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Teaching or Therapy?

The Presidential Address at the One Hundred and Twenty-Third Annual Meeting of the Royal Medico-Psychological Association held in London, 3 July, 1963

By DESMOND CURRAN

May I first express my deep appreciation of the very great honour conferred upon me in being elected President of the Association.

One of the privileges of giving a Presidential address—and I may add one of the few pleasures in preparing it—is that one can say anything one likes, with the knowledge that one cannot be openly contradicted or disputed here and now. I do not propose to say anything that does not seem to me to be perfectly obvious and platitudinous; but one cannot be a psychiatrist for any length of time without realizing that what may appear to oneself to be obvious and platitudinous may apparently be far from being so to one's non-psychiatric medical and surgical colleagues—and even perhaps to some of one's psychiatric colleagues.

My main job for many years has been in an undergraduate teaching hospital. It is, therefore, I hope you will agree, right and proper that I should raise the question of what should be the place of such hospitals in the mental health service as a whole.

Clearly one of the main functions of an undergraduate teaching hospital is to teach undergraduate medical students or the doctors of the future. But what should they teach? What facilities are desirable or essential? Is there, should there be, or must there be any marked discrepancy between, so to speak, teaching and therapy, or between the needs of the medical students and of the patient?

I think you will agree that teaching hospitals have held in the past, and to a considerable extent still hold, an extraordinary position of privilege and prestige in this medical world of ours; and indeed it could be plausibly maintained that until the developments that have taken place since the introduction of the National Health Service in 1948, which undoubtedly resulted in a general up-grading of non-teaching hospitals, the standard of general medical and surgical care and treatment was higher in teaching hospitals than elsewhere. Yet certain points are noteworthy. First, teaching hospitals tended to be national institutions whose clientèle was by no means confined to local catchment areas. Second, the patients admitted to teaching hospitals were largely restricted to what were regarded as good teaching cases, and good teaching cases largely consisted of acute or short-stay cases who either died or could be discharged. Chronic or long-stay patients blocked beds that might otherwise be occupied by good acute teaching material, and were either considered unsuitable for admission or, after they had served their purposes for teaching, were transferred elsewhere.

An important effect of this emphasis on the acute short-stay good teaching case was that the future doctor as a medical student tended to have his medical education largely concentrated upon case material in which the psychological aspects and social implications of disease were less obvious and prominent than they are in chronic and long-stay cases.

The third noteworthy feature of the traditional teaching hospital set-up and orientation was that the good teaching case did not include the psychiatric case in any form. It was not a question, as in general medicine and surgery, of refusing or rapidly transferring the chronic case whilst accepting the acute; the embargo extended to all psychiatric cases recognized as such, whether acute or chronic. This embargo has only been lifted in very recent times with the acceptance, in principle, of psychiatric

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in-patient units as an integral part of teaching hospitals, though, in too many instances, we have yet to see the principle put into practice.

It has been held that the emphasis of teaching hospitals upon the acute case to the relative neglect of the chronic has not only been bad for medical education, but has also had an unfortunate effect upon the health services as a whole; for it has tended to foster the conception of a professional élite not sufficiently concerned with the chronic sick or with community problems. If this sort of criticism can rightly be levelled at teaching hospitals, it is a matter of considerable importance that the same mistake, or error in emphasis, should not be made by the psychiatric in-patient units of our teaching hospitals—not that many of adequate size are either in being or in prospect, as we shall see.

Whilst nobody, I think, would dispute the general thesis that it is desirable to integrate psychiatry with the rest of medicine, there are, as we all know, a number of psychiatrists who view with some alarm and despondency the policy of the Ministry of Health in so far as it relates to the setting up of psychiatric units of up to 200 beds or more in the general non-teaching district hospitals of the future.

It has, for example, been suggested that such a course would be well calculated to downgrade the longer-stay mental hospitals that remained; it has also been suggested that psychiatric patients need special facilities, in the form of space and so on, that would most improbably be forthcoming in the all-purposes district hospital; and, further, that there would be a risk of the psychiatric units having to conform in their administration to the more authoritarian pattern that obtains in general medicine and surgery, which might not be in the best interest of psychiatric patients and might tend to stifle initiative.

My own view is that, if it is once granted that classification of patients is desirable, there can be little objection to one of the classificatory units being outside the curtilage of the parent mental hospital, so long as this does not imply a classification of staff as well as of patients; and there are some obvious advantages in patients being nearer their homes. And I am also tolerably sure that, in the present state of public opinion, many of the patients themselves would prefer an arrangement whereby they were nowhere near long-stay patients. This may be regrettable, but it is understandable; and I do not think that in this respect things have changed much from the reaction shown by one of the first psychiatric cases I admitted when I was a house physician at the old Bethlem Hospital in 1928. I found this patient weeping bitterly, and when I asked her why, she told me that one of the other patients (who was in fact a well preserved and most kindly paranoid schizophrenic who had assumed the role of an extra receptionist), had said to her: "My dear, I have been so happy here for the last twenty years and I am sure you will be so happy too."

But, whatever our views may be about the wisdom of the institution of psychiatric in-patient units in non-teaching district hospitals, I take it there would be no disagreement about the desirability of such units as an integral part of our teaching hospitals.

As my good friend Professor Erwin Stengel has pointed out (and what he has achieved at Sheffield is an example to all of us), the neglect of psychiatry in our medical schools is an anomaly that will puzzle future historians of medicine, who will find it hard to explain the discrepancy between the magnitude of the medical and social problems arising from mental disorders and the insignificant part psychiatry has played in the training of our doctors; so that, as the recent (1963) report of the Psychological Medicine Committee of the Royal College of Physicians puts it demurely, "It became unusual for clinical teachers and doctors outside psychiatry to be as proficient at or interested in the diagnosis and treatment of psychiatric states as they were at recognizing other common illnesses."

An interesting figure bearing on this point has been provided by an investigation carried out three years ago by Professor Trethowan, who found that the average number of teaching hours devoted to psychiatry in the provincial medical schools in the United Kingdom was about 85, which represents just under 2 per cent. of the total hours available for clinical instruction in all subjects.

I have said, perhaps optimistically, that I did

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not think there would be any disagreement about the desirability of psychiatric in-patient units as an integral part of our teaching hospitals, and it was encouraging that at a recent meeting of the Comitia of the Royal College of Physicians the report of the Psychological Medicine Committee advocating the institution of such units with approximately 80–100 beds was accepted without discussion. But I have been sufficiently involved in the problem not to make the mistake of supposing that acceptance in principle necessarily leads to any action, except after long delays and in a totally inadequate form.

I had and have two main fears. The first is that the in-patient units, when they are established, will be far too small. And the second is that the psychiatric departments in our teaching hospitals will be inadequately integrated with the psychiatric community services that are expanding so rapidly.

Looking back on my life, it seems to me that one of the most difficult problems in advocating any course of action that is obviously desirable is to decide the limits of beastliness to which one should go whilst retaining some degree of effectiveness. It is no self-praise to say that I think I have been far too decent. The story of the development—or non-development—of psychiatric in-patient units in our teaching hospitals is quite lamentable: and the case for in-patient beds for teaching is just as strong in psychiatry as it is in general medicine and surgery. I hope you will bear with me if I run over some of this story as it has come my way.

My first experience of a psychiatric unit in a teaching hospital was at the Phipps Clinic of the Johns Hopkins Hospital at Baltimore in 1930 under that great man Adolf Meyer: and, even in those days, psychiatric units in teaching hospitals had long been part of the American psychiatric scene, just as university psychiatric clinics had long been part of the Continental scene.

The position in British medical schools was of course quite different, although I understand that the position in Scotland was somewhat better. Before the last war not one of the twelve London teaching hospitals had any psychiatric accommodation for in-patients, nor, so far as I know, had any of the provincial medical schools in England and Wales. The teachers, or "Physicians in Psychological Medicine" as they were called, were either medical superintendents of mental hospitals, who had many other calls on their time and energy, and did one or two out-patient sessions as a part-time extra, or consultants engaged in private practice without beds behind them, and hence increasingly cut off from a large and essential range of clinical experience.

For myself, the carrot held out before me when I was appointed to the staff of St. George's in the 1930s was that the hospital was shortly to be rebuilt and that in-patient accommodation of perhaps thirty beds would be forthcoming. I did not then realize how totally inadequate such a number of beds would be, nor that there would be quite the same delay in rebuilding, for it seems likely to be a question of nigh unto "forty years on". Then came the war, which further reinforced my belief of the value of psychiatric units in general hospitals, for this was soon accepted as part of the set-up in the Royal Naval Medical Service.

It is hard to know, but I do not believe I would have returned to St. George's after the war with the indefinite prospect of being solely confined to out-patient work in cramped surroundings; however, the Board of Governors placed at the disposal of psychiatry an in-patient unit of some 46 beds at the Atkinson Morley branch of St. George's, seven miles from Hyde Park Corner, and provided fairly ample, if extremely inconvenient, accommodation for the Out-patient Department in a large house adjoining the hospital.

I shall return later to some of the lessons I think I have learnt from the psychiatric set-up at St. George's and digress to tell you of two completely unsuccessful ventures in planning.

It so happens that, shortly after the war, I was appointed one of the original members of the South-West Metropolitan Regional Hospital Board. I put up a proposal that an experiment should be tried of exchanging mental hospital and general hospital beds, so that several hundred psychiatric patients would be housed in general hospitals and vice versa:

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for experience in the war and subsequently at Atkinson Morley Hospital had convinced me that any ward can be adapted for psychiatric patients, although it is not of course ideal. In 1948 there was no prospect of any substantial rebuilding for some time, and this seemed to me the only sensible way of at least starting the integration of psychiatry with the rest of medicine. Needless to say this proposal was not accepted.

I was also, soon after the war, appointed a member of the committee with the resounding title of the Advisory Committee on Mental Health to the Central Health Services Council, and put up a memorandum advocating that Boards of Governors should be urged to provide units for the in-patient treatment of psychiatric patients, because of their value for teaching and research as well as treatment; and a report giving advice to that effect to the Minister of Health was unanimously agreed upon and duly signed by the then Chairman, Sir Alan Daly, on 3 December, 1950. It was promptly pigeon-holed, and was kept in its pigeon-hole until last summer when it was used again for another report to the same effect presented by the same body to the Minister (it will be found in the Report of the Central Health Services Council published on 5 July, 1963).

In the preamble to the 1950 report two previous Ministry memoranda are referred to. The first advises that "a unit of 60 beds or upwards would be a convenient size" for psychiatric in-patient units in University centres. The second is perhaps worth quoting more fully. In paragraph 67 of R.H.B.(48)1 it was stated that "It can be assumed that at every Regional Centre the University will provide a teaching psychiatric unit which should be in close liaison with the appropriate mental hospital, and it is desirable that the Professor of Psychiatry at the teaching centre should have access for teaching purposes to mental hospital beds. It is not anticipated that there will be any difficulty in arranging, by agreement, for the necessary clinical facilities to be provided. Conversely, and to everyone's mutual advantage, the medical staff of the mental hospital should participate in the work of the teaching psychiatric clinic."

Now comes a lull until an approach was made to the Ministry of Health in June, 1961, by a deputation from the Association of Teachers in Psychiatry in Undergraduate Medical Schools. We were told that so far as the Ministry of Health was concerned we were "pushing against an open door", since the setting up of psychiatric in-patient units was their accepted policy, but we were also reminded of the limitations imposed upon the Ministry by statute as regards the autonomy of Boards of Governors in the allocation of beds under their control. It was suggested by the Ministry that an approach to the University Grants Committee and also to the General Medical Council might be helpful. First, as regards the General Medical Council, you may recall that the last report on the curriculum, which gave all medical schools much greater freedom of action in planning, appeared in 1959. It was described by the then President of the Council as "a stimulus and a challenge", but a perusal of the reports sent in by the Deans of medical schools fails, with few exceptions, to bear this out so far as psychiatry is concerned. Nothing, I think, can be done until the next review of the curriculum takes place, which I hope will happen in the not too distant future.

The approach suggested by the Ministry to the University Grants Committee on the part of the Association of Teachers was postponed until after the appearance of the Hospital Plan last year, in which, you may remember, the proposed allocation of psychiatric beds in teaching hospitals is extremely meagre. The deputation of the Association of Teachers was received most courteously by Sir Keith Murray, the Chairman of the U.G.C., and we were asked to present a written memorandum, which was duly done, and a letter was received in reply in November, 1962, as follows:

"Dear Dr. Garmany,

"The Medical Sub-Committee, at a recent meeting, considered the memorandum which you submitted in May on behalf of your Association on the need for psychiatric in-patient units in teaching hospitals.

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"The Sub-Committee are in broad agreement with the views of your Association. They consider that when a new teaching hospital is being planned the target should be a minimum provision of 60 beds for psychiatry and that these beds should be located within the main teaching hospital, though they realize that in certain cases site restrictions or other local considerations may make it impracticable for these aims to be achieved in full: in such cases it will remain necessary to rely on beds outside the main teaching hospital. They also consider that it is desirable for each professorial unit to have an allocation of about 40 beds.

"The Sub-Committee are also in agreement with the importance which your Association attach to in-patient clerking by students and with the view that one month should be the minimum requirement, though there may be different views about the best way of organizing this within the students' clinical period.

Yours sincerely,

(Signed) Keith A. H. Murray."

Overleaf is a table summarizing the information collected last year (1962) by Professor Denis Hill in his function as the Secretary of the Psychological Medicine Committee of the Royal College of Physicians in the preparation of the recently published report to which I have already made allusion. I have added a few items.

In this table, you will observe that the "promised" beds are not included in the total of the last right hand column. Oxford and Cardiff at present have their in-patient beds in Regional Hospital Board Hospitals as indicated —viz. The Warneford and Whitchurch.

Scotland is rather a special case, because the Teaching Hospitals and the Regional Boards are not separated as with us; this may account for their better arrangements, which as indicated, do not fit into the table.

I most sincerely hope that this table is now out of date; and I understand, and am very glad to hear, that this is true for St. Thomas's Hospital.

This table does not include relatively remote prospects, such as the rebuilding of St. George's on the Fountain site of some 30 acres at Tooting, which it is hoped may start in 1968—to celebrate the date of my retirement.

At St. George's we put in for at least 80 psychiatric in-patient beds, but the present planners have only allocated 60. Let us hope there will be a change of heart. And let us also hope that the same will be true of other teaching hospitals.

To me, these figures are shocking; but they should certainly dispel any fears that undergraduate teaching hospitals in the future are likely to skim off much of the psychiatric cream. On the other hand they fully justify my fears that psychiatric in-patient units in teaching hospitals are likely to be far too small.

I think now that it was a tactical mistake to suggest 60 beds as a minimal figure, for which I hold myself partly accountable since I put up this figure to the Ministry soon after the war. I am sure the Royal College of Physicians' estimate of 80–100 beds is nearer the mark, and these should be in the main teaching hospital or in close proximity, i.e. walking distance. The reasons for this bed allocation are given in the R.C.P. Report and I need not recapitulate them, except to stress that this larger number of beds is essential for teaching if it is agreed that it is essential for students to do in-patient clerking; for otherwise there would not be enough in-patients to go round, and some patients cannot be subjected to frequent examination by a succession of students with any decency. Incidentally, in-patient clerking for only a month is far too short.

But quite apart from this in-patient clerking by students aspect, I am sure that a 40-bed in-patient unit—and you will see from the table that this seems quite a popular figure—is too small.

The Association of Teachers consider that for each 20 beds the equivalent of a full-time consultant is required if one is dealing with a rapid turnover. This may seem a high doctor–patient ratio; but teaching is time-consuming and it is desirable for students to be taught in small groups in tutorials and to see cases well worked up. You will remember that the

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PSYCHIATRIC BEDS IN TEACHING HOSPITALS, 1962

	On Site		Promised	At Distance		Promised	Total
London Teaching Hospitals:							
Guy's	44	(23 N.H.S.) (21 Private)	—	0			44
U.C.H.	0		—	76	(1 mile)		76
Bart's	4		(20)	0			4
London	8		—	18	(1½ miles)		26
St. George's	0		—	46	(7 miles)		46
St. Mary's	7		—	0			7
St. Thomas's	0		(24)	20	(½ mile)		20
Charing Cross	0		(40)	15	(5 miles)		15
Westminster	0		—	21	(1 mile)	(40)	21
King's	9		—	0			9
Royal Free	12		(35)	0			12
Middlesex	9		(15)	70	(4 miles)		79
Total	93			265			356
Provincial Teaching Hospitals:							
Leeds	18			30			48
Newcastle	20			54	(2 miles)		74
Sheffield	9		(30)	29	(3 miles)		38
Bristol	0			30	(5½ miles)		30
Liverpool	4			0			4
Birmingham	11			21	(1 mile)		32
Manchester	0			19	(¼ mile)		19
Cardiff	4		(42)	R.H.B.	(4 miles)		4
Oxford	0			R.H.B.	(2½ miles)		0
Total	66			183			249
Northern Ireland:							
Belfast	0			45	(1 mile)		45
Scotland:							
Edinburgh	57	(2½ miles)					
Aberdeen	38						
Glasgow	93+			190			
Dundee	22		(30)	70			
Total	210			260			

U.G.C. agreed with the Association of Teachers that 40 beds would be necessary for an Academic unit. Now, if you have only 40 beds and if all medical schools in the future have a Professor and Reader or Senior Lecturer (and this rightly or wrongly would seem to be the present trend, certainly in the Provinces if not in London), there would be no in-patient beds left over for any non-academic consultant teacher. I believe that would be a mistake. I do not believe all teaching on in-patients should be carried out by academics, and any such proposal would

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quite rightly be indignantly repudiated by general physicians and surgeons. There would be a real danger of the Professor becoming a Gauleiter ruling the roost, which has been an unfortunate feature of some Continental medical schools. And finally, I believe that experience of private practice and domiciliary consultations provides experience which can be obtained in no other way, and is invaluable for teaching.

I shall now turn to my second fear, namely that the psychiatric departments in our teaching hospitals will be inadequately integrated with the psychiatric community services. It would indeed be sad if the setting up of teaching hospital in-patient units should result in any perpetuation of isolation from community endeavours owing to any undue emphasis on or interest in the rare or exotic case—the hot house orchids rather than the peonies and the pinks—and also the common weeds that are to be found in all psychiatric gardens. As the Association of Teachers wrote in their memo to the U.G.C.: "We appreciate that teaching and research are primary considerations for a teaching hospital and that service to a catchment area is sometimes regarded as essentially the responsibility of the Regional Hospital Board. But, so far as the teaching of psychiatry is concerned, we consider that any sharp division between teaching and research on the one hand and community services on the other is to be deplored."

Surely we would all agree that the high standing that British psychiatry enjoys at the present time is due essentially to the remarkable initiative shown by many of our larger psychiatric hospitals with which, for example, the names of the late Dr. T. P. Rees of Warlingham (whose recent death has been such a shock to all of us), of Dr. Duncan Macmillan of Mapperley and of Dr. Carse of Graylingwell are so honourably associated—to the pioneer work done by them and others that has resulted in the striking liberalization of the conditions under which patients are treated, together with the concept of the therapeutic community. We would all also agree that, coupled with the transformation scene that has taken place within the walls of so many of our mental hospitals, a striking advance has come in our realization of the importance of social factors and in the development of community psychiatric services radiating from the parent psychiatric hospital into the community in association with the local authority services.

I speak with some feeling on this subject, for I have been acutely conscious of the difficulties and disadvantages in trying to teach psychiatry to medical students on out-patients the majority of whom do not come from the local area. Our experience at St. George's is not that we lack patients. On the contrary our out-patient department is saturated, since we see some 1,500 new patients a year. But many of these patients are sent to us, in the traditional teaching hospital way, from far afield; and adequate social work and investigations present almost unsurmountable difficulties when one patient comes from Croydon, another from Bournemouth and a third from Luton, as happened to me one afternoon recently. It is, of course, possible to take it as a compliment that patients are referred to St. George's from all over the country in this way; but patients who are sent any distance tend to be highly selected and not fully representative of ordinary psychiatric practice. And they also tend to present complex problems and are correspondingly difficult to teach on.

The same criticism applies to the clientèle of our in-patient unit, many of the patients also coming from far afield. We get patients referred from a wide variety of sources, such as Government departments, nationalized industries, various universities, and so on, and, like all teaching hospitals, we have our full quota of doctors, doctors' wives and other medical relations and members of the nursing profession. Whilst it is true that many of the cases referred in this way present fascinating problems, I sometimes wonder whether our students during their in-patient clerking for a month, which has been in operation since 1956, might not leave with the impression that a typical schizophrenic is a brilliant scholar with a public school background.

It would seem to me quite essential that the teaching hospitals in the future should be closely linked with the area within which they are located, although I am certainly not suggesting

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that the patients admitted should be solely confined to this area; and this linkage should obviously be with both the mental hospital serving the area and also with the local authority psychiatric services. I would entirely agree with the 1948 memorandum, previously quoted, that it would be to everyone's mutual advantage that the medical staff of the mental hospital should participate in the work of the teaching hospital psychiatric clinic and vice versa. But such a general plan is difficult of fulfilment for historical and geographical reasons, perhaps especially in London where, as you know, many of the teaching hospitals are concentrated in central London—or perhaps stranded would be a better term. To illustrate how the historical background has affected planning, may I take as an illustration my own hospital, St. George's? As mentioned previously, it is proposed that the new hospital should be rebuilt on the Fountain site of some thirty acres, at Tooting. This site is almost in the middle of the catchment area served by West Park Hospital, which is located 9 miles away at Epsom; whereas Springfield Hospital, which is less than one mile away, has its catchment area away in Middlesex. If the catchment areas could be reshuffled and Springfield made to serve the area surrounding it, a close link with the new St. George's would be possible. In the meantime, however, the Board of Governors of St. George's have agreed to make a start in trying to develop the liaison I have mentioned by providing a Day Hospital for West Park in one of the old huts of the Fountain Hospital, where there is reasonable space and accommodation for 40 patients, and by allocating another of the huts to the local authority mental health services. There has so far been no difficulty whatever in getting the closest liaison between the Board of Governors of St. George's, the West Park Hospital Management Committee and the London County Council. Now, although it is certainly a pleasing prospect to have an increasingly close liaison with Dr. Schlicht and his colleagues at West Park, it would surely be more sensible to have this liaison with the nearby Springfield Hospital and perhaps also with Tooting Bec Hospital, which is also quite near.

My pipe dream for the future at St. George's, which, if it ever comes true, will be long after my time, would be some 80–100 in-patient psychiatric beds, about 40 of these forming the Professorial Unit and the remainder being apportioned to consultant psychiatrists primarily on the staff of St. George's and also to consultant psychiatrists primarily on the staff of Springfield. All these should be joint appointments. It is, for example, most important for the future Professor of Psychiatry to be in constant and close touch with medium and long-stay patients. It should also be possible for instructional and diagnostic purposes to have a shuttle service with both Springfield and Tooting Bec. Potentially, at least, there is an opportunity for a most interesting psychiatric set-up, comprising a teaching hospital unit, associated with all the facilities of a general hospital, including an active neurosurgical and neurological department, and a day hospital as part and parcel of the main teaching hospital—all closely linked with the local authority psychiatric services, whose centre would be on the same site, and the closely adjacent mental hospitals of Springfield and Tooting Bec, the latter with its extraordinarily rich geriatric material.

I have said nothing about many very important topics, such as child psychiatry or postgraduate training and have been mainly concerned with in-patient rather than with out-patient services. I have dwelt upon the in-patient aspect because the first or basic psychiatric instruction of students must I think be with in-patients. To take a case properly, the first essential is for students to have an opportunity of examining patients themselves, which takes a lot of time, more time than many out-patients can be expected to tolerate; and this, quite apart from the "pot luck" aspect of out-patient work. A student who was clerking for me in out-patients recently hit on a continuous run of overseas students from Earls Court who all showed the same syndrome—sexual problems and difficulty in concentration and working for their examinations.

I have entitled this address "Teaching or Therapy?" This is, or should be, a false antithesis; for I have tried to stress the importance as I see it of teaching hospitals having an

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adequate in-patient unit, closely integrated with all the other psychiatric services of the area, and for students to have an opportunity of instruction, both intra-murally and extra-murally, on a representative sample of what does in fact constitute psychiatric practice, with the emphasis not unduly biased in favour of the "good acute teaching case". It is I think high time that teaching hospitals should cease to lay themselves open to the criticism that they are—rather disdainfully—out on a limb on their own.

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