion or otherwise. With regard to the comparison with general practitioners, he thought that those engaged in mental hospital practice might regard themselves as better clinicians. The general practitioner did not realize how much he depended on the patient's statement as to the whereabouts of the pain, and so forth. The clinician who had to deal with mental patients, on the other hand, found quite usually a total absence of co-operation and of volunteered information. Moreover, the specialist in mental disease could say that he was looking after the most important organ in the body, the brain, and the most important function in the human being, that of the mind. How then could they be the " duds " they were supposed to be ?

It was said there was a lack of psychiatrists in the country. That was false. Every district asylum had a medical officer who was quite competent to help the sheriff, the judge, the chief constable, or the procurator-fiscal, and give an expert opinion in consulting practice.

Sir Laurence Brock: But in England he is very often not allowed to do private practice.

The President wondered whether there was any harm in pointing out that in Scotland they did not suffer from this evil. But one point of view that was finding wide acceptance was that the Department of Health seemed convinced that the title " M.O.H. " stood for " Man's only hope ". At least that was the attitude the public were coming to adopt. It was a serious innovation in public administration that when medical officers of health were appointed, they had to agree that all fees for consultations accrued to the committee. What man was going to make himself competent to be a consultant merely to forfeit his fees to a committee ? As for the question of degrees, what had happened was that there were any number of so-called mental specialists who had the D.P.M., but had not had even one month's experience of mental hospital practice. However, they had the satisfaction of knowing that this and other matters had been very well ventilated that afternoon.—In spite of the protracted nature of the discussion, the attendance had been fully sustained to the end.

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