SUGGESTED TITLE FOR COVER OF THESIS:

" A CASE STUDY OF PSYCHIATRY AS A NEW MEDICAL SPECIALTY "

A CASE STUDY OF PSYCHIATRY IN RELATION TO OTHER MEDICAL SPECIALTIES IN A HOSPITAL

BY

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INTRODUCTION

Empirical Observations

In recent years the attention of sociology has been increasingly focused on the world of work and with one aspect of this in particular - that of the professions. The study of the problems of one such institutional system would, therefore, throw sociological light on the strains and stresses to which the human being is subject in the whole work world. As Professor Parsons observes:- "The analysis of modern medical practice has not only given us a 'case study' of a type of social structure which is interesting and significant in itself ... more than that, it has opened a 'window' which can be used for the observation of balancing processes within the social system, which have generalized significance far beyond the 'room' within the larger edifice of society into which this particular window opens ..." [1]

As an emergent rather than an old established profession, Psychiatry has had to face considerable opposition and the severity of its birth pangs has been increased by criticism and resentment from the medical profession, on the "fringes" of which it lies.

The object of this study is to consider the relationships between parent profession and offspring, as a means of ascertaining what occurs during the process of acceptance.

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[1] T. Parsons. "The Social System"
The Free Press, Illinois, 1951, p.479.

Sociological Area of the Problem

One fruitful medium in which to explore these relationships is that of an ongoing institution, such as the hospital, possessing a distinct form and features shared with other social institutions. The practitioner in such a setting has to be visualized as part of a social structure - as fitting into a system of interpersonal relationships, a system of formal organization, a system of informal relations and a system of technical services. A study of the hospital in this fourth perspective - as a system of technical services - is most helpful to our present investigation. One sees a set of technical specialists, armed with trained skills, aided by technical assistants, providing a set of professional services for an appropriate set of clients. Such a structure is easy to visualize, the elements noted forming a neatly articulated system, with little difficulty in specifying the purpose of each element in the system. By exploring the impersonal relationships of the specialities within the structural and functional framework of one specific hospital, it would thus be possible to clarify the relationship between Psychiatry and the medical profession in general.

Specific Problem of the Study

Contemporary sociological study is largely concerned with three distinct but inter-related fields - the field of social psychology and questions of interaction, the cultural field and the field of institutionalized structures. Any study of an institutional system such as the medical profession

would, therefore, include psychological and cultural elements within its frame of reference: the sociologist must reach the human experiences and attitudes which constitute the full live and active social reality beneath the formal organization of the social institution; he must consider not only objective but subjective elements, not only the empirical content but the meaning given to phenomena by the individual in the totality of his cultural milieu.

The purpose of this study is to investigate the attitude of the medical consultant towards the psychiatrist and of the psychiatrist towards the consultant, the conflicts and tensions underlying their working relationships, the problems involved in the rise of a new specialty and its incorporation into the institutionalized field of medicine. It is apparent that the interplay of many factors is here involved - the religious, racial and educational elements in the community, the press, the public, the "fringe" professions of psychiatric social work and nursing - but, for the purpose of this study, the focus will be confined to the attitudes of the medical consultants themselves.

Attitudes may be deceptive in that some are naturally idiosyncratic, some representative of the service grouping; they do, however, reflect the structural strains between specialties in a professional organization, an ongoing institution like the hospital, and it is with these strains that we are concerned.

In this research, an attempt will be made to examine what

is happening at one moment in time. The specialty of Psychiatry can be seen from two angles:-

First, as a professional group of specialized medical practitioners, with a body of emerging knowledge, in the process of becoming established by

a) marking off the boundaries of their field of knowledge and limiting their work within this area; and

b) obtaining State licence to protect their rights within that field and prevent unauthorized intruders from entering it.

Second, as a new specialty emerging in an institutional setting and in the initial stage of its adjustment to others of longer standing in the hospital. With these it enters into both collision and collaboration, and fullest co-operation and collaborative effort is only achieved after early differences have been hammered out and compromises made.

By studying both of these aspects it is hoped to bring out the common fronts in these action patterns, the relationships which will survive after the early wranglings and petty squabbles of the initial period have worked themselves out and have become a thing of the past - the enduring relationships necessary to promote the ongoing activity of the institution: in other words, how the structural relationships are functional to the life of the hospital.

In the first chapter the focus will be on Psychiatry as a specialty in relation to others; in the second chapter on Psychiatry as an institutional unit; in the third chapter on Psychiatry as a profession.

By thus gradually widening its context, it may finally be viewed within the work world at large, with problems faced by others in the process of becoming established.

Method

Specialists in the main services in the hospital were interviewed, until no new factors emerged from the interview material.

The doctors were selected at random and therefore, as far as is known, the sample represents a cross section. The interviews were guided to the extent that their purpose was to reflect the opinions of the different consultants, both as individuals and as group members of their specialized field, of the value and potential use of Psychiatry as a medical specialty; thus could be deduced the basis for prevalent or universally held attitudes, and to what extent such were due to factors such as personal prejudice, conservative "philistinism", unconscious jealousies, suspected infringement of the medical code and institutionalized norms of behaviour. Similar interviewing of the psychiatrist was directed to throw light on the extent to which he had provoked this criticism and the difficulties he, in turn, encountered in his attempt to apply his skills and fulfil his institutionalized role.

From the total, unedited, cold facts of the interviews the materials bearing on the theoretical questions of the thesis were selected, and this is the form in which the interviews are reproduced in the appendix. For presentation and discussion

the most appropriate statements for illuminating the theoretical discussion were selected.

Only certain elements have been extracted from the interviews in this study; there may be others appropriate to other areas of investigation and fields of discussion.

It is possible that future research may be done into the question of whether or not doctors are predisposed to specialize in certain fields on the basis of their individual personalities; into the development of the self conceptions of the doctor as he passes through medical school; into the significance of the joking relationship underlying many of the comments.

In this event, it is hoped that the material gathered during this study will be of some value.

CHAPTER I.

PROFESSIONAL PROFILES

Park and Burgess maintain that the individual is influenced in differing degrees and in a specific manner by the differing type of group of which he is a member;[1] he tends to adopt the characteristics of the group - its mannerisms, attitudes and prejudices - within which behaviour tends to adhere to a uniform pattern.

The interview materials indicate that this is the case within the specialized groups of practitioners in the medical profession; the individual doctor becomes moulded, as it were, into the pattern of his group and adopts its way of thinking in general, and attitude towards Psychiatry in particular. From such conformity of purpose and community of interest in a specialized field of work a representative picture of the service as seen by others - a professional profile - emerges. Although this profile amounts to little more than a stereotyped notion it serves, nevertheless, as a basis for action; in that most specialties are conscious of the way in which others see them, and act in terms of such expectations, the profile is significant in influencing the interaction of doctors; this will be seen at a later stage concerning the specific question of referral of patients.

The feeling towards Psychiatry is not uniform throughout the medical profession but, to a considerable extent, it is so within each service. A study of the "personality" of the

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[1] R. Park and E. Burgess: "Introduction to the Science of Sociology" University of Chicago Press, Chicago, Ill., 1942, p.197.

various services is therefore fundamental to an understanding of the orientation of each towards Psychiatry and thus to an understanding of the position of the new specialty and its acceptance at this stage of development, which is the purpose of the investigation.

The "personality" of each service will be looked at through the eyes of individual doctors, both within that specialty and within other specialties, to draw a representative profile of the service and to see the relationship of each towards Psychiatry. The actual statements made by doctors regarding themselves and those in other services, as verbalizations of perceptions, will form the basis of these respective pictures. Drawn together as it is from various respondents, the picture is not one of totality but rather an overall one and the profile is collective rather than representative. Such a formulation, however, eliminates the interviewer's bias and, although statements are liable to be coloured by the doctor's personal feelings, or the limits of his own experience, a consensus regarding the personality of other services would indicate that it is of valid use to this study.

Attention will be focused on the surgical and psychiatric profiles as polar elements on the pictorial scale.

1. SURGERY

Clues to the surgical personality are found in comments by doctors in other specialties:-

"They are the military men of medicine ..."
"Men of action of the old school ..."
"Overbearing, aggressive ..." "loud and boisterous..."
"Forthright, above board..." "Slapdash and intolerant..."
"Their appeal is to the dramatic, to the overt, to the cut and dried, to results, to proof - this is their romantic ideal."

One pediatrician said:-

"They are individualistic; their attitude is one of rationalization, "it wasn't my fault" ...."

More illuminating remarks came from the psychiatrists:-

"They have a greater capacity for getting mad, for exploding, than all the others."

"They have an urge to cut to prove their masculinity; it was Freud who noticed that the little boy who delighted in cutting off puppy dogs' tails became a surgeon when he grew up and from this he conceived of the term "sublimation"...".

"Surgery carries many connotations that deep down we don't like, that upset us ... surgeons are sadistic as a body but they have to sublimate these impulses; many of their operations are unnecessary - they will do a gall bladder operation on a schizophrenic, for instance. One of them said: "I take out lots of normal appendices"..."

"They make no differentiation between people and are thus liable to precipitate a psychosis ..."

"They are inhuman in the way they refer to patients as 'the appendix, the gall bladder in Ward X'. I remember when I was in medical school the surgeon conducting the ward round stopped at the bedside of a patient and told us within her hearing 'She may die, she may not, in the operation tomorrow'; the woman was so upset I stayed behind to comfort her - I have never forgotten the incident ..."

"They never doubt why they are training to be surgeons - only how they can make money or get a good appointment ..."

Many surgeons admitted to being "intolerant", "dogmatic", "cut and dried", to "holding fixed views" and making "snap

judgements". Just before operating, one said: "It's fun"!

The surgical personality was revealingly summed up in the words of an Assistant Resident, which largely bear out the comments of other doctors already noted:-

"We're a very peculiar branch - more unstable and psychological than the rest of the profession - aggressive and sadistic because of the nature of our work, which involves a lot of personal responsibility - the resulting tension gives rise to guilt feelings.

"We cut out a stomach and then, if the patient dies, we say to ourselves, 'What did I do? I killed him ... I might have saved him'.

"We can't afford to be sympathetic - our stock in trade is to get the patient better ... we treat ... we try to find out what is wrong ... if he's deformed or injured we do what's necessary; if we meet with no success we conclude the patient is neurotic and say 'to hell with him' ..."

The illustrations given above indicate a consensus among doctors regarding the surgical profile and a certain unanimity of feeling towards the service.

Relation to Psychiatry

One surgeon remarked:-

"90% of surgeons hate Psychiatry and psychiatrists because of an initial distrust of the whole basis, the ambiguity of Psychiatry and the large number of times it has fallen down ..."

A gynaecologist also referred to this:-

"They (the surgeons) have gone too far in their attitude, but they have had their troubles too - surgical patients were mistreated in a number of instances by psychiatrists, which annoyed and upset them ..."

Many surgeons cannot see a meeting place with Psychiatry or how it can be applied, as the following remarks, made by several of them, indicate:-

"We have no common ground - they don't understand about Surgery and vice versa; we don't get along - we don't speak the same language ..."

"Psychiatrists don't know the technical aspects or prognosis - the surgeons are better qualified to do Psychiatry."

"We deal with the organic, and Psychiatry can't be much help as far as that is concerned."

"The patient is handled better by the surgeon."

"We have no time for psychiatrists - they get on the surgeon's nerves. Psychiatry is superfluous; the surgeon is the authority in a situation pertaining to an operation - the patient wants to speak to the man who's going to do the job and for <u>him</u> to say, 'you'll be okay' ..."

One psychiatrist voiced the opinion of many when he said:-

"Most of the opposition seems to stem from their primary interest in physical disease and a corresponding lack of understanding of mental illness ..."

As another said:-

"They feel that Psychiatry is 'gilding the lily' if they have done it for so many years themselves."

A gynaecologist remarked:-

"If there is an appendix they cut and cure in an hour - they don't understand how a treatment can take six months; we (surgeons and gynaecologists) deal quickly and successfully with patients and this leads to shortness of patience with Psychiatry."

"Most surgeons tend to think of patients as weak characters", one psychiatrist commented, "one of them says to me from time to time, 'I have no trouble with neurotics and don't know why you do ... I give them a kick in the pants and never see them again' ..."

This lack of knowledge and interest in Psychiatry, and inability to understand its province, gives rise to resentment on the part of psychiatrists.

"They are always glad to dispose of their 'nuisance' patients if they don't respond to surgery."

One admitted he reacted "by not seeing surgical patients when asked to".

Conclusion

In Smith's study of a Chicago hospital he quotes a surgeon who states that a "good hospital is run for the comfort and convenience of the surgeons".[1] In this hospital, too, the surgeons are imbued with a sense of their own importance and indispensability - this is manifest, for instance, in the expectation that emergency cases should be answered at once and their annoyance with the psychiatrist who fails to do so. This will be further discussed at a later stage when the referral system is considered.

There seems to be general agreement that Surgery as a service is not well disposed in attitude towards Psychiatry, opposition being less from the junior men 'indoctrinated in medical school', but amounting to a pronounced antagonism on the part of some senior men. However, although the prevailing mood is now one of 'intelligent acceptance but emotional oppositi (in the words of a psychiatrist), there are indications that this will mellow in time as more surgeons become more aware of the psychiatric point of view.

As one said: - "We expect too much - we don't appreciate the limits of psychiatry - where it stops and starts ..." and as individual psychiatrists produce more convincing evidence of the value of their work. Several psychiatrists emphasized this as a means of "boosting" the profession and quoted examples of

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[1] H.L. Smith - "The Sociological Study of Hospitals" - Unpublish PhD. Thesis. Department of Sociology, University of Chicago

treatments which had considerably impressed their surgeon-colleagues.

In one instance a patient with a broken femur refused to have an operation, thinking this implied an amputation; the psychiatrist was asked to 'see and advise' and, within fifteen minutes, by careful explanation, had changed the patient's attitude.

On another occasion, a psychiatrist was called in to see a patient dying of a bleeding ulcer, who was unwilling to undergo an operation. After a few minutes with the psychiatrist, the patient agreed to have this because "he talked to me differently from other doctors ..."

One surgeon spoke of an out-patient with cut wrists, who had been greatly helped by a psychiatric consultant.

As a psychiatrist said, surgeons "could often treat patients in this sort of way", but, in the words of another, they are "pleased when a patient gets better after psychiatry", and instances of the above nature further the psychiatrists' cause far more than any advertisement on a theoretical plane.

At one time Surgery was provided with a psychiatric interne on the same basis as the Psycho-somatic service but, unfortunately "he upset them by using too much psycho-analytic terminology" and the rotation was discontinued. Several surgeons expressed the hope that this would be reintroduced, which may be another sign that the attitude of this service towards Psychiatry is beginning to mellow.

2. MEDICINE

The picture of the professional profile of the physician appears to be universal and is summed up in the words of a gynaecologist:-

"They are quiet and reserved and, because they are used to prolonged treatment, more patient ..."

Relation to Psychiatry

The orientation of medical men towards Psychiatry differs from that of the surgeon for two possible reasons - the personality type of the medical specialist and the intrinsic nature of his work. With a certain variation according to individual personality and age, they are well disposed as a group because, as one psychiatrist said, "they are quiet-thinking on the whole", and because, unlike the surgeons, "they are used to dealing with the family as a unit and the patient as a whole".

As one surgeon remarked:-

"They can't do as much as we can for the patient - often only offer a good deal of support, which tends to make them 'aware of their own shortcomings' and to sympathize with difficulties of a similar nature with which psychiatrists have to contend ..."

The development of the whole field of psycho-somatic medicine in recent years has served to bring out the importance of the psychogenic components in disease and to strengthen the liason between Psychiatry and Medicine. This is reflected in the hospital where, for the past three years, there has been an interchange of internes from the psychiatric and medical departments on three-monthly rotations. On the Psycho-somatic service, a psychiatrist said that he received most referrals from Medicine. Recently the

head of the Medical Department has requested psychiatric instruction for his junior staff in the treatment and prevention of psychiatric disorders on the ward, which is further indication of a generally favourable orientation of the service towards Psychiatry.

3. OBSTETRICS & GYNAECOLOGY

An indication of the obstetrician's personality was given by one when discussing the nature of his work:-

"Dealing exclusively with women, infinite patience and handling of the patient's emotional side is required and women resent too great a delving into their emotional problems ... You have to assume an understanding and a pose - if you sit back and let it come the flood gates will inevitably burst."

These remarks also reveal an insight into feminine psychology, an aspect of the gynaecologist's work which approximates more closely to that of the psychiatrist. As a rule, however, his role is more akin to that of the surgeon whose "shortness of patience with Psychiatry" he tends to share. This may also stem from the fact that, as one of them said, "Unlike other services we produce more cures than alleviations".

Relation to Psychiatry

The orientation of this service towards Psychiatry seems to be "half-way" between Surgery and Medicine. The psychiatric consultant felt "they were well disposed as a body", particularly the younger men, with some variation according to individual personalities. This seems to be due partly to the favourable outlook of the head of the Department and partly, as a gynaecologist said, "to an awareness of the psyche and function through giving a good deal of medical, as opposed to surgical, treatment".

All the gynaecologists and obstetricians interviewed felt happy to do "superficial" psychiatry themselves and think the patient prefers it; as such, Psychiatry represents "no threat to our work ..."

"Most gynaecological disease has a psychogenic overlay, but we can take care of that."

This would explain the psychiatric consultant's comment that "rejection, such as it is, is subtle - they just don't refer patients ..."

Gynaecology and Obstetrics have to cope with a "number of psycho-neuroses and an occasional psychotic", however; a psychiatric consultant was requested by the Department four years ago and his services have been utilized consistently ever since.

4. PEDIATRICS

There appears to be complete unanimity among doctors regarding the professional profile of the pediatrician, as illustrated by the following remarks:-

"They have to be sensitized to the environment of children."

"They identify with, and feel for, the kids to a great extent ..."

One pediatrician felt that this accounted for the fact that many of his colleagues were small in stature and of a mild and gentle disposition.

Relation to Psychiatry

This is revealed in the words of pediatricians themselves:-

"We have to understand the real or imaginary illness of children in terms of the family situation; we must, therefore, have a psychiatric orientation ..."

"We can't get on without training or self training in relationships - otherwise we are not doing good pediatric work..."

"We became psychiatrists before we knew the meaning of the word: we knew a child could suffer from 'motheritis' and that its behaviour was closely connected with the family situation, but we didn't appreciate the concepts of rejection and overprotection, and the importance of the parents' own personality and background, until the psychiatrists showed us the way ..."

Medical men also recognize this liason between the two specialties:-

"They share a common interest with Psychiatry in the formative years of life."

The general feeling was neatly summed up by a psychiatrist, who said:-

"Pediatrics mirrors the attitude of its chief and is very well disposed as a service towards Psychiatry."

5. NEUROLOGY & NEURO-SURGERY

It is difficult to outline a typical neurological "type" on account of the high degree of individual variance but, as one psychiatrist commented, "they are usually introverted and clever".

Relation to Psychiatry

Psychiatrists view the neurologists, in their "ivory tower on the hill under 'God'", with some misgiving:-

"They use physical methods of treatment for psychologically-determined illness, but resort to eclectic methods when their own fail."

"They treat many hysterics but it doesn't really matter."

"They know little about etiology, therapeutics or diagnosis and mistakes always lead to recriminations."

"Their fear gives rise to hostility and, in any case, they are organically orientated before entering Neurology; they explain things in terms of cerebral localization - diagnosis by exclusion ..."

One said that, on the whole, "Psychiatry was frowned on", but that there was a tremendous individual variation in attitude towards it.

An extreme opinion is evident in the following remarks made by a neurologist:-

"There is an old saying that 'neurologists will only succeed in X... (the city) if they practice Psychiatry'; it is therefore useful at the moment as a stopgap. Psychiatry has no place - no answer - they know nothing and will disintegrate as neurologists take over their work and as the organic cause of disease is discovered ..."

The feeling between the two services was described by more than one psychiatrist as being one of "sibling rivalry", since both were "treating the brain". This analogy, while descriptive,

is perhaps not quite accurate, since Neuro-Surgery has a parental connection with Surgery which Psychiatry lacks. It is more easy to agree with the psychiatrist who attributed the "schism" to the "blind-spots" of the heads of the departments. The situation is best understood from a historical perspective. As a pediatrician explained:-

> "At first, and to the present day in some hospitals, there were only neuro-psychiatric departments, which were mainly neurological. With the division, therefore, neurologists felt their services were being taken away and psychiatrists found neurologists doing Psychiatry, which has resulted in a distinct cleavage."

It is perhaps understandable that, when the question of introducing Psychiatry as a specialty in this hospital arose, the head of the department was averse to its being accommodated within the Neurological Institute. It was set up independently and has remained very independent. One psychiatrist spoke of the "link with Neurology as having been cut off ... there is no rotation and it is not required in post-graduate examinations".

Another commented that "there is very little co-operation - no joint conferences or rounds - and, unlike other hospitals, no one on the staff of both".

However, it appears the "attitude is now changing because of the pressure of events". According to one psychiatrist, the head of Neurology is "now prepared to give psychiatry a chance", and to another that "he has been forced into seeing psychiatric implications in cases".

In this connection it is significant that a psychiatrist has been engaged to do research by the Neurological Department over the past two years.

6. PSYCHIATRY

The general picture which medical men have of psychiatrists seems to be one of abnormality, of deviance to a greater or lesser degree according to the individual.

Gynaecologists made the following remarks:-

"Perceived as a whole they are rather odd in appearance, because they are dealing with things they can't understand and therefore become preoccupied in their business; they are referred to as 'nuts', which is only a joke, but they tend to be a little odd."

"In the majority they are a bunch of queers ..."

"There are a few sane ones ..."

Similar comments came from the surgeons:-

"They are queer types but we have our crack-pots in Surgery too ..."

"Those with their feet on the ground do a good job ..."

"Psychiatrists are 'nuts' - they are very unbalanced individuals: look at Dr. X - he's a psychiatrist - as crazy as hell. They contain more mentally sick individuals than in any other field; they go into it to cure themselves ..."

Regarding this charge, a psychiatrist said:-

"They are right - we <u>are</u> queer - they are always joking about it; sometimes we surprise them. One once said to me, 'You're a psychiatrist and you look normal'! ..."

Admitting their morbid interest in mental disease, he said:-

"It works like that: you'll find E.N.T. men are deaf, cardiologists die of heart failure and obstetricians never get pregnant ..."

Another remarked:-

"It is largely true that we specialize because of our own problems."

Apart from the more personal remarks directed against the psychiatrist, there were three major areas of criticism, a consideration of which may throw light on his professional profile. These were the behaviour of psychiatrists, the terminology and language used, and the division between the schools of Psychiatry: many of the accusations regarding these were acknowledged by the more enlightened psychiatrists.

I. Behaviour of Psychiatrists

In this connection the charges were of:-

(a) "Indiscretion, undermining our respect", levelled by one physician. But, he said, "in Psychiatry, as in every profession, some are brilliant, some are fools and only some leave a bad taste in the mouth".

One psychiatrist was doubtless thinking of these when he remarked: "Psychiatrists should keep their mouths shut ..."

(b) Smugness. One young interne said this had annoyed himself and many friends:-

"When we were medical students, the cigarette-holders of the psychiatric internes in the class made us feel inferior and consequently hostile. They make you feel they are a world apart."

(c) Over-enthusiasm.

"The young ones are over-enthusiastic - they go all overboard and accentuate things. They forget medical men and surgeons are not fired as easily." (Physician)

"Some psychiatrists are too enthusiastic and it's a little nauseating." (Psychiatrist)

(d) Aggression, provocation and tactlessness.

A dermatologist said:-

"The fact that they are a persecuted minority gives them a complex and this leads to aggressiveness."

And a surgeon:-

"Their attitude and behaviour is provocative."

But it was the psychiatrists who were most vehement in their attack, often on a personal level. One spoke of the "blustering, authoritarian approach of some psychiatrists", another that "some set themselves up in an ivory tower, but there is always a group of pseudo-scientists who jump on the band-wagon and do harm". Many felt that psychiatrists were responsible for provoking hostility towards themselves; as one said:- "We stick our necks out".

In this connection, an interne quoted an instance in a clinic where a patient came in for treatment of a swollen right hand. The psychiatrist present regarded this as a symbol of guilt for illegitimate pregnancy, an interpretation which profoundly shocked the staff physician.

The following remarks by a psychiatrist illuminate this whole question:-

"There is more self doubt in psychiatrists than in any other specialist; this perhaps makes us hostile by way of compensation; but then, too, we encounter so much hostility in our own work and it reappears in our relationships with others."

Herein lies a partial explanation of the charges of over-enthusiasm and aggression on the part of psychiatrists; this may also be due to the fact that, as one of them put it, "we have the sense of a call because we are a new gospel".

II. Terminology and Language

In addition to the accusation that psychiatric terminology was "veiled" and "hard to understand", there were more severe indictments.

From surgeons:-

"They speak a different terminology - their language is a 'cover up' for feelings of inadequacy and insecurity."

"When I'm going to cut something out I tell them - they use long fancy words when nice, plain simple ones would do. At one meeting the allergists and psychiatrists didn't understand each other at all."

"Their jargon is so god-damned complicated - we read their reports with amusement - mental conditions are described in such a complicated way. Funny as hell. I didn't even know of half the terms they used in one report - except for a Rorschach."

That psychiatric language and terms are often regarded with mere amusement by medical people is borne out by what one psychiatrist said:-

"They will often say jokingly, 'his patient is upset - he's in love with his mother!'."

and indicated by another:-

"Everyone knows a little psychiatric jargon - no one will dispute that of Gynaecology and Surgery, but everyone is an expert when it comes to discussing Psychiatry."

Psychiatrists agreed on the whole that doctors were often upset by their language:-

"If we refer to 'castration fear' they think it's plain dirty!"

but maintained that, though it was once "preoccupied with sex", it was so no longer. However, as one admitted:-

"It is still often out of taste and gives rise to unnecessary hostility ..."

And another:-

"While being necessary to psychiatrists, it is over-pushed by them."

The following remarks by psychiatrists help to place the whole problem of terminology in the medical profession in a wider perspective:-

"I found my reports were more acceptable in lay language."

"It is not wise to use big words if you can use small ones."

E.J. Holmyard deals with this specific problem, deploring the fact that

"the increasing specialization of knowledge has inevitably sharpened the appetite for economy of expression, with the result that the technical language of specialists in one branch of science is as intelligible to specialists in other branches as Ogham would be to a Pantagonian ... if specialization is knowing more and more about less and less it should not necessarily entail the penalty of having to know less and less about more and more."[1]

Recognition of this is evident in the words of a gynaecologist, who said:-

"Psychiatric terminology is not too clear but it is necessitated by reason of the complexity of their work. In a history report from them I don't get it all, but that is my fault. We don't understand their terminology because of our own inadequacies and disinterestedness - they are not guilty; their terms of reference are part of their business."

It appears that Psychiatry is no more guilty than other specialties of evolving its own distinct vocabulary, and the whole medical profession, in criticising this particular one, might do well to examine the more general implications involved.

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[1] "Terminology" - Editorial in "Endeavour", January, 1953. The Kynoch Press, Wilton, Birmingham 6, p. 1.

If "jargon should not be the barrier to ready dissemination of knowledge from each scientific study to all the others", each medical specialty, not only that of Psychiatry, should endeavour to make its terminology more comprehensible and acceptable to other colleague groups.

III. Division between the Schools of Psychiatry

The problem here is of making professional interest transcend sectional feeling; as Durkheim puts it, it is a problem of "church steeple patriotism against professional solidarity ..."[1]

The reference on the part of many doctors to "the warring schools in Psychiatry", "perpetual warfare"; to the fact that "psychiatrists haven't settled their own controversies", and that "interpretation is according to the individual psychiatrist", seems to indicate that, if opinion was less divided and unity greater, Psychiatry would win more respect from its fellow services. A surgeon said:-

"They could have become more integrated - it's better not to have too many divisions ..."

and a physician:-

"Their cause would be furthered if they were united among themselves."

Psychiatrists realize that they present a "confused and confusing picture" which occasions loss of respect from their colleagues:-

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[1] E. Durkheim. "De la division du travail social" 2nd Edition (Paris: F. Alcan, 1902). p. xxxii.

"We are divided among ourselves ... small points of disagreement are used in an argument as a 'football' with which to hit one's opponents - it is childish."

Only one psychiatrist felt that the division of schools was good in so far as it made for progress by creating "specialties within a specialty". The majority seem to reduce the problem to a personal level, blaming particular individuals in prominent positions for causing and maintaining the rift:-

"If there were more people like Dr. X. there would be a possibility of ending the warfare between schools in the future."

The question of this "warfare", as affecting the professional profile of the psychiatrist, merits fuller discussion.

The psycho-analytic school, in particular, came in for some bitter criticism, both from other specialties and that of Psychiatry itself. There were few who dismissed it as curtly as one gynaecologist, who termed it "damn tripe", and another "mystic - I would never send a patient to a psycho-analyst ...", remarks which indicate little more than a lack of understanding of this province of mental illness.

Most criticism was levelled against the high cost and length of treatment and its general impracticability. To quote one physician:-

"It is hopelessly impractical because of the time and expense, but it has its place, though small ..."

And an allergist who said he had asked one man who had been undergoing psycho-analytic treatment for five years whether his condition had improved and received the reply:- "It's too early to tell yet"!

Commenting on this aspect, a psycho-analyst said:-

"It is true that the only way to shorten an analysis is to improve it ... Freud, himself, admitted that the cost and length of treatment was 'too bad' ..."

Some of the classical school 'eclectic' psychiatrists were severely biased against psycho-analysis:-

"These Greek myths ..."

"I have yet to hear a psycho-analyst admit that he can't cure a patient."

"They always have an excuse - they profess to have a panacea for psychiatric ills but cannot begin to apply this to the patient therapeutically."

"Psycho-analysis tends to go over backwards and neglect the other side."

"It is no answer to the woes of the world - it is only applicable to a selected minority - most people are too bad for it or their intelligence is too low."

The intelligence factor is but one of the limitations to psycho-analytic treatment. As Dr. Stafford-Clark reminds us:-

"It is a highly selective and self-limiting form of treatment and is suitable only for patients whose intelligence, determination and resources of time and money are sufficient to enable them to go through with it and to profit from it."[1]

Wulf Sachs also notes:-

"Dramatic revelations are rare. Recovery is slow and imperceptible; it is not the concrete, tangible change that takes place before our eyes on recovery from bodily illness ..."[2]

Most psychiatrists are cognizant of their difficulties and that psycho-analysis is by no means suitable for all patients. They are agreed, however, that a "psycho-analytically" orientated psychotherapy", a "psycho-analytic approach - not

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[1]David Staffoed-Clark: "Psychiatry To-day"
The Whitefriars Press Ltd., Tonbridge, G.B. 1952, p.177.

[2]Wulf Sachs: "Black Anger"
Little Brown & Co. Inc. N.Y. 1940, p.294.

necessarily a method of treatment, but a way of looking at things" is highly desirable; that psychiatric treatment should be based on an "analytic understanding of what is best for the patient" and that, although psycho-analysis is impracticable except as a specialized method of treatment, "its principles are and will continue permeating Psychiatry and the Social Sciences":-

"It is the backbone of any psychotherapy."

"It is the framework upon which we can build."

"It is the answer because it gives insight into the patient's problems by identifying with the patient, by living through his problems and subjectively interpreting them."

In the words of the head of the Department:-

"Psycho-analysis is a psycho-therapeutic technique, not a research tool."

These remarks indicate a growing realization of the importance of psycho-analysis among psychiatrists, an importance which, to quote Dr. Stafford-Clark again:-

"Derives not simply from the results which it can produce in individually suitable patients, but, from the body of knowledge which the method has contributed to psychopathology and, most of all, from the application of both the knowledge and the method in modified form, to the evolution of various techniques of briefer psychotherapy devoted to the attainment of insight, but aimed at providing this at least in its immediate essentials within a matter of weeks or months, and by means less expensive in time and money."

As one psycho-analyst said:-

"It is a drop in the ocean as far as meeting the problem of neurosis is concerned but it allows us to penetrate in short-term methods ..."

The position of psycho-analysis in this particular psychiatric department has changed in recent years. In the words of one psycho-analyst:-

"Sometimes we wonder what the hell <u>are</u> we doing ..."

"The young psychiatrist, like the young surgeon and gynaecologist, takes on cases beyond him, which leads to insecurity."

Dr. Stafford-Clark draws attention to a contributory factor in the popular conceptions of psychiatry which have been built up:-

"There belong the couch, the recumbent patient, the wise, silent and, in the popular eye, faintly ludicrous figure of the psychiatrist, industriously writing down the random and remarkable statements uttered in the secrecy of the consulting room. All this of course is a heaven-sent gift to the robust opponents of psychological medicine in any form, as well as to the lively satirists and cartoonists, whose admirable task is to reflect our pompous foibles and to invite our mirth. The psychiatrist who resents this barrage of ridicule (i.e. the conventional profile of his profession), by no means all of it malicious, is partly at the mercy of his own inner insecurity."[1]

This insecurity, it would seem, stems from two sources: the nature of the psychiatrist's work in respect to the patient, and the instability of his role with respect to his medical colleagues and institutional setting.

1. <u>The nature of the psychiatrist's work</u>

This is most clearly seen in the light of Professor Parson's analysis of the role of the medical practitioner, which will be more fully discussed later. Here it will be noted how the psychiatrist finds difficulty in maintaining objectivity and good judgment in relation to his job on account of the personal involvement and element of transference. The patient's attempt, by projection, to assimilate the physician to a "pattern of particularistic personal relationship

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[1] D. Stafford-Clark. op. cit. p.173.

to himself" is conspicuous in psychiatric cases; it accentuates the elements of uncertainty and insecurity, the emotional strain to which every doctor is subject. [1]

Stafford-Clark also emphasizes the nature of psychiatric treatment which, in aiming to increase the awareness and thereby to liberate the patient from the bondage of unconscious conflict and emotion, imposes a considerable strain upon both doctor and patient and does not permit the doctor to relieve his anxiety about the patient by taking the patient's fears out of his own control.[2]

Dr. Hughes draws an apt analogy between the psychiatrist and the prostitute, whom he regards as facing similar problems with respect to their clients, arising from a relationship of combined involvement and impersonality:-

"The psychiatrist and the prostitute must both take care not to become too personally involved with clients who come to them with rather intimate problems ..."[3]

A psychiatrist also used this analogy, in stressing the difficult orientation of his profession to the patient, and went on to say:-

"A psychiatrist is more like a T.B. doctor - he can give no promise of cure, only rest and food. He can offer only uncertainty ..."

That the uncertain nature of the psychiatrist's work gives rise to insecurity is further borne out by Stanton and

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1 T. Parsons. "The Social System". p.460.

2 D. Stafford-Clark. op.cit. pp. 167-177.

3 E.C. Hughes. "Mistakes at Work" reproduced in the Canadian Journal of Economics and Political Science. University of Toronto Press. Vol.17, Aug. 1951, No.3. p.320.

Schwartz's studies on dissociation in a mental hospital ward, where they found that the uncertainty of the authority's integration with the patient led to his own inconsistency of action and expression.[1]

2. Instability of the Psychiatrist's institutional role

In a structured situation such as that of a hospital there is a certain stability to the inter-personal relationships within which the status, or position of each member within the group, determines the role or behaviour attendant upon that position.

The status, and consequently the role, of a new specialist like a psychiatrist, however, is not clearly defined. A reply to the question: "What is the psychiatrist's work - who is he?" should, according to Dr. Hughes, define the role of the psychitrist for us.[2] When a doctor asks this question, however, in view of his conception of the psychiatric profile the answer is confused; he sees the psychiatrist both as a custodian for the mentally sick and as a useful agent on whom to "dump" nuisance patients. This will be brought out more clearly when the whole referral system is considered in the next chapter. Here it is only of relevance to note that the expectations which other medical specialists in the institution have of the psychiatrist are not clearly patterned, the exact role he should play is not defined. Of this the psychiatrist is

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1 Alfred H. Stanton and Morris S. Schwartz. "Observations on Dissociation as Social Participation". Psychiatry. Wash. D.C. Vol.XII No. 4, November, 1949. p.353.

2 E.C. Hughes. "Mistakes at Work" p.325.

inevitably conscious, the ensuing role-instability contributes to his general insecurity.

The orientation of Psychiatry towards other services, then, is now more easily understood. As Mead emphasizes, the individual derives his conception of himself largely from the way in which he is conceived by others.[1] The psychiatrist faces the other services with full awareness of the conception they have of him, of the perspective from which he is viewed. If this is biased, as in the case of Surgery which he knows to be antagonistic, he is predisposed to expect maltreatment and will react, for instance, by "not seeing surgical patients when asked to ...".

Thus, his orientation is largely determined by the self-knowledge of his professional profile as it exists for others.

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[1] G.H. Mead. passim. "Mind, Self and Society". Ed. Charles W. Morris University of Chicago Press, Chicago, Ill. 1934.

Conclusion to Chapter I

From the study of professional profiles in this chapter it is evident that the orientation to Psychiatry is not uniform throughout the profession but varies according to the specialized service. Moreover, it is reflected in the individual doctor within that specialty.

In this particular hospital the main specialties are clearly differentiated solidary units in which the "in-group" feeling is strong, tending to make the opinion of members fairly uniform. At the same time there are factors, such as the age and personality of the individual doctor and the influence of the head of the department, which cut across the group opinion preventing more than a generally representative estimation. However, it seems fair to summarize the orientation of the services in the words of one psychiatrist:-

> "In Pediatrics and Medicine there has been general penetration on a broad front; in Surgery and Gynaecology outposts have been established, but the greatest dent has been made in Medicine ..."

This raises the interesting question of the extent to which the orientation of the individual, or group specialty, towards Psychiatry is determined by the general perspective of that specialty. In terms of the theory of "trained incapacity", which Kenneth Burke revives,[1] it is seen that work

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[1] Kenneth Burke. "Permanence and Change" N.Y. New Republic Inc. 1936. pp. 14-20.

both reflects our interests and forms them. One may study medicine through an interest in medicine - but when one has steeped oneself in its discipline it will become creative, supplying one with new incentives for seeing all life from the doctor's point of view; occupation leads to preoccupation - a "way of seeing becomes a way of not seeing". It is possible that such impairment of vision may be further localized according to the specialized fields of medicine.

Thus a surgeon, dealing constantly with the "organic, the concrete, the dramatic", would find it difficult to appreciate the intangible aspects of the psychiatrist's work, just as the psychiatrist is guilty, in the words of a gynaecologist, of

"trying to put everything on a functional basis, as we are guilty of trying to put everything on an organic basis ...".

In each case, constant preoccupation within a specific field, a highly specialized approach towards certain conditions, and the description of such in a terminology of a highly specialized and technical nature, may well give rise to an inability to see things in a different way, from a broader point of view. This is apparent in the more biased and prejudiced comments so far quoted.

An attempt has been made to sketch the professional profile from statements actually made by doctors regarding themselves and those in other services. These statements reveal certain stereotypes, built up, in many cases, because of the field of specialization in which the individual practises, and incorporated into the individual mind, affecting his

attitude and way of acting towards others - possibly, too, as we have seen, affecting his "way of seeing". Stereotypes, while serving essentially as rationalizations for attitudes or actions, are yet, as Stanton and Schwartz found[1] more stubbornly held than rationalizations, since it is easy for a person believing a stereotype to find many others to agree with him.

In the next chapter will be seen how these stereotypes, the perceptions which medical men have of each other, are built into patterns of habitual action, into working relationships essential to the ongoing functioning of the institutional system.

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[1] Stanton and Schwartz. "Medical Opinion and the Social Context in the Mental Hospital". Reprinted from Psychiatry Wash. D.C. Vol.XII No. 3, August, 1949. p.245.

In the social drama of work, people interact in several established roles, whether in the work world at large or in the more localized medium of a hospital. Doctors in each specialty, for example, have their own conceptions of their interests, rights and duties towards one another, and towards doctors in other specialties; the desirability of teamwork among specialists working together, each with his own clearly defined responsibilities and authority, is evident.

The two most significant roles which a practitioner occupies in the work world are in an ongoing institution and in an historical occupation. In the institution his role is that of functionary and his services are combined, under a system of authority, with the services of a wide range of other functionaries, some of a professional character, others ranging up and down the occupational scale. Indeed, the very nature of the orientation of co-ordinated action to an "order" demands an internal differentiation of roles with respect to authority; this is the distinguishing feature of Weber's "corporate group"[1] and, likewise, of the institution. The prevailing relationship in the medical institution - the hospital - is that between the medical man and his subordinates.

The historical occupation - the profession, whether it be of Medicine or of other social functions like Science, Law and Teaching, is carried on within an institutional framework

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[1] Max Weber: "The Theory of Social and Economic Organisation" Translated by Henderson and Parsons. William Hodge & Co. Ltd. London, 1947. pp.133-138.

CHAPTER II.

PSYCHIATRY AND RELATED SPECIALTIES:

CONTACT AND CONCERTED ACTION

involving a complex balance of diverse social forces.[1] The patterning of the institutional role is reinforced by its relation to the cultural tradition and practitioners share the functional elements inherent in their specific professional role. The prevailing relationship here is that between practitioner and client or, in the case of the medical profession, between doctor and patient.

A practitioner functioning in both of these capacities concurrently - in the institution and in the profession - and entering into the relationship required by each is subject to a certain amount of strain.

In the introductory pages of this study it was seen that Psychiatry could be regarded from two angles; as a professional body of medical practitioners in the process of becoming established, or as a new specialty emerging in an institutional setting. In this chapter Psychiatry will be considered in both of these capacities, as it enters into collaborative relationship of a formal or informal nature with other specialized fields of Medicine - in the specific medical institution within which this analysis was made and in the medical profession at large. Similarly, the psychiatrist will be seen in his respective role as functionary in the institution and colleague in the profession.

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1 T. Parsons: "The Professions and Social Structure"
Essays in Sociological Theory.
The Free Press, Ill. 1949, p.199.

1. Relationships in the hospital setting

An organization like the hospital in many ways falls into the category of Weber's "corporate group" referred to previously. One finds a "chief" and an "administrative staff" but, in the hospital, the highest authority of Weber's "chief" is only nominal and his individual status is replaced by a "collegial" body of equals.

Smith, in his researches into hospital organization,[1] located two types of control in hospitals generally - an administrative line of authority emanating from the Board of Managers and channeled down the usual hierarchy found in established organizations, and an authority vested in the professional staff of the hospital, its locus being in the executive committee of the medical staff; action, when taken, resulted from the joint activity of these two centres of power.

Such centres are found also in this hospital under different names:-

The Board of Governors is composed of laymen - a President, elected and 'ex-officio' Governors, an Associate Governor and an Advisory Board - and meets quarterly.

The Medical Board is composed of doctors only - Chairman and the heads of all the departments, including Psychiatry, on equal status - and meets every month.

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[1] H.L. Smith: "The Sociological Study of Hospitals"

The secretary of both these Boards is the nominal "chief" of the hospital - the Executive Director, who not only acts as a liason between them but also, in a sense, like Mead's "Statesman"[1], incorporating different and differing attitudes into his own "generalized other" and reaching a compromise between them.

The Psychiatric Department under consideration is an administrative unit of the hospital, with the other segments of which it has enjoyed a colleague relationship and a place in the teaching programme of the university since its inception within recent years.

The role of the head of the Department, as occupying the key office in a new unit of a stabilized medical institution, is that of the promoter. As such, promotional drive and inventive ingenuity are demanded, with the risk of accusation, as in this case, of being "over-aggressive" and of "over-selling" the new discipline. His influence is of paramount importance, not only in stabilizing working relationships and supervising the training programme in his own department, but in establishing and maintaining contacts with his colleagues in other services of the parent institution.

The Psychiatric Department is, in some ways, unique and in many ways different from those in other hospitals.

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[1] G.H. Mead. op.cit. pp. 256-257.

First, its physical isolation aggravates the traditional aloofness between psychiatrists and medical men since, in the words of a psychiatrist, the "daily contacts are cut down". That, as a surgeon said, "it is a contiguous, not an integrated part of the hospital" seems to be one of the contributory factors in the attitude of hostility towards Psychiatry. The position is quite different in other hospitals where the Psychiatry Department is an integrated unit within the hospital, the general feeling towards it is well-disposed and there is a high degree of co-operation between it and other services.

Secondly, although there are private, semi-private and general wards, there is a large proportion of out-patients who come in daily for treatment in the "Day Hospital".

Thirdly, treatment, teaching and research are combined in the one psychiatric unit; one of the trainee psychiatrists expressed the general feeling in saying:-

"We're not supposed only to cure patients; we're here for experience and we're not just going to bring money into the Department ..."

Fourthly, treatment is given to a "multiplicity of patients", neurotics, pre-psychotics and psychotics, although the original intention was to cover only psycho-neurotics. Psychotics really need better security but, such is the pressure on the local mental institutions, that there is difficulty over admission of committable cases. Although only those psychotics who are likely to benefit by treatment in the Psychiatric Department are taken, they amount to fifty per cent of all patients. These patients create an anxiety to

the staff as, although they are not in a position to choose whether or not they are fit to leave the Department, they can "refuse treatment and walk out". Furthermore, the preponderance of the more incurable psychotic cases reduces the number of cures effected in the Department, which does not enhance its reputation in the eyes of other services.

The whole question of hospitalization of the mentally ill in this Department is linked with two other main problems - that caused by the shortage of psychiatrists, and by the lack of facilities; this does not allow complete separation of wards containing different types of patients and, further, creates problems regarding the admission of emergency cases for which overnight confining facilities are necessary.

Psychiatrists are aware that emergency services for acute cases are not provided and that, on this score, doctors in other services have a just grievance, but do not feel they are fully conscious of their problems. Many doctors do realize, however, that difficulties over consultation are due to the fact that psychiatrists are so overworked:-

"It is nice to have a psychiatrist when you can get him ..." (Gynaecologist)

"So many patients have psychiatric difficulties; more psychiatrists are needed - they have too much to do and no time ..." (Surgeon)

"It all boils down to a question of time; psychiatrists have none ..." (Dermatologist)

and that they are handicapped by inadequate facilities:-

"If they had a hospital here as they have in X ... it would put up their prestige ..."

"I feel really sorry for those guys ,,, they'll get it some day I hope ..." (Gynaecologist)

One gynaecologist approved the extension of psychiatric facilities now under way and expressed "faith in the organization" for deeming this necessary.

Certain criticisms levelled against the Department can be understood in the light of these local problems.

Formal relationships

In addition to administrative connections, there are four main areas of formal contact between Psychiatry and other specialties in the hospital:-

a) The psychiatric consultant to Gynaecology and Obstetrics, Medicine and Surgery.

b) An interchange of internes, between the psychiatric and medical departments on three-monthly rotations, and psychiatric instruction for the junior medical staff. Inter-disciplinary group research meetings, with representatives from various services, have also recently been introduced.

c) Teaching of medical students.

The growing recognition of Psychiatry as a necessary part of general medical education, and its contribution to this, is stressed by Ebaugh.[1]

"The general practitioner's diagnostic competence would be furthered if he were more skilful in detecting the signs of actual mental disorders. The idea is not that the medical student should be trained to deal intensively with definite mental disorders, but that he be trained to recognize signs of these disorders not generally appreciated by the medical man. Recognition of these signs would eliminate loss of time, money and human productivity ..."

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[1] F.G. Ebaugh & C.A. Rymer. op.cit. p.70.

The importance of "making the ordinary G.P. more aware of the psyche", to quote one psychiatrist, and of the application of psychiatric principles by every doctor, is now generally recognized: however, as one said:-

"They must learn to drawn the line - to recognize what they can, and cannot do, by common sense Psychiatry ..."

Such education comes through the medical school.

Since the extensive inclusion of Psychiatry in the university medical curriculum within the last decade, it is generally felt that there has been a marked improvement in the position of Psychiatry in the hospital and a growing interest in its work. Only a few doctors most hostile to Psychiatry considered it "overplayed"; as one psychiatrist said:-

"Criticism of Psychiatry to the students from other university departments would be inappropriate ..."

The hostile reaction of the medical student to Psychiatry, often due to anxiety, is largely determined by the influence of his teachers, presentation of the subject and his own individual personality.

One psychiatrist said:-

"The position of Psychiatry will improve with continued indoctrination in the medical school - it will mellow in the medical school ..."

Another:-

"The seeds of co-operation are sown in the medical school; as you join the allotted club you tend to move apart, but there is the probability of working more together as, for example, junior psychiatrists and surgeons, who were former classmates, become seniors ..."

It is thus clear that the medical school is important, not only as a medium for the inculcation of the psychiatric viewpoint, to the possible improvement of the position of Psychiatry as

a whole, but also as a means of increasing collaborative effort between it and other specialties.

d) The Referral System.

Although this is the cause of a certain amount of friction, it is perhaps the most important area of formal contact between Psychiatry and the other services. As Dr. Hall notes:-

"The practice of specialized medicine hinges around the referral system ... the chief vehicle for acquiring patients is the referral of another doctor ..." [1]

In the case of Psychiatry, however, hospital connections are not as essential as in other specialties; although a certain proportion of patients are referred from colleagues in the hospital, the psychiatrist is by no means dependent on these. He has a large independent practice, consisting of private patients who come to him direct, and those referred from other institutions, such as clinics, social welfare agencies etc. He can succeed without being incorporated into the local system and, having no position to maintain in such, is not obliged to remain "personally acceptable to the membership of the inner group ..."[2] Furthermore, he has little occasion to refer patients to colleagues in other specialties,[3] and this lack of reciprocity in referral also serves to exclude him from the "inner fraternity".

In this hospital, as in most, referral of private patients is to particular psychiatrists on a consultative basis and, of public or ward patients, to the Department generally. All doctors

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1 O. Hall. "The Informal Organization of the Medical Profession" Reprinted from the Canadian Journal of Econ. & Pol. Science. Univ. of Toronto Press, Vol. 12, No.1, Feb. 1946, p.43

2 Ibid. p.41.

3 c.f. Table of Transfers in Appendix.

seem happy to call in a psychiatrist when a certain limit is reached; as described by one physician, "after the exclusion of all organic possibilities ...". Many find Psychiatry a useful "dumping ground" for their so-called "nuisance patients" (to quote one physician). As another said:-

"G.P's are glad to 'get rid' of patients ..."

and a surgeon:-

"If we get a crazy person we like to transfer him to a psychiatrist ..."

This attitude is confirmed by psychiatrists in such remarks as:-

"They have a tendency to use Psychiatry when on the spot or can't find an answer ..."

"They find Psychiatry invaluable when the patient goes wacky on the ward or obviously needs commitment ..."

One psychiatrist was called in by a surgeon who had been unsuccessfully treating a case of chronic ulcerative colitis for five years, confessed to being stuck and smilingly said:-

"Come quickly - I've a raving lunatic on my hands and I want to get rid of him ..."

The question of the treatment of emergency cases is one of the chief bones of contention and, as has been seen, is intimately bound to that of the local situation.

Complaints that emergency calls are neglected or not answered come mainly from the surgeons, who accuse psychiatrists of being "unwilling to drop what they are doing for an emergency". As one said:-

"Consultations over an epileptic, for instance, must be answered quickly - we must keep the patients moving. We can't keep them waiting for a psychiatric consultation for three days ..."

This is also the "gynaecologists' gripe", as described by one;

another:-

"It's our chief beef - many times when we want a psychiatrist we want him in a hurry ..."

While condemning the psychiatrist for this time-lag, however, some are willing to concede that they, in turn, "expect too much". There seems some justification, too, for the psychiatrist's complaint that the surgeon "leaves it too late" and that, in any case, to him it is "just a way of getting rid of a patient ..." The tendency, for instance, is to refer post-operative rather than pre-operative cases although, in the words of a consulting psychiatrist:-

"When a patient blows up, a lot of pre-operative consultations are evident for a while ..."

The general feeling, however, is that patients are not referred at the optimum time for the psychiatrist. A gynaecologist admitted that it was used as a "last stand" and that "most doctors concede patients would have a better chance if referred sooner ..."; and a psychiatrist affirmed:-

"We are the last resort; they come to Psychiatry with a big file from all the other departments ..."

The expectations of other services regarding emergencies often produce a negative reaction in psychiatrists, one, as noted earlier, of "not seeing patients when asked to". Furthermore, the pressure to take incurable patients contributes to the insecurity of the psychiatrist; as one said:-

"If we do take them we get stuck with them; if we don't we're no good ...".

This is significant in the indication it gives of the difference between Psychiatry and other specialties; unlike these,

Psychiatry has no "grave-yard"; its patients, though incurable, do not die and, while they live, they present a perpetual challenge and source of anxiety.

Informal Contacts

a) Referral

Underlying the formal system of referral, informal mechanisms are obviously at work; most doctors like to know the psychiatrist personally and be assured that he has had a good general medical and surgical training before calling him in to see a private patient. This attitude is summed up in the words of a gynaecologist:-

"I would want to know the psychiatrist and evaluate his approach towards the patient ..."

Another said:-

"If the patient is 'close to me' I would want to know the specific psychiatrist; private patients prefer to go to one of their own kind ..."

A psychiatrist remarked:-

"I get referrals only from good friends I know personally or whose friends I've successfully treated ..."

The residents in each service, who are most concerned with referrals, all spoke of getting to know the "soft areas", the "easy spots", as they called them. In the words of one:-

"Those I knew personally or who had had psychiatric experience were more understanding and sympathetic ..."

A frequent remark was:-

"It's no good asking Dr. X..., he wouldn't help us ..."

One young surgical resident said:-

"I wouldn't call in the others but I know Pete - he's good. We were in medical school together."

In addition to the effects of such friendly contacts, the referral system is influenced at an informal level by pressure from the younger on the older doctors. Many of the senior men feel that the junior staff and internes are over-enthusiastic in their referrals to Psychiatry and exert an influence on their superiors in this direction. As a gynaecologist said:-

"The younger men are psychiatrically-conscious and explain everything away by Psychiatry, which is irritating; they tend to label a psychiatric case too soon, which is not necessarily bad because psychiatrists are doctors too, but it is a source of annoyance that they tend to put pressure on the staffmen, who want to find out if there is a physical source before referring ..."

The effect of the upward pressure is evident from a four-fold increase in surgical requisitions which occurred after a recent change in the junior interne staff.

b) A second area of informal contact is the dining-room of the hospital. Here, unfortunately, psychiatrists again tend to be an "isolated unit"; as one said:-

"We like to eat alone for three reasons: to discuss our own problems; because we feel unwanted - they prefer to keep separate; because we're sensitive - we know they think we're neurotic. They think we're dangerous and have a lean and hungry look ..."

One surgeon remarked:-

"With exceptions, they don't mix ..."

And another:-

"Everyone stays the hell away from them - even at dinner they sit apart ..."

A gynaecologist said:-

"Rubbing elbows at an informal level has a serious reflection on what is done during the day; if we had lunch with them every day they would get more referrals. They eat in their own corner ..."

A move from both sides at this informal level would clearly help to improve relationships between psychiatrists and other medical specialists.

c) The influence of the head of each department is important at an informal level in determining the attitude of the department, in this case towards Psychiatry. He tends, in the words of an interne, to become "semi-deified - how many young graduates really think for themselves ...?", which suggests that his effect is greater among the younger men, to whom he is exemplary in the technical field.

In the first chapter, it was seen that the head of the department was most influential in the case of Neurology and Pediatrics, to the extent of being able to locate "clusters" of antipathy or sympathy towards Psychiatry. The inclination of surgeons to be scornful with regard to this may, in part, be attributed, as one of them said, to "a feeling of identification with my chief ...". In Medicine, one of the chiefs, and his adherents, is violently opposed to Psychiatry and, in consequence, no research work is being done on hypertension, which represents a big loss to the university and the medical field in general. It is noteworthy that there were no referrals at all from the allergy clinic to the psychiatric rotator on the psycho-somatic service until recently, when a new head of the allergy department was installed. One psychiatrist said:-

"If the head of the department is afraid of contacts and keeps people (in other services) at arms length, it affects the whole department",

and felt this to be a contributory factor in the isolation of his own department.

It is thus evident that the head of the department is instrumental in promoting or retarding, by informal means, collaborative relationships between specialties.

The importance of such underlying informal relationships to the functioning of the hospital as a whole has been brought out by Dr. Hall:-

"The allocation of positions in the institutions, the pace at which one receives promotions, the extent to which one has patients referred to him, all hinge on the workings of the informal organization ..." 1

It would seem that the acceptance of a new specialty such as Psychiatry in a medical institution is correlative with its incorporation into the "inner fraternity", and that such can be achieved in large measure by informal mechanisms operating at the levels indicated.

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1 O. Hall. op. cit. p.31.

2. Relationships in the Medical Profession at large

Psychiatry will now be considered as part of the medical profession; as a member of this profession the psychiatrist, as was seen in the introduction to this chapter, shares with other doctors the functional elements inherent in the role of the physician.

The role patterns of the medical role are described by Professor Parsons.[1] As a member of the medical profession, the doctor sees his function predicated upon his relationship with the sick person who is his patient. He believes that it is his obligation to do all that he can to restore the patient to health. He does not believe that he has obligations towards the patient that transcend what is necessary to achieve that goal. He believes that he should treat all persons alike, that is, not to differentiate between patients in his medical decisions on the basis of other relationships. Furthermore, he believes that these decisions should not be influenced by his affective reactions to the patient's behaviour. Professionally speaking, the interests of the patient always take precedence over his own. In return, the doctor expects the patient to recognize that he is sick and be willing to do all he can to co-operate with the doctor. The doctor expects the patient not to expect him to do more than is called for medically, nor to differentiate in the doctor-patient relationship on the basis of other relationships.

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[1] T. Parsons. "Propaganda and Social Control" Essays in Sociological Theory, pp. 292-3.

Professor Parsons stresses the importance of the institutionalization of the medical role, the features of which are "insulated" by control mechanisms against possible deviant structures.[1] The functional significance of the combined role patterns lies in enabling the physician to "penetrate sufficiently into the private affairs or the 'particular nexus' of his patients to perform his functions".[2]

Dr. Hughes refers to these features, and others characteristic of the professions in general, which Medicine and Psychiatry exhibit[3]: the separation of the individual's professional life from his own home, his action without respect of persons, himself or others, and the building up of a personal clientele. The freedom of the professional man, as a man with many employers, rests ultimately on the fact that he could lose any one of his clients without great loss. Dr. Hughes also discusses an important factor in medical discipline - the defence of its integrity by controlling the practitioner. He sees effective professional control as emanating from generations of men whose success and prestige depend completely and permanently on the practice of the profession:-

"The profession has not an unthinking devotion to a sacred ritual (like the nun) but it may lean in that direction; the individual is permanently dependent on his profession and somewhat devoted to it. His initiation into the ideals of his profession is a slow process accompanying his training and experience; thus the profession achieves consensus and co-operation ..."

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1 T. Parsons. ibid. p.294.
2 " " "The Social System" p.459.
3 E.C. Hughes. "The Growth of an Institution". The Chicago Real Estate Board. The Society for Social Research of the University of Chicago. Series 11, Monograph No.1. Chicago 1931. pp. 1-45.

An important controlling device in an occupation is the development of a code of practice which is at once a common law and a creed - a concrete definition of practice and an expression of hope that, in the future, practitioners will behave as they should. In both aspects the objective is control, for the direct protection of competitors from each other's wiles, and for indirect protection through the establishment of amicable relations with their clients and their publics. It will be seen later in what way Psychiatry is suspected of infringing the specific medical code.

Dr. Hughes draws attention to two further features which the medical profession, including Psychiatry, possesses. The first of these is a common concealment of any resistance or antagonism towards their "dear, but troublesome patients". This is observed among all those professions which publish a stereotype of themselves, that the contention, of there being no conflict of interest between professional and client, may be maintained.[1] In the second place, in Medicine, as in all occupations where unavoidable risks are great, a certain ritual is developed, an "art", a "cult", giving rise to a set of emotional and organizational checks and balances to counteract the subjective and objective risks of the trade.[2] There is a system of delegation to spread or, in some cases, to concentrate the risk of guilt of mistakes, and also to spread and to

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1 E.C. Hughes: "The Sociological Study of Work". an editorial foreword. A.J.S. The University of Chicago Press, Ill. Vol. LVll, No. 5. March, 1952. p.425.

2 E.C. Hughes: "Mistakes at Work". The Canadian Journal of Economics & Political Science. University of Toronto Press, Vol. 17, No. 3. August, 1951. p.325.

allocate the losses which result from them. In Medicine, as in many occupations which can be considered as "bundles of skills", criteria of success and failure, mistakes and the proper execution of work, are difficult to establish. This is even more pronounced in the case of Psychiatry than in other specialties.

The purpose of psycho-therapy is to encourage and permit the patient to change his values and thus to rechannel his behaviour, aimed to satisfy his needs, into socially acceptable patterns. Conditions fundamental to the therapist-patient relationship are that the therapist should "support" the patient, should be "permissive", should reciprocate to the patient's behaviour only in terms of a correct attitude and should manipulate rewards, contingent upon the patient's behaviour, which are orientated to the goal of therapy. However, the present state of Psychiatry precludes absolute certainty in many areas of what is good therapy. Dr. Hughes notes that success and failure are not discussed among psycho-therapists and feels that, because their standards of cure are so uncertain, they find reassurance in being adept at the art of reconstruction of the history of the patient's illness.[1] This incurs criticism of psychiatric method from other specialties, as will be seen in the next chapter.

Every physician is subject to a certain degree of emotional strain on account of the responsible character of his work and

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1 E.C. Hughes. ibid. p. 324.

the factors of uncertainty and impossibility which enter into it; a "purely rational" orientation to one's job is always more easy if success is guaranteed. An additional strain is imposed on the psychiatrist due, as has been seen, to the nature of his work and to his close involvement in the private affairs of the patient, which create "complications of the function of medical practice on the level of human adjustment ..."[1]

Certain general and basic features which Psychiatry shares in common with the rest of Medicine and, to some extent, with other professions, have been discussed and several features which occasion problems peculiar to Psychiatry pointed out. Two specific and formal areas of collaboration between Psychiatry and other specialties must now be reviewed - the field of psychosomatics and a common interest in the patient.

a) Psycho-somatics

Organic illnesses, in which psychological stress appears to play a prominent and perhaps predominant part, are given the name of psychosomatic disorders; however, as Dr. Stafford-Clark points out, all illness is essentially psychosomatic, in as much as all illness forms part of the experience of the sick person, and both affects, and is affected by, that person's mind as well as his body.[2]

It is generally agreed among medical people that at least fifty per cent of all medical complaints are psychiatric in

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[1] T. Parsons. "The Social System". p.453.

[2] D. Stafford-Clark. op.cit. pp. 165-188.

origin;[1] psychological factors are among those significantly operating in such diseases as the common cold, asthma, catarrh, hay fever, hyperthyroidism, gall bladder trouble, gastro-intestinal ulcers, irregular menstruation, sexual impotence and migraine headache. Descriptions of pain and suffering by the patient are often linked by the doctor with an underlying psycho-pathology; such links occur repeatedly in practice in, for example, the association of repressed disgust with the subjective complaint of nausea; hostility and aggressive feelings with the symptoms of stabbing or gnawing pain in the abdomen or head; anxiety with palpitations, breathlessness or muscular tension, felt as cramp or aching in the limbs. These examples reflect a fundamental relationship between emotions and bodily symptoms which finds expression in such everyday terms as a "sick or aching heart", "cold feet", or "a pain in the neck".

The treatment of physical diseases or defects, in the course of which mental illnesses arise, is a task which may be carried out by the general physician or surgeon, or by the psychiatrist whose background is sufficiently comprehensive, or such treatment may be shared between them. Examples include the treatment of acute toxic confusional states, of which delirium tremens is only a special example, by correcting underlying infection or physical disturbance, and the treatment of general paralysis of the insane by the modern anti-syphilitic methods, such as penicillin, designed to destroy the disease

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[1] 1925-1927 Survey (directed within the Department of Medicine, Royal Victoria Hospital, Montreal) into the incidence of emotional disabilities within the population of a general medical ward.

parasites in the brain.[1]

There is a growing recognition of the importance of psychosomatic factors in disease, as reflected in the one hospital under consideration.

As a surgeon said:-

"Psychiatry can help - mainly in ulcerative colitis ..."

And another:-

"In treatment - medical, surgical, psychiatric therapy - each must be used when appropriate; there are psychiatric overtones in ulcers, for instance, when therapy relieves pain ..."

Various investigations are carried on in conjunction with Psychiatry:-

In plastic surgery there is a monthly meeting on cleft palates which includes a psychiatrist as a member of the team.

A joint study concerning the cortical hormones, into the effect of treating endocrinological disease by adrenalin, is being conducted, and conferences between endocrinologists and psychiatrists are held twice weekly.

Collaborative discussion and research also takes place with Dermatology into the relevance and importance of psychological factors in the pathogenesis of skin disease. Stressing the interplay of many and varied factors, some as yet unknown, in disease and condemning the "sole cause attitude", a dermatologist[2] writes in a paper on the psycho-physiological phenomena of the normal and abnormal skin:-

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[1] D. Stafford-Clark. op.cit. pp. 165-188.

[2] As the dermatologist was one of those interviewed for this study his name cannot be disclosed.

"The short-sighted psychiatrist who points out a stressful life situation, or a neurotic reaction in a patient, and then jumps to the conclusion that therefore all his signs and symptoms of disease are solely caused by his emotional maladjustment, commits a logical error, beclouds our understanding and may do serious damage to the patient. A rigid dermatologist, who refuses to see the importance of psychological factors, commits a similar sin and renders the same disservice to the patient ..."

This plea for a combined approach is made with an understanding of the essential interdependence of mind and body in health and sickness; that health is, in the words of Professor Parsons, "a matter of a person's total adjustment to his life situation".[1]

It is made even more strongly by Drs. Ebaugh and Rymer in their discussion of the treatment of the individual as a whole:-

"In this age of specialization and short cuts to diagnosis the whole individual is often lost to view ... The penetration and co-ordination of the specialties at times seems to threaten the perspective of the technical developments. The entire trend of medicine calls for a degree of mutual understanding between the branches of medicine, of the patient as a person, for the collaboration of the physician in a programme of health and for the intensive study of the specific factors in the public and individual needs of treatment. The general advance in medical knowledge should render the appreciation of the concept of the patient as a whole individual more thorough, more complete, than ever before ..."[2]

As they maintain, the true relations of the parts with the whole should never be lost sight of for a moment; failure to consider the patient as a whole leads to failures of diagnosis and treatment, promoting the growth of "cults, fads and even quackery ...".[3]

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1 T. Parsons. "Propaganda and Social Control". p.286.

2 F.G. Ebaugh and C.A. Rymer: "Psychiatry in Medical Education" New York. The Commonwealth Fund, 1942. p.9.

3 Ibid. p.72.

In this respect Psychiatry, in over stressing the importance of mind, has been as guilty as other services who have concentrated merely on the physical factors in disease. However, with the departure from the old descriptive type of Psychiatry to the present day genetic dynamic concepts, the object of study is the total organism reacting to a total situation - the psycho-biological method of approach towards the whole person.

In the handling of human relationships in Medicine a common approach with Psychiatry is also adopted. Professor Parsons observes a certain "unconscious psychotherapy in general medical practice"[1] and, in its widest sense, psychotherapy forms the basis of much that is most valuable in the relationship between doctor and patient; its principles are employed, sometimes almost unwittingly, in what is known as the good "bedside manner".

In the words of one psychiatrist:-

"The bedside manner is really no more than the psychotherapeutic approach; it is inborn in some but in others it has to be taught ..."

In this connection, another psychiatrist regretted that the "art" of medicine, the "bedside manner" was not taught and that the emphasis on, and adoration of, medicine as a science, had only now reached a turning point.

Another psychiatrist referred to Psycho-somatics as "a dramatization necessary at first to put the idea over",

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[1] T. Parsons. "The Social System". p.462.

and said that it was now going out as a separate specialty as "all medicine becomes psycho-somatic".

Whether or not this is true, psycho-somatic medicine has, nevertheless, served an important function in fostering, as has been seen, the psycho-biological and psycho-therapeutic approach and in providing an opportunity, in the words of a psychiatrist, for the "two fields (of Psychiatry and Medicine) to meet", and work together in concerted action.

b) The Patient

As attended by both general medical practitioner or consultant and psychiatrist, and referred from one to the other, the patient provides a second common meeting ground and focus of interest. In his sensitivity to the doctor's attitude, whether consciously or unconsciously expressed, he also acts as a "barometric" measure of the climate of relationship, favourable or unfavourable, between practitioners.

This is borne out by the studies of Stanton and Schwartz in a mental hospital ward.[1] They observed increased agitation and dissociative behaviour when two staff members, with power over a patient, disagreed as to how the case should be handled; moreover, such behaviour was subdued or disappeared within a few days - often within a few hours - after the two staff members had been induced to discuss their differences directly with each other. The patient's participation in this triangular process is significant.

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[1] Stanton & Schwartz. "Observations on Dissociation as Social Participation". pp. 339-354.

Stanton and Schwartz also made a social-psychological investigation of the incontinent act as a pattern of participation in the social process.[1] They found that the staff's attitude of despair and discouragement about the patient was reflected in the patient's own feeling of despair and discouragement about ever becoming a full human being and participating at a level which was more acceptable.

In the same way, in this hospital psychiatrists find, as one said, that:-

"The doctor's attitude is reflected in the patient; it is sensed on referral when a 'negative' feeling, if present, is transmitted ... They are tactfully advised to go and see a 'neurologist' and fifty per cent of patients are surprised to find the psychiatrist doesn't deal exclusively with the insane ..."

This attitude is a hangover from the "mad-house" days of Psychiatry; the stigma attached to the patient suffering from mental illness is still in the process of being removed and creates certain difficulties in the relationship of the patient to the psychiatrist. Some show appreciation, as in this remark to a therapist;-

"Isn't it wonderful to be able to do so much without touching me?"

In others, as a psychiatrist said:-

"Just because you're a psychiatrist they do just the opposite of what you tell them; a surgeon, on the other hand, can cut off their leg and they will only congratulate him on performing a good operation ..."

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[1] Stanton & Schwartz: "A Social Psychological Study of Incontinence" Psychiatry. The William Alanson White Psychiatric Foundation, Vol. XIII, No. 4. November, 1950. pp. 399-416.

It is evident that, although the psychiatrist and his medical colleagues share a common interest and often work together, in the treatment of the patient, the orientation towards him is less clearly defined in one than in the other. This may contribute to the insecurity felt by the psychiatrist and considered previously.

Both the formal areas of collaboration in the profession between Psychiatry and other specialties, which have been discussed, were seen to contain certain "institutional" aspects. The informal contacts in the profession occur mainly with reference to the referral system and have been mentioned in a discussion of this in the specific medical institution.

Conclusion to Chapter II

In both the profession and the hospital, Psychiatry and other specialized fields of Medicine are brought together, formally and informally, in certain areas of common interest and common action. Many general and basic features are shared in the profession at large; the field of psycho-somatics has provided a common meeting ground, a combined psycho-biological and psycho-therapeutic approach has been fostered, and to a large extent adopted, and various investigations carried on in conjunction; there is common interest in, and treatment of, the patient, although the lingering stigma attached to the mentally ill complicates the relationship of the psychiatrist to his patient. However, the degree of contact and collaborative effort achieved in the profession at large is high.

In the hospital under consideration there are certain local problems, such as shortage of psychiatrists and lack of facilities, which occasion difficulties over consultation and co-operation between the psychiatrist and his colleagues in other fields; this gives rise to a certain amount of friction, particularly with regard to the question of referral. However, in other areas of formal contact - the psychiatric consultants to various services, the interchange of internes and the teaching of medical students - the collaborative relationship is strong. Basic to this are the underlying informal mechanisms - operating in referral, in the dining-room of the hospital and through the influence of the head of each department, - important levels

at which greater collaboration is most desirable. This would, in all probability, result in greater acceptance of Psychiatry as a new specialty in the medical institution and an improvement in the functioning of the hospital as a whole.

This analysis was made within a specific institutionalized structure and the psychiatric department considered differs from most in a number of ways, so that it is impossible to generalize these findings in relation to another hospital differently organized; but there is no reason to believe that essentially similar processes may not occur in any medical institution.

Although the focus in this chapter has been placed on the "institutional" aspects of the new specialty, many of the findings are applicable to the profession in general. In the next chapter the focus will be on the "professional" aspects in its reaction to the old established profession of medicine and the response of this, in turn, to the newcomer.

CHAPTER III.

THE ACCEPTANCE OF PSYCHIATRY WITHIN ESTABLISHED SPECIALTIES

The acceptance, by any established body of practitioners within the work world, of a new and specialized branch emerging in its midst, is seldom wholehearted; in the initial stages it is merely tentative and one which occasions apprehension and misgiving among the older members.

The reaction from some quarters to the new specialty is one of fear or prejudice; in others, of suspicion that it is no more than a "quack" profession; frequently it is governed by uncertainty and lack of understanding of its technical province. Such factors are all conducive to non-rational resentment and criticism. From other quarters of the established body there is a more constructive approach. Criticism pertains to techniques, to questions of advertisement by the new members of their gospel, the limits to which it should be taken without infringement of the professional "code" and the adequacy of control mechanisms; such is based on more logical and justifiable grounds. From other quarters, the reaction to the new field is one of sympathy; there is appreciation of its difficulties and problems and of its potential use.

The emerging specialty is sensitive to the reactions it evokes from its parent body and its own response to this is thereby affected. While recognizing its own shortcomings and limitations, a purely emotional and irrational response on the part of others is resented. The new specialty is put on the defensive, as it were, and its as yet ill-defined place arouses a group consciousness among members which often gives to them the appearance of a secret society.

In both old and new fields, however, enlightened practitioners realize the importance of an overture being made from each side.

A consideration of all these responses reflects the degree to which the new branch has been accepted by older colleague groups; in the case of a new medical specialty, it is a measure of the position it occupies within the entire professional field.

The lenses of the sociologist will, therefore, now be focused to encompass such a scene; to view Psychiatry as an invader into the field of Medicine as a whole and to see the responses, both of friction and congeniality, which are evoked from either side. These serve as a basis, not only for the assessment of the present position of Psychiatry, but for the determination of the means by which the new specialty could become more acceptable, and its role more distinct, in the future.

Although impressions are gathered from one institution, they would seem to have general significance and, therefore, in this chapter, "professional" and "institutional" aspects will be considered together.

1. Responses of the established specialties to Psychiatry

Professor Parsons has shown that scientific medicine has come to be highly institutionalized, but that this process is far from complete within the profession itself.[1] In the past there has been strong, often bitter, resentment from within the profession of what have turned out to be critically important scientific advances in its own field - the initial reception given to the work of Pasteur and Lister, for instance. It seems the treatment of mental illness, which is the concern of Psychiatry, is suffering the same fate.

H.S. Sullivan also notes that, despite the twentieth century changes which gave rise to therapy of many mild, and some severe, mental disorders and fostered the mental hygiene movement, and a growing appreciation of the possibilities of Psychiatry for individual and social welfare, "the medical profession has been rather slow to appreciate the new role of this discipline ..."[2].

Resentment of Psychiatry may be accounted for, in part, by such conservatism within Medicine, in part by the reaction of any group of competing colleagues who do not welcome competition. The interplay of both these factors may be suspected in the attitude of the medical profession towards Psychiatry; and, as in the case of any newcomer to an established field, the responses evoked are of a critical and a sympathetic nature.

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[1] T. Parsons. "The Social System". p.433.

[2] H.S. Sullivan. "Psychiatry". Encyclopaedia of the Social Sciences. MacMillan Co. N.Y. Vols. XI-XII, p.58.

Critical responses: destructive or non-rational

These seem to be due mainly to a lack of understanding of mental disease which is manifest in several forms.

a) Impatience for evidence of results and cures, as illustrated in the following comments:-

"I have yet to see any good results; Psychiatry has as yet nothing to offer ..." (Allergist)

"The results produced are very small at the moment - they take on things they can't handle ..." (Dermatologist)

"Medical men want proof of cure - it will legitimize their position ..." (Neurologist)

"No doubt when they produce the goods - when they can say "We can get these patients better" - they will get recognition ..." (Gynaecologist)

Psychiatrists felt these demands stemmed from a lack of understanding of Psychiatry.

"Psychiatry doesn't lend itself to a high percentage of cures - we can't point to figures ..."

"Criteria of improvement and cure in Psychiatry are more abstruse than, for example, in pneumonia; Psychiatry is like the chronic asthmatic and cardiac illnesses, of which few are cured in a general hospital ..."

"The rest of Medicine should examine its own back-yard; fifty per cent of Surgery is supportive - it relieves obstruction, carcinoma, etc. and so is the treatment of the arthritic and T.B. patient, ... the epileptic and diabetic are never really cured ... no cardiologist ever cured a heart ... Psychiatry doesn't give a cure either, except for depressives and some schizophrenics; we can only support, rather than cure, emotional disturbances, and it is most important to give education in the fact that we can't give cures ..."

One of the more enlightened surgeons agreed on this score. He said:-

"We expect results and don't understand when they can't offer us the cures ..."

This may be because, in the words of a psychiatrist:-

"Doctors like to see the dramatic; consequently the 'push-button' psychiatrist is rated highly by some ..."

In view of the present uncertainty in standards of psychiatric cure, which was discussed in the previous chapter, it seems that psychiatrists are justified in condemning the attitude of other specialists in this respect. Moreover, Dr. Stafford-Clark shows that, relatively speaking, the results are good:-

"The percentage of patients with psychoneurosis who can expect to be restored to health, or relieved in varying degree by psycho-therapy, is between 60 and 90 per cent ... in every case help can be offered and at least some degree of relief expected. No patient is beyond aid; many can be cured ..."[1]

b) The suspicion that Psychiatry is a "quack" profession is a second non-rational response which stems from a lack of understanding of its province.

Malinowski has shown that magical beliefs and practices tend to cluster about situations with important uncertainty factors[2], and these are found, as has been seen, to a high degree in Psychiatry; it is also true that the field of mental medicine has been exploited by the incompetent and the "quack" so that, as Ebaugh laments, "confusion exists, even in fairly well informed circles, as to who are the sound and who are the meretricious exponents ..."[3]

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1 D. Stafford-Clark. op.cit. p.225.

2 B. Malinowski: passim. "Magic, Science and Religion" in Science, Religion and Reality, ed. by J. Needham, The Macmillan Co. N.Y. 1925.

3 F.G. Ebaugh, op.cit. p.71.

One psychiatrist said that a friend of his had set himself up as a Marriage Counsellor for two weeks in Florida and made enough money to pay for his holiday; instances of this kind - of quacks pretending to be psychiatrists - are unfortunate and harmful to the cause of Psychiatry. As one physician said:-

"Medical people were so put off by quacks and osteopaths in the past that it makes us cautious in our approach towards Psychiatry ..."

It may be that those who persist in regarding the psychiatrist as a quack would define him in Hughes' terms, as "the man who continues through time to please his customers but not his colleagues"[1] and resent his success merely as a competing rival.

Misunderstanding of its function may, alternatively, lead them to feel that referral to Psychiatry would be a reflection on their own reputation, or an unnecessary "gilding the lily"; or to accusations of its being "unscientific". This charge is strongly denied by psychiatrists. As one said:-

"Psychiatry is like Astronomy - it can't be measured - it is a science of the observation of behaviour and our theories arise from deductions ..."

Regarding this, a pediatrician commented:-

"It is a science in that it attempts to classify behaviour ..."

c) A third non-rational response is one of fear.

Fear in the first place, among certain doctors, that Psychiatry represents a threat to their own service. Several psychiatrists referred to this:-

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[1] E.G. Hughes: "Mistakes at Work". p.325.

"There is a fear in Medicine of Psychiatry "swallowing Medicine ..."

"They see it as a threat to their economic position ..."

"Their patients may be taken away if Psychiatry is right - as such it represents a threat to the doctors' income"

"Their attitude is: 'they take my patients away from me'"

However, there only appears to be one undeniable example where this factor might operate; this is in the case of the senior man in Medicine, a kidney specialist already referred to, who is extremely hostile to Psychiatry. He maintains that kidney trouble is the root cause of hypertension and, for fear that the disease may be found to be of psychiatric origin, refuses to allow any investigation to be carried on in the field.

Hughes notes that "the established occupations are dour and canny in spotting potential squatters on their grounds ..."[1] In this case, however, the fears seem to be unfounded and irrational. Most of the younger doctors concede this and psychiatrists themselves feel that other services have nothing to lose by a psychiatric approach:-

"There is a great need for psychiatrists in the city - we don't know what to do with patients ..."

"Psychiatry represents no threat to Gynaecology, E.N.T., abdominal Surgery, Neurosurgery, and only very little to Medicine as a whole ..."

That physicians are generally well disposed towards Psychiatry indicates that the fear and hostility of other

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1 E.C. Hughes. "The Growth of an Institution". p.31.

services, who are in fact not threatened, is of an irrational nature. This contributes to the psychiatrists' dilemma already referred to and revealed in the remark:-

"If I do something I represent a threat; if I don't I'm no good ..."

Another voiced the general sentiment in saying that the attitude of doctors would mellow as they were educated to realize that Psychiatry represented no threat to their work:-

"The answer lies in the fact that the older men have had poor training in Psychiatry, know little about it and feel it is a threat. It will be okay when psychiatrists can show they are working for, not against, them ..."

Fear also takes other forms - a fear of being analysed by psychiatrists and an avoidance of them "like the plague ... of course everyone has the sneaking suspicion that something is wrong with him ...", or fear can cause an emotional block. In the eyes of some the "emotional block", so called, of one eminent neurologist who insists that an "I.Q. of 130 can't be insane", amounts to mere stupidity. Or fear can be the cause of a bravado of aggression.

"How are the nuts (patients)?" - a question asked of one psychiatrist in a public elevator, and "Are you still in that madhouse?" of another, are instances of this.

The joking relationship evident here, and previously with regard to the "abnormality" and terminology of psychiatrists, is characteristic of situations in which elements of uncertainty and fear are present.

d) A fourth non-rational response is one of prejudice.

This has been touched on previously with regard to the

question of referral, when it was seen that the younger men in all services were more inclined to use Psychiatry at the consultative level. This seems to indicate a more "psychiatrically-conscious" disposition than is found among senior men, a fact which was borne out by personal interview and by remarks from psychiatrists such as:-

"The younger men are more psychiatrically-orientated than their chiefs ..."

"The older ones, over forty-five, are sceptical ..."

It is generally agreed that this can be attributed to the fact that Psychiatry has only been taught in the medical school for some years and the effect of this is now, to an increasing extent, being felt in the hospital. A psychiatric orientation is most pronounced in the internes and residents; the junior staff are more detached - "a half-way house"; the senior staffmen on the whole comprise the most prejudiced and intolerant group, as they had little or no psychiatric training and are, in many cases, ignorant of its techniques. One physician, on being asked if he had done any Psychiatry in medical school, replied:-

"Thank God, no!"

There is here a direct correlation between attitudes and the degree of exposure to, and familiarity with, a particular field of knowledge, a correlation in keeping with the findings of psychological studies on prejudice and tolerance.

Professor Parsons, in writing of the profession's traditional belief in the "art" of medicine[1], feels that this presumption

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[1] T.C. Parsons: "Propaganda and Social Control" p.285.

has been questioned by the psychic factor in disease. Such would serve to increase any resentment and prejudice already felt by medical practitioners against the field of Psychiatry.

Non-rational critical responses, whether due to lack of understanding, fear or prejudice, lead, as has been seen, to hostility towards Psychiatry, varying in degree with the age and individual personality of the doctor. It may be, as many psychiatrists feel, that doctors who are most hostile "have the greatest personal problems". However, the fundamental problem which has to be faced is that of uncertainty about the intrinsic nature of mental illness and the need for education to remedy this; as the context of Psychiatry is more appreciated by the medical profession, the more acceptable will it become.

Critical responses: constructive

It is evident that some of the criticism levelled against Psychiatry is superficial and indicates deeper resentment; in other instances, however, it is genuine and constructive and often acknowledged by psychiatrists themselves. A consideration of such criticism is useful as a reflection of the status of the new specialty.

a) Psychiatric techniques

In this respect there were accusations of psychiatrists being unsatisfactory and unhelpful:-

"Most medical doctors feel Psychiatry rarely adds anything to the patient - but then it often can't offer anything ..." (Physician)

"I have yet to see them help anyone; some patients get worse - they give them a lot more things to worry about ..." (Dermatologist)

Of doing harm:-

"For every person they help (and even these are questionable) I have seen many more who have been harmed ..." (Allergist)

"They do more harm than good: they cause fixation in patients; minor aberrations become magnified in their minds and molehills become mountains ..." (Gynaecologist)

"They can do an awful lot of harm through their techniques - they can make neuroses worse than anyone else and a psychosis to jump out of the window ..." (Dermatologist)

Of over simplification and categorization:-

"They are inclined to categorize people as misfits of greater or lesser degree ..." (Surgeon)

Several expressed disapproval of the fact that sixty thousand recruits were rejected on psychiatric grounds alone from the United States Army last year.

However, one surgeon said he thought there were "too many odd people around, nuttier than fruit cakes!", so there is perhaps some justification for psychiatrists wishing to classify them.

Bad medicine and bad methods were also criticized:-

"Many surgical patients were mistreated in a number of instances by psychiatrists; patients with organic injuries have been treated psychiatrically; inflammatory processes, tumour growths, constriction of scars, healing of bone cannot be treated by pschiatric measures - only surgical ..."
(Gynaecologist)

"There will be no improvement in the position of Psychiatry until their methods are better ..."
(Dermatologist)

In this respect psychiatrists admitted:-

"Bad medicine produces bad feelings - we have no excuse when a perforated gastric ulcer is treated as a hysteric ..."

"There has been a lot of very poor practice which has created justifiable suspicion ..."

Bad diagnosis and reports were also complained of:-

"They give us detailed histories which don't tell us anything ..." (Gynaecologist)

"They won't give a diagnosis and their reports are very nebulous ..." (Surgeon)

This was acknowledged by psychiatrists, one saying that there had been unfortunate incidents: George Gershwin, for example, had died of a brain tumour after being treated by a psycho-analyst for one year.

However, as a psychiatrist pointed out, diagnoses are, in any case, only "labels" and mistaken ones occur in every specialty.

b) Excessive and unjustified claims

One dermatologist regarded this as having rendered

"the greatest disservice to Psychiatry; they promised far more than they could achieve ..."

H.S. Sullivan also writes:-

"Psychiatry has many limitations, not the least of which is the enthusiasm that has led to exaggerated claims as to current accomplishments ..."[1]

Most psychiatrists are fully aware of this:-

"We have overplayed to the public ... they ask 'Where is the miracle we've been promised?'..."

"80 per cent is our fault, because of the incredible material we give them ..."

"It has become too popular ... it was dramatized by the patients ..."

"Psychiatry on the whole has oversold to the public - they have come to expect more than it can give ..."

"Either the claims were exaggerated or the interpretation on the part of the public was wrong - they tended to endow it with a magic it hasn't got - it was grabbed as a panacea by the public ..."

"We have oversold to the public beyond our abilities - the public are told by the psychiatrist they will be cured and are not ... we have to do what the public ask for ..."

One psychiatrist coined two terms to describe these unfortunate complaints from which Psychiatry is suffering:-

""Psychiatrism" - the belief that modern Psychiatry claims to cure all the world's ills, and:

"Psycho-damnitis" - the situation that has arisen whereby patients come complaining of an 'Oedipus complex'..."

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1 H.S. Sullivan. op. cit. p.59.

The indictment of Psychiatry in this respect is closely related to the following, and of both psychiatrists are cognizant.

c) Publicity

Some doctors felt that the unfortunate publicity given to Psychiatry was the fault of psychiatrists and could have been controlled, but the majority laid the blame on the press and radio and the confusion with Psychology:-

"The Yanks played it up in psychological movies etc. and it was over-publicized in the press and magazines ..." (Gynaecologist)

"It was pushed a little too far but there will be a swing back ..." (Dermatologist)

"The more the public understands the greater the phobia developed - it is just like the cancer drive; Psychiatry should be eliminated from Medicine because it is running a racket; the medical profession generally is running a racket ..." (Gynaecologist)

"It has gone to extremes - the public are now mentally-health conscious and must have reassurance ..." (Gynaecologist)

Psychiatrists agreed:-

"It has been dragged out too much - a muddy mess - but it is now swinging back ..."

"50 per cent of the medical column in 'Time' deals with psychological problems; the public have become psychologically minded - even children turn on their parents if reproved for being naughty, and say:- 'It's not my fault Mum - it's yours!'."

Dr. Stafford-Clark feels that this "confusing blend of popular interest and suspicion"[1], responsible for the recent "avalanche" of films and books and cartoons, can be attributed

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1 D. Stafford-Clark. op.cit. p.174.

to a "sincere conflict of feeling which we have seen characterizing the public attitude to mental illness from time immemorial".

Many doctors, however, feel that, by such advertisement, psychiatrists have infringed the sacred medical code, referred to in Chapter II, and thus lowered the dignity of the whole medical profession. At the same time, the majority are agreed that, if publicity serves to educate the public to an awareness of the problem, it is a good thing. As a gynaecologist said:-

"Propaganda - to remove the stigma to the patient and to show that a psychiatrist is also a doctor - is necessary ..."

Stafford-Clark stresses the fact that "the public as a whole need to be taught the truth about Psychiatry",[1] and Davies, that Psychiatry must secure the confidence and good will of the public if it is to play its true functional role in society:-

"With society's increasing exoneration of the feeble-minded and the psychotic from the stigma of being guilty of wrong-doing, the area of psychological medicine is further enhanced in value and extent ..; it then becomes "far more than folly and a waste of time ... "[2]

This indicates the importance of control of the press and judicious publicity which many psychiatrists advocate. Some felt an increase in mental health and child guidance clinics etc. would help considerably in promoting this. Education was being brought to the community through the Mental

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1 D. Stafford-Clark. op. cit. p.292.

2 J.E. Davies. "Principles and Practices of Rehabilitation". A.S. Barnes & Co. Inc. N.Y. 1943. p.xviii.

Health Institute but, as a psychiatrist said:-

"More are needed - it is only a beginning ..."

Even so, as a surgeon remarked:-

"The lay public has accepted Psychiatry more than the doctors ..."

Opinions on the subject of publicity are revealing in the insight they give into the self conceptions of the medical profession generally. A psychiatrist said:-

"They feel their dignity has been lowered, but then doctors on the whole are pretty stuffy people anyway - they solidify in medical training and their range becomes limited - it is not a liberalizing experience ..."

And another:-

"The medical profession is notorious in its dislike of advertisement etc.; it doesn't like doctors talking before clubs ..."

There is here an indication of the "aura of respect" which doctors have institutionalized into their medical code. It helps perhaps to explain why doctors, in condemning Psychiatry for "advertising" itself, forget that such is practised by any young profession. Dr. Hughes notes that a programme of education was aimed at that "ephemeral, all-inclusive group, the general public", whose approval was essential to its success, by the Chicago Real Estate Board.[1] Similarly, in its efforts to become established is propaganda employed by the psychiatric profession. Moreover, as a means of development of knowledge, this is one of the required duties of the "promoter" discussed in the previous chapter. That such unorthodox behaviour is

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[1] E.C. Hughes. "Growth of an Institution". p.66.

not subject to adequate control mechanisms doubtless labels Psychiatry as a "deviant" profession in the minds of many medical men.[1]

The response of doctors to psychiatric techniques and claims and to the publicity given to Psychiatry, while critical, is yet rational, for it is seen that resentment on these grounds is justified and often acknowledged by psychiatrists themselves. In any new profession these are the three areas most open to scrutiny and censure by the older established members, and the medical profession keeps a more than watchful eye open in the case of its own "fringe" members.

A sympathetic response to Psychiatry, however, is given by many doctors - those who, in the words of a gynaecologist:-

"are pretty sober in evaluating the benefits of certain techniques ..."

There was recognition of the differences between Psychiatry and other services:-

"It's such a different thing from all other branches of medicine - you can't see a mind or cut it up ..." (Gynaecologist)

"It's a difficult specialty; it's in the same boat as the law of the land - like pulling teeth ..." (Physician)

"It is unable to use the same measures of weight as other fields - its foundations are less sure than those of, for example, Surgery ..." (Neurologist)

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1 c.f. T. Parsons, "Propaganda and Social Control" for a full discussion of control of deviancy.

"We don't think of Psychiatry as a live member of the medical profession; it's not exactly a medical specialty, because it deals with mind - it's so intangible ..."
(Surgeon)

"They are working in a tough field ..."
(Gynaecologist)

"Surgery is easier because there are no variables - it deals with pain, change of appearance and function - things you can put your finger on; psychiatric complaints are more confusing ..." (Psychiatrist)

Many expressed appreciation:-

"Its establishment is very welcome - it is wonderful to have it available if needed ..." (Surgeon)

"It has its place - busy specialists can't give the intensive psychiatric treatment required by psychotics ..."
(Gynaecologist)

"It is imperative, in that any doctor can give psychiatric help, but cannot replace the specialist psychiatrist ..."
(Surgeon)

"They are doing some good now and are encouraged; I personally hope they will do more .."(Gynaecologist)

"When met on a shoulder to shoulder basis we found psychiatrists were wonderful people - on their feet ..."
(Gynaecologist)

There was recognition of the fact that an improvement in attitude towards Psychiatry was dependent not only on an overture from psychiatrists but from other medical specialists also. In the words of one surgeon:-

"The solution lies in the education of surgeons and medical men to understand psychiatrists and to help Psychiatry over the job of referral and communication ..."

It may be, in the words of J.E. Davies, that "there will always be those who can be impressed only with the white gowns and symbolic trappings of conventional medicine, who find it

difficult to ascribe to psychological methods the dignity of a valid treatment for disease ..."[1]

But the general opinion appears to be that this attitude is dying and will soon be extinct. Mention was made of the contributions and possibilities of Psychiatry and many doctors remarked on "the whole idea of Psychiatry gaining ground in the last few years", and that the pendulum had perhaps

"Swung too far but would swing back". (Dermatologist)

"It will settle down like all new specialties - there are places where they fit in very nicely ..." (Dermatologist)

"It is now a cult but will assume a proper perspective ..." (Gynaecologist)

"Psychiatry is on a firm basis ..." (Gynaecologist)

"Psychiatry is here to stay ..." (Physician)

One surgeon said:-

"It is a younger subject which is getting more important in our way of life ...."

And it seems legitimate to agree with another who regarded the establishment of Psychiatry as an evolutionary process which will develop "as it becomes more integrated into the scheme of things ...".

By noting the successes and failures, the sympathy for, and the criticism of, Psychiatry that is the response of those who consider themselves affected by its actions, the conception which the rest of Medicine has of the specialty can be seen.

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[1] J.E. Davies. op.cit. p.xviii.

In some it is based on rational, in others on non-rational grounds according to the age and personality of the individual doctor; it seems likely, however, that further education as to the province of mental illness will serve to effect a more rational response.

2. Responses of Psychiatry to the medical profession

The reactions of Psychiatry and psychiatrists in various specific areas have been noted throughout this discussion.

It was seen that a certain degree of collaborative effort with other specialties has been achieved, that psychiatrists realize, in the words of a doctor interviewed in Dr. Hall's study, that:

"It is from the convinced colleague that one gets his referred cases ..."[1]

and that their anxiety to be convincing, to become fully accepted, the underlying insecurity in their institutional and professional roles, has led, in some cases, to an aggressive manner and to charges of overpushing the "new gospel".

It was seen that psychiatrists are largely aware of their own professional profile and of the attitude of particular services towards their own; that they acknowledge much criticism and are sensitive to their limitations, as shown in these remarks:-

"Our goals must be limited ..."

"Let us not delude ourselves as to what we can really do ..."

"You must remember you're not God ..." (a teacher to a trainee psychiatrist)

and that they are conscious of their difficulties. The main question to be faced is perhaps that described by Sullivan:-

"The best Psychiatry is still more of an art than a science and, however much this may be deplored, it can be remedied only by extensive research ..."[2]

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[1] O. Hall. op. cit. p.35.
[2] H.S. Sullivan. op. cit. p.58.

In recognizing their shortcomings, however, psychiatrists naturally resent an irrational or emotional response to their work on the part of other medical specialists. As one said:-

"Critics won't take the trouble to learn our method - they react emotionally ..."

Another said that some physicians provoked the annoyance of psychiatrists by their interest in the disease rather than the patient:-

"On a joint ward round, for example, in most organic cases they disregard the human being and discuss the prognosis etc. - our aspects are not considered ..."

He also cited an instance during a psycho-somatic lecture to general practitioners on a "refresher course" at the hospital. One asked:-

"Do people still believe in a certain fellow called Freud?"

Such lack of understanding of their work, particularly among the older doctors, naturally gives rise to a response of resentment on the part of psychiatrists.

An improvement in attitude towards Psychiatry is felt by some doctors to be dependent on an overture from psychiatrists. One surgeon said:-

"They have got to cultivate the surgeons - it must come from them at an informal level ..."

Psychiatrists, while feeling an overture from <u>both</u> sides is necessary, acknowledge the part that they must play:-

"There is a great need of dynamically-orientated psychiatrists ..."

"It is up to us to go out and work honestly ..."

This attitude was neatly expressed by a senior psychiatrist:-

"The psychiatrists have the job of sawing wood; let the wood-pile speak for itself ..."

Conclusion

Stafford-Clark writes:-

"Psychiatry today remains a study whose boundaries seem all the wider because of the mystery and deliberate obscurity in which the subject was for so long confined[1]... the subject has emerged from the mists of witchcraft and yet has not entirely shaken itself free from the shadows of fear and shame ..."[2]

This perhaps accounts for certain qualities of relationship among psychiatrists, similar to those found in Simmel's "secret society"[3]- the group egoism, seclusion and separateness, the formal self-sufficiency, the consciousness that members form a society - all of which are observed in Psychiatry as a group. However, as Sullivan notes:-

"Since the public has grown less superstitious about mental disorders the specialty has become a fairly attractive field of private practice ..,"[4]

and it seems likely, as the educational process continues, and the community at large becomes more informed about its province, that Psychiatry will exhibit less of the qualities of the secret society.

At the moment it is one of the coming specialties, the place of which is not yet formally defined; although, unlike the anaesthetist,[5] the psychiatrist has "arrived", in that he is a specialist among equals with whom he enjoys a consultant

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1 D. Stafford-Clark. op. cit. p.296.
2 Ibid. p.232.
3 "The Sociology of Georg Simmel". Translated and Edited by Kurt H. Wolff. The Free Press, Glencoe, Ill. 1950. pp. 345-375.
4 H.S. Sullivan. op. cit. p.58.
5 D. Lortie. "The Sociologist looks at the Profession of Anaesthesiology". Current Researches in Anaesthesia and Analgesia. Vol. 29. July-August, 1950. No.4. pp.183-188.

relationship, like the anaesthetist, he yet suffers from a certain ambiguity of status. As seen in the previous two chapters, he is regarded by other medical men both as a custodian for the mentally sick and as a useful agent on whom to "dump" nuisance patients.

However, as the position of Psychiatry becomes more clearly defined in the medical community, it will, presumably, like other established professions,

> "in the course of time develop a sort of organization which functions to provide order, to ascribe and maintain status, to control the conduct of members and to minimize competition and conflict. In other words, they will develop an orderly manner of incorporating new members into their community, of repelling the unwanted and the intruder, of allocating rights and privileges, of distributing clients among colleagues, of applying sanctions and penalties and preserving their status."[1]

As Lortie states:-

> "It takes some time before any field of endeavour becomes recognized as worthy of respect and its corresponding status."[2]

Acceptance of Psychiatry at this stage of its development is only tentative; it is greeted by various responses, with that of sympathy from some quarters only. However, if the new specialty follows the pattern of others which have emerged in the work world, it will gradually become fully incorporated into the fraternity of other specialties - into the body of Medicine as a whole.

Like the anaesthetist, the psychiatrist can become indispensable through gradual extension of his services, thus

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[1] O. Hall. op. cit. p.32.
[2] D. Lortie. op. cit. pp.181-188.

achieving prominence in the profession generally, and in the hospital in particular. Likewise, his role will become increasingly distinct with the development of peculiar knowledge and skills, for, as the store of knowledge increases, the necessity for specialization becomes apparent.

As psychiatric teaching is developed on a parity with that of general medical teaching, as a better understanding arises of the role of Psychiatry and of the true nature of mental illness, and as psychiatrists themselves become better trained, so will the new specialty come to be accepted as a full-fledged unit of the medical profession.

Dr. Hughes maintains that "a feature of work behaviour found in one occupation, even a minor or an odd one, will be found in others".[1] It therefore seems fair to assume that, although this is a case study of one institution, it has common validity. The problems faced by Psychiatry, as newly arrived on the medical scene, are not too different from those found in other pioneering professions. The problems and processes met by those working in any new profession, not yet established in its work world, are applicable to other occupations in the whole drama of work; as such they have general relevance to the field of social science.

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[1] E.C. Hughes. "The Sociological Study of Work". p.425.

EPILOGUE

The picture drawn is one of a changing situation and, while the future scene cannot be painted, it seems fitting, in closing, to indicate the form this is likely to take on the basis of the development of earlier sub-specialties within the field of Medicine and other professions within the work world.

The enduring nature of the relationship between Psychiatry and other specialties in Medicine has been revealed in the sympathy and recognition accorded to it from many quarters; the extension of the psycho-somatic approach and the field of preventative medicine; the breakdown of the "body-mind dichotomy"; the realization that psychiatrists are also doctors and the anticipation of improvement in their methods and techniques; the promise of greater understanding through educational publicity, and of greater collaboration among the specialists of the future in the medical school. These are the elements which ensure the survival, and likelihood of a fuller acceptance, of Psychiatry as a specialty.

One psychiatrist said:-

"It is inevitable it will be accepted - ten to fifteen years from now its position will be vastly different ..."

The reason for this "inevitability" is the essential link between Psychiatry and the rest of Medicine - the ultimate impossibility of treating states of mind apart from states of body, or states of body apart from states of mind, which, in the resolution of the age-old dichotomy of mind and matter, has at last begun to be realized. Educational methods and

programmes are, and will be further, unified through bringing the divergent teachings of the many branches of medicine to a better intrinsic understanding of the common root and goal, by focusing on the nature and need of the live person. A great deal of what figures in this education as Psychiatry has to be recognized as common understanding of the problems of man and the physician. As Ebaugh writes:-

"An immense gain for humanity can come from basic cultivation of sharable organized common sense, and a sane and sound grasp on personal and social facts and methods."[1]

For many years Psychiatry was largely preoccupied with humanising the treatment of persons confined in asylums and mental hospitals, a work by no means finished; it has only gradually entered upon the tasks of public enlightenment and prevention and come to offer much in the sphere of human relations. It has contributions to make to man's happiness and security in childhood, in adolescence, in work, in marriage, in sickness and in health. It is a useful tool in sociology and anthropology; it has something to bring to the appreciation of art and literature and to the interpretation of some aspects of philosophy and religion. Through the mental hygiene movement Psychiatry is playing an increasing part in the field of rehabilitation and an important role in big business - if one considers the employability of the individual, and his placement in industry, to be the concern of the whole society.

Co-operation between the psychiatrist and his brothers

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[1] F.G. Ebaugh. op. cit. p.xiv.

in the profession of medicine can lead to such results and is increasing, as Stafford-Clark notes in two illustrations:-

"First, they are far more ready to call him in than their forefathers would have been; second, they themselves and their students are studying the psycho-somatic approach and practising it, in many cases, with profound success."[1]

Those who follow these principles, in whatever field of medicine, are enabled to approach more closely the simple, modest aim of the good doctor ...

"To cure sometimes, to relieve often, to comfort always ..."[2]

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[1] D. Stafford-Clark. op. cit. p.244.
[2] Ibid. p.244.

APPENDIX

Over fifty interviews with doctors were recorded for this research but not all of them are reproduced here; there were several in which the same opinions were expressed, and it was not thought necessary to include such repetitive material.

The form in which the interviews are presented here is not that in which they were given; the statements have been reordered and categorized for purposes of analysis, as explained in the introduction, but their original formulation is unchanged.

PSYCHIATRISTS

INTERVIEW 1

Criticisms of Psychiatry

1. A lot of very poor practice giving rise to justifiable suspicion.

2. A hodge-podge branch - many disagreements.

3. Treatment of mind only - a whole approach to the patient is necessary.

4. Psycho-analysis - cost and length of treatment. No answer to the woes of the world - only applicable to a selected minority - many are too bad for it.
   Clumsiness of analytical terminology.
   But it upsets people who are upset anyway, not those who are aware Psychiatry is trying to produce an answer to some problems.

5. Inadequate short-term therapeutic methods. We have to produce better methods.
   E.C.T. - accusation of sadism on the part of the psychiatrist and masochism on the part of the patient.

6. Publicity - lowering of the dignity of the profession.
   But doctors on the whole are pretty stuffy people anyway; they solidify in medical training and their range becomes limited - it is not a liberalizing experience. And publicity has made people aware of the problem.

7. Psychiatric Department

   (a) Fails to provide emergency services for acute cases - overnight confining facilities are necessary. Psychiatrists are aware of this problem.

   (b) Difficulty of selection: in the case of psychotics they are taken only if they are likely to benefit. 50% of admissions are psychotics, which is higher than previously. We can get them into X... (the mental asylum) so long as we have no closed wards. If we had closed wards we would be full up with chronics. The average stay for patients is six weeks and the maximum three months. A great many have to be protected against their own confusion, as in toxic states.

   (c) Physical isolation - daily contacts are cut down.

Attitudes of other services

The whole idea of Psychiatry has gained ground in the last

four years. In Pediatrics and Medicine there has been general penetration on a broad front; in Gynaecology and Surgery outposts have been established, but the greatest dent has been made in Medicine. The head of Medicine asked for psychiatric instruction for his junior staff so that at least they could recognize psychiatric cases and do "first aid".

Pediatricians identify themselves with, and feel for, the children.

The heads of departments are influential in determining the tone of the department.

We will have to wait for the senior men to "mellow".

Referral

With ward patients there is a tendency to use Psychiatry when they are "on the spot" or can't find an answer, the implication being "you'd better take him over".

With private patients, if the doctor is "enlightened", he refers to a psychiatrist on a consultative basis; if he is not enlightened, Psychiatry is only used in an emergency. If we do take incurable patients we get stuck with them - if we don't we're no good.

Psycho-somatics - Dramatization necessary at first to put the idea over; it is now out as a separate specialty, as was evident at the 1952 meeting of the United States Psychosomatic Society. We are now interested in more than just physical factors alone - there is a change to see the picture as a whole as all Medicine becomes psychosomatic.

INTERVIEW 2

Criticisms of Psychiatry

1. Psycho-analysis.
   They tend to go over backwards and neglect the other side. It is impractical except as a specialized method of treatment but its principles are permeating through Psychiatry and the Social Sciences.

2. Blustering authoritarian approach of some Psychiatrists.

3. Canadian-born psychiatrists are in a minority.

4. Psychiatric terminology is necessary to psychiatrists but is overpushed by them. I found my reports were more acceptable in lay language.

5. Publicity - it is a factor in any new thing. Either the claims were exaggerated or the interpretation on the part of the public was wrong - they tended to endow it with a magic it hasn't got. It was grabbed as a panacea by the public.

6. Emergencies are not answered but they leave it too late.

Other Services

There is a universal insecurity in doctors - they need to be little gods in their own sphere.

Pediatricians are sensitive to the environment of children - in adults the present situation is not so obviously at fault - and are therefore well disposed.

Surgeons can't see a meeting place with Psychiatry. They see dramatic results to a greater extent. But they would like a consultant similar to the psychiatrist on the psycho-somatic service.

Physicians are aware of their own shortcomings and feel threatened when a psychiatrist comes in. There has been a request from Medicine for instruction to the junior staff on prevention, detection and treatment of psychiatric emergencies.

The psycho-somatic approach is pushed by psychiatrists -

it will come by degrees from those who are aware of the psychiatric point of view.

The outlook depends on the Resident.

Referral

The junior staff are pretty good - a half-way house. On the psycho-somatic service referrals are from the out-patient clinic and from other clinics, endocrinology, plastic surgery, etc. There are now many more from the allergy department since they had a new head. On the ward service most referrals are from Medicine. Surgical referrals are mainly post-operatives or acute emergencies. The three-month psychiatric rotation is a disadvantage because it doesn't give us long enough to adjust.

Mental Health Institute

Brings education to the community. It is only a beginning, more is needed.

Mellowing of attitude

1. A liason is provided by the university clinic and by projects like Dr. X's "bridge-gap".
2. More education of the doctors is necessary: it will come through the medical students.
3. It is most important to give education in the fact that we can't give cures. Psychiatry is like the chronic illnesses - asthmatic and cardiac. Few are really cured in a general hospital.

INTERVIEW 3

(Consultant to Gynaecology)

Referrals

They occur in clusters but there are approximately three or four a week and two new patients in the clinic. Private referrals are rare - bad cases only because it is to the doctor's advantage to keep them. There is considerable "dumping" of patients on Psychiatry. On the whole Gunaecologists are well-disposed in attitude, varying with their individual personalities. But there is "lip service" and a certain amount of "subtle rejection" when they just don't refer patients - perhaps because for years they had dealt with psychiatric cases themselves.

Criticisms of Psychiatry

1. A time-consuming business - it takes years to cure a patient.
2. The Department is "closed" - it is difficult to get a patient in and private patients can only be admitted through a psychiatrist.
3. Expensive - patients object to paying $10.00 an hour.
4. Language - it was at one time preoccupied with sex but is not now.

Much of the criticism is superficial, indicating deeper resentment. The attitude of some is "they take my patients away from me", because they see Psychiatry as a threat. The doctor's attitude is reflected in the patient and is sensed on referral when a negative feeling, if present, is transmitted. They are tactfully advised to go and see a "neurologist" and 50% of patients are surprised to find that a psychiatrist doesn't deal exclusively with the insane.

Medical Students

Their attitude varies according to the teaching they are

given and to their own personality. Criticism of Psychiatry to the students from other departments at the University would be inappropriate.

Psycho-somatic service

A medical outdoor rotator was instituted because consultations were not answered quickly enough. In Surgery, when a patient blows up against the doctor, a lot of pre-operative consultations are evident for a while.

Mellowing

It is an evolutionary process which will come with an increase in understanding and with increased indoctrination in the medical school. It is inevitable it will be accepted.

INTERVIEW 4

The doctor's reaction to Psychiatry varies according to his personality and degree of indoctrination. It may be one of:-

(a) fear giving rise to hostility: this occurs mainly in the senior men although some are psychiatrically orientated, or

(b) interest because he himself is philosophically orientated.

Hostility is sometimes justified because bad medicine produces bad feelings; there is no excuse when a perforated gastric ulcer is treated as a hysteric.

Lack of proof

Psychiatry is considered "unscientific" by, for example, neurologists, which is unjustifiable. Psychiatry is like Astronomy - it can't be measured. It is a science of the observation of behaviour and deductions give rise to theory. Critics won't take the trouble to learn our method - they react emotionally.

Fees: are high, but not higher than other services.

Division of schools: is good because it leads to progress. Psychoanalysis is a specialty within a specialty.

Groups

1. Surgeons: the language upsets the older ones, provoking hostility. They are overbearing and push because they feel threatened, varying with the individual. Most opposition comes from them because they are primarily interested in physical disease.

2. Physicians: they realize the importance of psychogenic components because 60% of patients have psychiatric trouble. We have a link with Dermatology too, so they are more understanding.

3. Obstetricians: it is possible the overture will come from them.

4. Pediatricians: a Rotator was sent there.

5. Neurologists: there is sibling rivalry because both of us are treating the brain; it is probably six of one and half a dozen of the other. They know little about etiology therapeutics or diagnosis. Mistakes always lead to recriminations. The head of our Department maintains contact with Neurology but doesn't encourage it.

Medical Students -"all or nothing".

They are naturally anxious about things they cannot understand: it is a difficult subject and therefore they tend to react emotionally. They feel threatened because they can't help psychiatrically. Psychiatry is poorly presented at the University. In their first lectures they get a psycho-biological slant with no psycho-analytic jargon, then they go to the Department for lectures on psycho-analysis which provokes hostility.

The position of Psychiatry will improve with the continued indoctrination of the medical students; it will mellow in the medical school.

INTERVIEW 5

The physicians and the younger men are more favourably disposed towards Psychiatry than surgeons because they are used to dealing with the family as a whole.

The surgical personality is the answer to their attitude. They are the military men of medicine, aggressive, sadistic, men of action: it was Freud who noticed that the little boy who enjoyed cutting off puppy dogs' tails became a surgeon when he grew up. They have an urge to cut to prove their masculinity: they never doubt why they are training to be surgeons - only whether they can get good appointments and make money etc. Their attitude is that Psychiatry is "gilding the lily", since they have done it for so many years themselves. Often an emotional block gives rise to fear and thus to aggression. For instance, one remarked in an elevator: "How are the nuts (patients)?", and another: "What on earth do you want to go into Psychiatry for - a lot of goddam foreigners telling us what to do". They have no reticence. They expect emergencies to be answered at once. I was called in to see a man dying of a bleeding ulcer who wouldn't have an operation. I said: "Why didn't you call me in before?". The patient agreed to have the operation in five minutes because, as he said, "he talked to me differently from other doctors".

Some instances give a boost to Psychiatry but a psychiatrist is not really needed. They use us mainly for cases of hypertension and ulcerative colitis.

They are inhuman in the way they refer to "the appendix, the gall bladder in Ward X". I remember, when I was in medical school, the surgeon conducting the ward round stopped at the bedside of a patient and told us within her hearing: "She may die, she may not, in the operation tomorrow". The woman was so upset I stayed behind to comfort her. I have never forgotten the incident.

They are glad to dispose of "nuisances" if they don't respond to surgery - when they cannot localize aches and pains.

Psychiatric personality

It is largely true that we specialize because of our own problems. There is more self-doubt in the psychiatrist than in any other specialist; this perhaps makes us hostile by way of compensation. But then, too, we encounter so much hostility in our own work and it reappears in our relationships with others.

Our orientation to the patient is very difficult - rather like that of the prostitute to her client. Just because you're a psychiatrist they do just the opposite of what you tell them; a surgeon, on the other hand, can cut off a leg and they will only congratulate him on performing a good operation.

A psychiatrist is more like a T.B. doctor - he can give no promise of cure, only rest and food. He can offer only uncertainty. But, statistically, our success with neurotics is as great as T.B. and cardiac patients.

Isolation

They are more integrated in the X... Hospital than here and doctors are therefore more favourably disposed towards

Psychiatry.

We like to eat alone:

(a) To discuss our problems;

(b) Because we feel unwanted: we are made to feel different and they prefer to keep separate;

(c) We're sensitive - we know they think we're neurotic. They think we are dangerous and have a "lean and hungry" look".

We are divided among ourselves. Small points of disagreement are used in argument as a "football" with which to hit one's opponent. It is childish. We present a confused picture. There would be a closure of the warring schools in the future if there were more people like Dr. X. The personal element is important. There is antagonism towards Dr. A. and Dr. B., for instance, particularly from medical students.

Language: they are upset by non psycho-analysts with a smattering, not a deep knowledge.

Publicity: unfortunate - harm has been done by the confusion of Psychology with Psychiatry. In New York every meeting etc. is psychiatrically orientated: it is over-played.

Psycho-analysis is the answer because it gives insight into the patient's problems - by identifying with the patient, by living through his problems and subjectively interpreting them. It is like a blind person telling his companion what he should be able to see through a telescope. Scientific, objective medical training is a barrier to psycho-analysis because it is a different kind of scientific logic: it draws deductions and hypotheses but of a different quality. It is therefore

easier for a non-medical person to go into psycho-analysis. The American Psycho-analytic Association is a closed shop - perhaps their reaction is only human, having gone through so much training themselves.

Opportunity for Psychiatry

To make the ordinary G.P. and the medical student more aware of the psyche - it is inborn in some but in others it has to be taught. A G.P. must use a "psychiatric opthalmoscope" when investigating trouble. A "bedside manner" is really the same as a psycho-therapeutic approach.

We must teach in layers, according to the degree of psychiatric experience they have had - only superficial to new medical students and surgeons.

The accent should be on the educational, preventive aspects.

INTERVIEW 6

There are about 168 patients referred every six months, from Medicine, asthma, migraine, peptic ulcer and thyroid cases. Patients from the medical wards are:-

1. Crazy, senile or schlerotics, putting a strain on the nurses or disorganizing the ward.
2. Psychotics.
3. Those who, on investigation, are found to have imaginary complaints - gastro-intestinal cases and headaches of psychiatric origin.

Medicine: those I knew personally or who had had psychiatric experience were more understanding and sympathetic.

Junior internes: varying reactions:-

1. Smitten - psychiatry in everything.
2. Sceptics - "the best" - Freud said you want "intelligent sceptics"; they are critically constructive. One interne was pleased when a patient got better after psychiatric treatment.
3. React in the same way as the staffman because of contact with him and use Psychiatry as a "dumping ground".

Staffmen: tend to ask for psychiatric consultations spontaneously or on the prodding of the interne. The older men are not very co-operative because of a lack of psychiatric training in medical school.

Surgery: carries many connotations that deep down we don't like and which upset us. They are sadistic - they will do a gall bladder operation on a schizophrenic, for instance.

One psychiatrist I knew admitted a hostile reaction in not seeing surgical patients when asked to.

The older men make no differentiation between people and are liable to precipitate a psychosis. One admitted: "I take

out lots of normal appendices". One case had bad psychiatric after effects which made him feel guilty; he kept on saying to me: "I didn't know she was that sick, Doc.".

The younger men are more co-operative because we have friends among them: one, for example, admitted his mistake in taking out haemaroids.

In another case the brother of a patient died in hospital after many painful operations. The patient internalized the struggle and suffered from regression. He made a verbal attack on the surgeon and went into mourning for his gall-bladder, the loss of which he identified with that of his brother. We forced him to eat and at first he suffered from diarrhoea etc. because of his inhibitions, but gradually the conflict disappeared. The surgeon was interested in the episode because the psychiatric implications were evident.

Pediatrics: on the whole mirrors the attitude of its chief.

Neurology: in an ivory tower on the hill under "God". They treat many hysterics but it doesn't really matter.

Faults of Psychiatry

1. Language upsets others.

2. Their reluctance to take note of psychogenic factors until recently.
   The answer to the psycho-somatic problem may lie in the province of the medical man with an understanding of Psychiatry: he must be human as well as having insight. To abolish the mind-body dichotomy is a physical exercise.

3. Overplayed to the public.
   They ask: "Where is the miracle we've been promised?" Therefore we tend to choose patients from the group with the best prognosis.

4. Individual personalities of some psychiatrists.
   Dr. X... leaves patients in the ward which, perhaps, is a superficial approach: but, on the other hand, it is better than the extreme and definite approach of some psycho-analysts which provokes hostility.

5. Lack of proof, which is disheartening.
   Sometimes we wonder what the hell are we doing.

The Department is unique: we have a mixture of neurotics, pre-psychotics and psychotics, many of whom would be better in X.... (the mental asylum).

Mellowing

Psychiatry has only been included in the medical course since 1945 and the effects are not yet too apparent.

In 1945 the attitude was: "What the hell?" - "Psychiatry is a lot of nonsense".

In 1953 there is more interest because of the increased proportion in teaching, the highlighting of Psychiatry and the spreading of the gospel by converts.

All doctors must learn to draw the line, to recognize what they can and can't do by common sense Psychiatry.

As you join the allotted club you tend to move apart, but there is the probability of working more together as, for example, junior psychiatrists and surgeons who were former classmates become seniors. The seeds of co-operation are sown in the medical school.

INTERVIEW 7

(Consultant to Surgery)

Surgeons are not very well disposed, particularly the senior men, and some are antogonistic. They have a greater capacity for getting mad - for exploding than all the others. Surgery is easier because there are no variables; it deals with pain, change of appearance and function - things you can put your finger on. Psychiatric complaints are more confusing. There is lack of understanding of mental illness among surgeons. One said:

"I have no trouble with neurotics and don't know why you do; I give them a kick in the pants and never see them again."

Most of them tend to think of patients as weak characters. For example, they had a woman with a broken femur who refused to have an operation because she thought "operation" meant "amputation". I was asked to "see and advise" and changed her attitude in fifteen minutes by explaining that we would get the thing "fixed".

Another time a hysteric had a scratch on his arm and became paralysed. They gave him penicillin, without effect, and then asked for a requisition. The arm was okay after manual stimulation.

They could often treat patients themselves in this sort of way, but incidents like these, which impress them, gave a boost to Psychiatry.

Referral

About two patients a week from the ward - mainly post-operative cases. There was formerly a psychiatric rotator to Surgery

like that in Medicine but, unfortunately, a young interne upset them by using too much psycho-analytic terminology and the rotation was discontinued. They find Psychiatry invaluable when a patient goes "wacky" on the ward or obviously needs commitment, but they like to know the psychiatrist personally and be sure that he's had good general medical and surgical training.

Criticism of Psychiatry

1. Oversold.
2. Some psychiatrists are too enthusiastic and it's a little nauseating.
3. The publicity is resented by the medical profession; they feel it has lowered their dignity.
4. It doesn't rest on an empirical basis: but then it shouldn't necessarily - not entirely.
5. The Head of the Department is discussed informally by the senior men in Medicine. He is aggressive, pushes programmes, advertises meetings on elevators, etc.

There is a fear in Medicine of Psychiatry "swallowing" Medicine.

INTERVIEW 8

(Rotator to the Psycho-Somatic Service)

Approximately ten patients are referred from Medicine to Psychiatry a week. We would like to transfer 10% but it is impossible because of the accommodation question. There is a long waiting list at the Department.

Medicine and Surgery are glad to get rid of patients if diagnosed as psychiatric cases. They are afraid of treating "hysterical stomachs". The complaints of 60% of medical patients are psychiatric in origin. There is not much argument in diagnosis over, for instance, the case of an acute appendix; if it is chronic it is more difficult.

There are "clusters" of antipathy - personal biases - but you get to know the "soft" areas.

Neurology, and its head, are hostile: also the head of Surgery. Surgeons are men of action, of the old school: they have no knowledge of, or interest in, Psychiatry. If we refer to "castration fear" they think it's plain dirty. One young surgeon - indoctrinated in medical school - is kindly disposed.

One of the chiefs of Medicine is hostile to Psychiatry because of personal contrariness and because Psychiatry is a threat to his own work. He maintains that kidney trouble is the root cause of hypertension and won't allow any investigation to be done in that field.

The head of Gynaecology is easygoing and asked for a psychiatric resident to help out.

Hostility - caused by psychiatrists themselves. We stick our necks out. It is because we encounter a lot of hostility in our own work. The Head of the Department is aggressive, enertetic and an eclectic. He pushed Psychiatry - when he came to the hospital it was not represented. He is interested in ability but prefers staff without a pronounced bias.

There are warring schools of thought in Psychiatry which are confused and confusing, and perhaps occasion loss of respect. Hostility will mellow as more doctors become available, costs are lowered, knowledge is increased and more indoctrinated medical students are turned out.

INTERVIEW 9

Psycho-Analysis: Criticisms

1. Results not published except for Glover in England.
2. High fees charged - $25 per hour.
3. Physical methods of treatment used for psychologically-determined illness.
4. Pressure exerted in the Department.
   Fourth year medical students are told: "If you don't get an analysis you must be a neurotic."

There has been a trend towards psycho-analysis, although it has been thrown out in Europe. In English Psychiatry there is greater solidarity, the approach is more conservative and they are not carried by whims; here we are so restless.

Shortcomings of Psychiatry

There is a division between schools and no united front. Psychiatry has been a field in which few have accomplished anything: it has been sterile for a long time because of the field of medical development; there has been no change in twenty years. We have no proof, only clinical impressions; there is no dramatic proof to our statements - unlike a surgeon. We have oversold to the public beyond our abilities: there has been an outcry because of the publicity. The public have become psychologically-minded because of the radio and the press - even a child, when reproved for being naughty, will turn round on his parents and say: "It's not my fault, Mum, it's yours...."

We have to do what the public asks for; the public are told by the psychiatrist they will be cured and are not. 80% is our fault because of the incredible material we give them; the antagonism is to a large extent our own fault. Neurologists have not

interfered with the public; therefore, no one would speak against them, although they have nothing to offer.

We're not very secure as a group: we're overanxious and restless - we can't sit still.

Our language is often out of taste and provokes unnecessary hostility. We have got to do something about it.

Remedies

1. It will burn out with better cures.
2. All psychiatrists should do one year in general practice.
3. Re-education of the public: there is still a stigma attached to mental illness.
4. Research into the physiology and metabolism of the brain - there is an opportunity for biochemists etc. here.

Psychiatry represents no threat to Gynaecology, E.N.T., abdominal surgery, neurosurgery and very little to Medicine as a whole. Other services have nothing to lose by a psychiatric approach - they are glad to get rid of psychopaths and neurotics.

Neurologists - the Head is now prepared to give Psychiatry a chance, but the link with Psychiatry has been cut. There is now no rotation and it is not required for post-graduate exams as in England.

INTERVIEW 10

Criticisms of Psychiatry: Psycho-analysis

1. I have yet to hear a psycho-analyst admit that he can't cure a patient. A lot of their work is unnecessary and unlikely to benefit the patient. They have a tendency not to make a diagnosis. Their cost is high.

   Psycho-analytic concepts shouldn't be given to medical students, who require a wider perspective.

   The publicity given to Psycho-analysis is resented by the eclectic school: it has lowered the dignity of the profession as a whole. It was dragged out too much - but the pendulum is now swinging back. 50% of the medical column in "Time" deals with Psychology. However, it is good in that it gives an awareness of inner life to people.

2. It went too far, but now there is a swing back to a physiological orientation.

   (i) "Psychiatrism" - modern Psychiatry claims to cure all the world's ills.

   (ii) "Psychodamnitis" - patients come complaining of an "Oedipus complex" because they believe what they read.

3. Psychiatrists should keep their mouths shut.

Attitude of other services - varies according to the individual personality type.

Medicine is well disposed because physicians are quiet-thinking on the whole.

Surgeons are not so well disposed because they are intolerant and slapdash.

Gynaecologists are half way: some are like the surgeons, others more favourably disposed.

Neurology: there is a schism due to the blind spots of the heads of the two departments.

The attitude of neurologists varies with the individual, but they are usually introverted, clever, hostile because of fear and, in many cases, are organically orientated before entering Neurology; they explain things in terms of cerebral localization - diagnosis "by exclusion".

The juniors in all services are more enthusiastic.

Suggestions

1. Curbs should be placed on the material written in the Press.
2. Ideally the training desirable for a psychiatrist is a year's general interneship in Gynaecology, Surgery and Medicine equally, a year's interneship in general Medicine or Neurology, six months to a year in a mental hospital and two years in a psychiatric Institute.
3. The usefulness of the Mental Hygiene Units is questionable; the money could be more profitably spent on clinics and hospitals where the charge per hour for salaried psychiatrists would be $5.00 - not $25, as now.

INTERVIEW 11

Attitude of other services

The younger men are more psychiatrically orientated than their chiefs. Hostility is due to the fact that the older men are not trained in Psychiatry and some see it as a threat to the doctor's income - they feel if Psychiatry is right their patients would be taken away.

There is a lack of understanding of Psychiatry: we can't point to figures: the criteria of improvement and cure in Psychiatry is more abstruse than, for example, in pneumonia. It is difficult to prove one school wrong. Medicine deals with more tangible things and one method can be demonstrated as better than another which is eliminated.

Surgeons perform a lot of useless operations.

Physicians should look at their own 'back-yard'; diabetics, epileptics and heart cases are never really cured - no cardiologist ever cured a heart.

There is tremendous individual variation in the attitude of Neurologists towards Psychiatry. On the whole Psychiatry is "frowned on". Our chief refused to start up a department in the neurological building on account of the glory of its name and that of its head. He therefore set up our department independently and it has remained very independent. Real co-operation will have to wait until it is up to the standard of the Neurological. There is very little co-operation between the two and no joint conferences or rounds. No one is on the staff of both - which is at variance with other hospitals; we are kept quite separate. It is felt neurologists should not treat psychiatric cases and vice versa.

Neuro-surgeons are very hostile and anti-Psychiatry.

The chief is ignorant of Psychiatry and refuses to have anything to do with it because of an emotional block. Though disproved by Psychiatry, he believes an I.Q. of 130 can't be insane, which is mere stupidity. However, his attitude is now changing because of the pressure of events: he has been forced into seeing psychiatric implications in cases and for the past two years has engaged a psychiatrist to do research work in the Neurological.

Criticisms of Psychiatry

1. Bad manners - reports on transfers are not forthcoming.
2. Psychiatrists have not been very tactful.
3. Some psycho-analytic concepts upset the doctors.
4. Patients with organic injuries have been cared for in a psychiatric way.
5. Publicity - but patients demand psychiatric attention. The medical profession is notorious in its dislike of advertisement - it doesn't like doctors talking before clubs etc.
6. Psycho-somatics - has been oversold.

Psycho-analysis - is gaining ground and is the backbone of any psychotherapy. In a random sample of people a great percentage could be helped to function more efficiently with an analysis; most patients in the department are unsuitable for psycho-analysis because their intelligence is too low. But, in any case, all psychiatric treatment should be based on an analytic understanding of what is best for the patient.

INTERVIEW 12

The Department is a teaching rather than a curative unit; a preponderance of Dr. X...'s patients is therefore admitted because they are good teaching material. As we are in training we are not just going to bring money into the Department: we're not supposed only to cure patients. We are conscious of our difficulties. Psychiatry doesn't lend itself to a high percentage of cures; as the Head of the Department said:- "Our goals must be limited", and a visiting psychiatrist:- "Let us not delude ourselves as to what we can really do in a psychiatric hospital! My tutor also remarked:- "You must remember you're not God...".

Criticism of Psychiatry

1. It became too popular; it was dramatised by the patient.
2. Admissions are a little distorted - they are not equitably divided - there is a preponderance of the patients of some of the senior men.
3. Because of the pressure of patients "dumped" by G.P!s etc. there is a quick turnover and a reluctance to take in patients; long-term patients are sent to other clinics but there is a bottleneck at the mental hospital.
4. A multiplicity of patients. Equivalent treatment is given to private and public patients, however, and a complete physical examination is always held.

INTERVIEW 13

Criticism of Psychiatry

1. On the whole it has oversold to the public - they have come to expect more than it can give.

2. Individual psychiatrists - some set themselves up in an ivory tower, but there is always a group of pseudo-scientists who jump on the bandwagon and do harm.

3. Psycho-analysis: the pendulum has swung too far which has led to suspicion. They are aware of the hostility: even the head of the department referred to "these Greek myths". Their language and the length and cost of treatment upset people. They are not realistic and are liable to blow a psychosis up. They always have an excuse and profess to have a panacea for psychiatric ills but cannot begin to apply this to the patient therapeutically. They are aware of this themselves but feel that they are doing experimental work, learning and teaching psycho-pathology. Their contribution is theoretical - a framework upon which we can build.

4. The Department.

   (a) There is too great a pressure to get patients in and out, therefore treatment is inadequate.

   (b) Patients can refuse treatment and walk out, which creates a problem and anxiety to the staff. It should be restricted to neurotics, because psychotics are not in a position to choose whether or not they are fit to go.

   (c) It is designed for the treatment of psycho-neurotics but psychotics are admitted. They really need better security but it is difficult to get a patient into A... (the mental hospital). If they are Roman Catholic they are sent to B... but get no treatment there and are left to vegetate.

Attitude of other services

1. Some patients "dumped".

2. Influence of heads of departments - they are semi-deified; how many young graduates really think for themselves?

Surgery: their appeal is to the dramatic, to the cut and dried, to proof; this is their romantic ideal. Their attitude is one of intelligent acceptance but emotional opposition, of resentment because of suspicion and lack of knowledge. It is less in the

junior men.

Criticism of attitude

The rest of medicine should examine its own back yard. 50% of surgery is supportive - they relieve obstruction, carcinoma, etc.; cardiologists support, not cure, hearts, as do the psychiatrists with emotional disturbances; arthritics and T.B. patients are not cured. Psychiatry doesn't give a cure either, except for most depressives and some schizophrenics.

Their attitude will mellow as our methods and techniques improve.

Suggestions

1. Post-graduate training should include a thorough grounding in internal medicine and neurology.
2. Provision of psychiatric care by the Federal Government, not private practitioners. Private psychiatric care is financially prohibitive and inadequate in the whole of Canada.
3. An increase in mental health and child guidance clinics etc.
4. There is a great demand for dynamically-orientated psychiatrists.

INTERVIEW 14

(Consultant to Surgery)

Referrals from Surgery

Formerly 2 per week; since a change in the interne staff in July only 1 per month. Opposition is due to the traditional training of the older men and the 50% of patients referred is due to pressure from the junior men. However, if they were strictly honest, they would have to refer to a much greater extent, since 50% - 90% of all illness has a psychiatric basis. I get referrals only from good friends I know personally or whose friends I've successfully treated; if they don't know me and refer it is because they have a patient they want to get rid of. For example, a surgeon, who had been unsuccessfully treating a case of ulcerative colitis for five years, confessed to being stuck and smilingly said: "I just want to dump her on you, old man". But if I do something I represent a threat and if I don't I'm no good.

The pre-operatives are referred to get rid of them, to "get him off our hands" or, in the case of an alcoholic, to see how he'll respond to psychiatric treatment. The post-operatives are mainly alcoholics or D.T. cases. They use an emergency call as a way of getting rid of a patient; for instance, I had a telephone call: "Come quickly, I've a raving lunatic on my hands and I want to get rid of him". But on the whole we are the last resort; they come to Psychiatry with a big file from all the other departments.

Criticism of Psychiatry

1. Bad diagnosis ("neurosis with mestasices").
   George Gershwin died of a brain tumour after being treated for a year by a psycho-analyst, for instance.

2. So many schools of thought.

3. Terminology: they are getting more used to it and often turn it into a joke - they say: "His patient is upset - he's in love with his mother".

4. The great demand for Psychiatry is unfortunate. Psychiatry has suffered from the suspicion of being a "quack" profession. A friend of mine went down to Florida for two weeks and made enough money as a Marriage Counsellor to pay for his holiday. But the patients are appreciative. One said: "Isn't it wonderful to be able to do so much without touching me?".

5. They are always joking about the fact that we are "cracked". Sometimes we surprise them - one once said to me: "You look normal and your'e a psychiatrist!". They are right - we are queer, but then E.N.T. men are deaf, cardiologists die of heart failure and obstetricians never get pregnant!

6. Teaching methods - there must be an improvement. The reaction to Psychiatry in the medical school is "all or nothing".

Psycho-analysis

An analytically-orientated psychotherapy, making use of the lessons used in class Psychiatry is necessary. I haven't seen a really competent psycho-therapist; shock treatment is dramatic.

Hostility to Psychiatry

Those most hostile have psychiatric problems of their own. Or else they see Psychiatry as a threat to their economic position. Their attitude will mellow as they are educated to realize that Psychiatry is not a threat. The answer lies in the fact that the older men have had poor training in Psychiatry, know little about it and feel it is a threat. It will be all right when psychiatrists can show they are working for not agin them. The attitude towards Psychiatry has mellowed, especially in the younger people and undoubtedly will ... it is inevitable... it has got to come. Ten to fifteen years from now the position will be very different. But psychiatrists must go out and work honestly. Doctors can do psycho-therapy; they should do more and would do more if they understood it.

INTERVIEW 15

The Department: unique position, not general to others. The Head is ambitious; in ten years he has really done something and must be given full credit for it, but many feel he has oversold Psychiatry - we should not promise too much. He is afraid of contacts because of his personality, which keeps people at arm's length, and this affects the whole Department; it contributes to our isolation.

The hospitalization question is difficult. Neurotics don't require hospitilization and therefore nearly all our patients are Psychotics because the others won't come in. These bad cases limit the number of our cures and, again, it doesn't work very well because the wards are not separate.

Psycho-analysis

The cost and length of treatment Freud, himself, admitted was "too bad". It is true the only way to shorten an analysis is to unprove it. It is a drop in the ocean as far as meeting the problem of neurosis is concerned, but it allows us to penetrate in short-term methods. In selective interview tests for army candidates we did better than the others who had no psycho-analytic procedure. The psycho-analytic approach is not necessarily a method of treatment but a way of looking at things. The Head of the Department recently came round to psycho-analysis and adopted a more liberal attitude. For two years he has allowed psycho-analytic teaching to the post-graduate students - brought up by teachers who were no analysts. With very few exceptions, they come round to an analytical viewpoint, a psycho-pathalogical frame of reference which is most gratifying. However, the danger is that if it

is stressed too much they become disappointed because they can't give their patients an analysis.

Insecurity of psychiatrists: this occurs particularly among the young ones who, like the young surgeons and gynaecologists, take on cases beyond them - especially here because there are not enough analysts.

The Press is in closer contact with Medicine than Psychiatry. The pressure from the patient ("We want to see a psychiatrist") is sound. The publicity given to Psychiatry is resented by the doctors because they think they will lose a patient and the money factor is significant. Their fear is irrational, however, because there is a need for psychiatrists in Montreal - we don't know what to do with patients.

Jargon: it is not wise to use big words if you can use small ones. Everyone knows a little psychiatric jargon - no one will dispute that of Gynaecology or Surgery but everyone is an expert when it comes to discussing Psychiatry.

Diagnoses are only labels, and mistaken ones occur in every specialty.

The expectation of dramatic cures in Psychiatry is due to a lack of education. Doctors like to see the dramatic and, consequently, the "push-button" psychiatrist is rated highly by some. There is an emphasis on Medicine as a science rather than art, but this has reached a turning point and the stress is on the individual, rather than the emphasis on the disease. There is an adoration of Medicine as a science in the city; few teach the art of Medicine; there are few lectures on the "bedside manner". A combined approach would be better. But Psychiatry will come

into its own.

The attitude of the doctors towards Psychiatry varies according to age, and there is some emotional hostility. The older generation have had very little contact with Psychiatry and don't know what it means. For example, in a lecture to general practitioners on a refresher course at the hospital, one asked: "Do people still believe in a certain fellow called Freud?". Some physicians also provoke the annoyance of psychiatrists. On a joint ward round their interest is in the disease and not the patient; in most organic cases they disregard the human being and discuss the prognosis etc. - our aspects are not considered. The older ones - those over forty-five - are sceptical but pressure is exerted on them from below, by the younger men.

An overture from both sides - from the psychiatrists and the other specialists, is necessary. Inter-disciplinary group research meetings further the cause and the two fields meet in psycho-somatic medicine.

SURGEONS

INTERVIEW 16

Criticisms of Psychiatry

1. They are queer types - but we have our "crack-pots" in Surgery too.

2. I like to know the man I refer a patient to - I must know him personally. Some do more harm than good.

3. The psychiatric unit is isolated; they dont mix - with a few exceptions. They have got to cultivate the surgeons - it must come from them at an informal level, by more discussions etc.

The surgical personality

We are inclined to be intolerant, dogmatic, cut and dried, to hold fixed views and make snap judgements. Operating is fun.

We do not appreciate the limits of Psychiatry, where it stops and starts; we expect results and don't understand when they can't offer us cures. We expect too much but they, in turn, are responsible for too much of a lag. A consultation over an epileptic, for example, must be answered quickly. We must keep the patients moving; we can't keep them waiting for a psychiatric consultation for three days. If we get a crazy person we like to refer him to a psychiatrist after first ruling out any organic possibilities.

Psychiatry is a younger subject which is getting more important in our way of life. There has been an improvement in attitude towards it since the department opened and therefore the publicity given to it is okay.

A psycho-therapeutic approach is good, but is inadequate to deal with the real psychiatric cases. We would welcome a psychiatric rotator to Surgery. There are too many odd people around - nuttier than fruit cakes!

INTERVIEW 17

Criticisms of Psychiatry

1. They won't give a diagnosis and their reports are still very nebulous. They could classify and predict behaviour, but don't.

2. Their attitude and behaviour is provocative.

3. It is overplayed at the University.

4. They won't handle any case.

5. They could become more integrated; it is better not to have too many divisions.

6. They speak a different terminology.

   When I'm going to cut something out I tell them. They use long, fancy words when nice, plain, simple ones would do. At one meeting the allergists and psychiatrists didn't understand each other at all. Their language is a cover up for feelings of inadequacy and insecurity.

7. On a few with their feet on the ground do a good job; the patient is handled better by the surgeon. However, psychiatrists can help - mainly in ulcerative colitis. Education, as to their problems, is necessary.

INTERVIEW 18

Criticisms of Psychiatry

1. Over-emphasis in university teaching.

2. Neglect of acute cases; they are unwilling to drop what they are doing for an emergency.

3. Opinion divided; the interpretation and treatment vary with the individual psychiatrist.

4. Cost: psychiatrists charge every time they see a patient.

5. Publicity: doctors are more amused by it than anything else.

6. The patient undergoing psychiatric treatment is stigmatised.

7. Local resentment: the Department is only part of the hospital from an administrative point of view. Its position is strong and it is used in the hospital more than in many other places.

8. Unsatisfactory - not very helpful in our type of patient. The psychiatrist doesn't know the technical aspect or prognosis; the surgeon is therefore better qualified to do Psychiatry. We deal with the organic and Psychiatry is not much help as far as that is concerned and little help with regard to requisitions.

Referral

Four to five patients a month, mainly alcoholics, drug-psychoses and senile psychotics.

The house staff are over-enthusiastic to refer: it is unnecessary.

INTERVIEW 19

Criticisms of Psychiatry

1. They are inclined to categorize people as misfits of greater or lesser degree; 60,000 recruits were rejected on psychiatric grounds alone from the U.S. army last year.

2. It has its place as a specialty but, like so many other things, is in danger of going too far.

3. Publicity: it was overpublicized in the press and magazines but psychiatrists couldn't have helped it and the stigma to mental illness has now pretty well disappeared.

Improvement of position with:-

1. Development of methods and techniques.

2. Reduction of time consumption on the part of Psychiatry to a practical degree.

It is popular and its establishment is welcome; it is wonderful to have it available if needed. In treatment, medical, surgical, psychiatric therapy - each must be used when appropriate. There are psychiatric overtones in ulcers, for instance, when therapy relieves pain.

Referral

The post-operative cases are usually psychotic, the pre-operative anxiety cases.

The staffmen are suspicious - in a "rut" - the juniors more psychiatrically-conscious. No pressure is required to refer because we don't like having to contend with psychiatric patients, even anxieties, and particularly public patients. But Psychiatry is costly for private patients.

INTERVIEW 20

Referral

The extreme cases, in particular, are referred and we rarely come across the others. I refer to anyone - mainly the "classical" psychiatrists, but sometimes the personal touch is important. The juniors are more enthusiastic.

Everyone is keenly aware of Psychiatry, because many patients with physical impairment require help in adjusting. (Invalids needing prolonged care have to become re-established in the world). In ulcerative colitis the dividing line is narrow. The monthly meeting on cleft palates includes a psychiatrist as a member of the team.

Psychiatry is imperative; any doctor can give psychiatric help but cannot replace the specialist psychiatrist. Psychiatric help is very important. For example, a psychiatrist was called in to see a patient with cut wrists in the out-patient clinic, and helped him considerably.

The publicity given to Psychiatry in the press was unfortunate and committees could be set up to control this.

INTERVIEW 21

Surgeons

We're a very peculiar branch, more unstable and psychological than the rest of the profession, aggressive and sadistic because of the nature of our work. The personal responsibility entailed gives rise to tension and guilt feelings. We cut out a stomach and then, if the patient dies, we say to ourselves: "What did I do? .... I killed him .... I might have saved him". We can't afford to be sympathetic; our stock-in-trade is to get the patient better. We treat, we try to find out what is wrong; if he's deformed or injured we do what's necessary. If we meet with no success we conclude the patient is neurotic and say "to hell with him"....

Relation to Psychiatry

90% of surgeons hate Psychiatry and psychiatrists because of an initial distrust of the whole basis, the ambiguity of Psychiatry and the large number of times it has fallen down. Organic complaints have been treated as functional complaints, for instance, tetanus as catatonic schizophrenia. We don't think of Psychiatry as a live member of the medical profession; it's not exactly a medical specialty because it deals with the mind - it is so intangible. Sometimes we pick out an appendix when we're not sure about it and it ought to be seen by a psychiatrist. I don't mind referring but others don't like to admit to themselves that there is a psychiatric reason and, in any case, the psychiatrists may be wrong.

We have no common ground with psychiatrists. They don't understand about Surgery and vice versa. We don't get along; we

speak the same language,and their Freudian terminology upsets us. There is also a fear of psychiatrists - a fear of being analysed by them, so we avoid them like the plague. Of course everyone has the sneaking feeling that something is wrong with him.

Criticisms of Psychiatry

1. Warfare - they haven't settled their own controversies.

2. Psychiatrists are nuts - very unbalanced individuals. Look at Dr. X... - he's as crazy as hell. They contain more mentally sick individuals than in any other field. They go into it to cure themselves.

3. Psychiatric jargon is so goddam complicated; we read their reports with amusement. Mental conditions are described in such a complicated way - as funny as hell. I didn't even know half the things except for a Roischach.

4. Isolation from the rest of the hospital, physical and otherwise. They are a contiguous, not an integrated unit; everyone stays away from them - even at dinner they sit apart.

5. Psychiatry is superfluous. We have no time for psychiatrists - they get on the surgeons' nerves. The surgeon is the authority in the situation pertaining to an operation and the patient wants to speak to the man who's going to do the job, and for him to say, "you'll be okay".

Attitude towards Psychiatry varies with the service, the time of graduation and the home background. The younger men are not as opposed because of their psychiatric teaching in medical school; all internes are more psychiatrically orientated. The tone is set by the head of the department, however, and surgeons are inclined to be scornful because of an "identification with my chief".

Physicians are more concerned with the patient as a whole; they can't do as much for the patient - often only offer a good deal of support and therefore have more use for Psychiatry.

Publicity is good because it is educating the public. They have accepted Psychiatry more than the doctors, but there will be a mellowing with the general integration of Psychiatry into the scheme of things. So many patients have psychiatric difficulties; psychiatrists have too much to do and no time; more of them are needed. Their techniques and cures are as adequate as anywhere. The solution lies in the education of surgeons and medical men to understand psychiatrists and to help them in the job of communication and referral.

In medical school a small percentage of students are fascinated by Psychiatry, a small percentage are upset and shocked because of a strong religious background and react violently. A large percentage study it, joke at the bizarre and don't take it very seriously. If they could meet their psychiatric teacher individually in their first year and discuss their problems it would create a bond and help them to relax and be less tense about the subject.

PHYSICIANS

INTERVIEW 22

Criticisms of Psychiatry

1. Most medical doctors feel Psychiatry rarely adds anything to the patient. But then it often can't offer anything.

2. Some psychiatrists are disturbed but the best ones are normal.

Referrals

Usually depend on the knowledge of the interne. There is reluctance to call for advice over private patients because of ignorance. The older men are ignorant of what Psychiatry has to offer. Just because E.C.T. doesn't offer a permanent cure, they think it's not worth trying. The dermatologists may concede that a skin condition is psychiatric in origin but they say: "So what! ... you still have to treat the complaint dermatologically".

Psychiatry is here to stay. The general attitude towards it will mellow as it comes to offer more; as there is an increase in knowledge, particularly within the psychosomatic field, and as there are more psychiatrists. Some young physicians don't refer to Psychiatry now because they can't: there are not enough psychiatrists to deal with all their cases.

INTERVIEW 23

Attitude of other services

Physicians are psychiatrically orientated: also the internes in all services. The staff members hold it in horror and Psychiatry is the last, not the first, resort.

Surgeons are only aware of the psychiatric history after an operation.

Pediatricians are well disposed.

Psycho-analysis is hopelessly impractical because of the time and expense involved. It is only applicable in 5% of psychiatric cases but it has its place, though small.

Psychiatry is in the same boat as the law of the land; it has the job of pulling teeth. In the city, socially, they are twenty years behind; psychotics are allowed to run loose if they are not overtly dangerous, instead of being committed.

They are overworked in the psychiatric department.

INTERVIEW 24

Criticisms of Psychiatry

1. Unconvincing except for E.C.T.
2. Never any beds in the Department.
3. Oversimplification from the psychiatric side - a duodenal ulcer, for example.

Medical people were so put off by quacks and osteopaths, etc. in the past that it makes us cautious in our approach to Psychiatry. Many are scared and their antagonism is a defence. Their attitude will mellow. There is a demand for psycho-analysis and the younger men are psychiatrically-orientated. The publicity is good because now more people are prepared to see a psychiatrist.

I had to do three months in the psychiatric department but now I'm glad. However, I would only use Psychiatry as an extreme measure.

(Apparently this physician asked a psychiatrist: "Are you still in that mad-house?")

INTERVIEW 25

Criticisms of psychiatry

1. Does patients little good - it goes so far and then stops.
2. Lack of proof for diagnosis: can offer no cure except E.C.T. and insulin.
3. Language: at first it was used to impress but, now that it is not so new, it is less offensive.
4. Psychiatrists should have general training in internal medicine and not just psycho-somatics.
5. Their cause would be furthered if they were united among themselves.

The younger men are well disposed towards Psychiatry and influence the older men, who feel that it is a reflection on their reputation not to be able to deal with psychiatric cases themselves. Their attitude will mellow as Psychiatry develops newer techniques; it has a wide field of therapy. The public's interest is being followed by medical people.

I would refer patients, if necessary, but would want to know the psychiatrist personally first.

INTERVIEW 26

Criticisms of Psychiatry

1. Felt to be unscientific by the older men.
   In the out-patient clinic one day, for example, a psychiatrist said that the swollen right hand of one woman was a symbol of guilt for illegitimate pregnancy, an interpretation which profoundly shocked the staff doctor.

2. Indiscretion of psychiatrists, undermining our respect.
   But in Psychiatry, as in every profession, some are brilliant and some are fools and only some leave a bad taste in the mouth.

3. The young ones are over-enthusiastic; they go all overboard and accentuate things; they forget that physicians and surgeons are not fired so easily.

4. Smugness of psychiatrists: they make you feel they are a world apart. When we were in medical school the cigarette-holders of the psychiatric internes made us feel inferior and consequently hostile.

5. They place a stress on mind instead of trying to close the body-mind dichotomy.

6. Psychiatric hypotheses are hard to understand.

The possibilities of Psychiatry are immense, but psychotherapy has produced no startling results in the medical ward as yet. It is not as applicable to surgical patients. Psychosomatics will close the gap but psychiatrists should do internal medicine too.

Referrals

These vary according to the age of the doctor but there are more every day, even among the older men. Patients are usually referred too late - not at the optimum time for Psychiatry. I and my friends feel that, unless it is a "nuisance" case, common sense can cope with superficial therapy.

INTERVIEW 27

Criticisms of Psychiatry

1. Too much time is devoted to it in the medical curriculum.

2. Psychiatric consultations are difficult.

3. Poor patients are neglected; I have yet to see a public treatment by a psychiatrist.

4. I have yet to see any good results, despite their "palace on the hill" and the immense amount of money at their disposal. Insulin and E.C.T. are their best contribution, but for every person they help (and even these are questionable) I have seen many who have been harmed.

5. Abnormality of nearly all psychiatrists.

6. Terminology is veiled, but in this it is like all specialties.

7. Length of treatment.
   On enquiring as to whether he had improved after five years of psycho-analytic treatment a patient was told: "It's too early to tell yet"!

8. Publicity could have been controlled or could be directed into useful channels.

Psychiatry has as yet nothing to offer; it should restrict itself to psychotics. The best kind of Psychiatry is done by the ordinary doctor. It is used by endocrinologists for the sake of completeness, because the importance of the emotional factor is still obscure.

Psychiatry has a role to play in big business.

INTERVIEW 28

Criticisms of Psychiatry

1. Cost and length of treatment; a shorter method of therapy is required - they may or may not get it.

2. Little time for public patients.

3. The results produced are very small at the moment. They take on things they can't handle; I have yet to see them help anyone. Some patients get worse - they give them a lot more things to worry about.

4. Their reports are numerous, their diagnoses inadequate.

5. It has been pushed a little too far; it has swung too far but there will be a swing back; some of the saner psychiatrists agree.

6. Some psychiatrists are fools - there are people of all grades.

Referrals

Six to eight patients a month are referred from the ward. We want to know the psychiatrist before referring private patients. The juniors exert pressure on the staffmen; they are too keen to refer because as students they were told, for instance, that 40% of all skin problems should be treated psychiatrically.

Psychiatry will settle down like all new specialties; there are places where it fits in very nicely.

INTERVIEW 29

Criticisms of Psychiatry

1. There are few well-trained psychiatrists, which has caused a lot of mischief. They have promised more than they could achieve which has been the greatest disservice rendered to Psychiatry.

2. Psychiatric terminology is overdone. Psychiatrists have a complex because they are a persecuted minority and it makes them aggressive.

3. Psychiatric techniques can do an awful lot of harm. Psychiatrists can make neuroses worse than anyone else and a psychosis to jump out of the window.

4. Publicity has lowered the dignity of the whole medical profession.

5. Foreign blood in Psychiatry is disliked by many.

It all boils down to a question of time and psychiatrists have none. Naturally, too, they like to do the things they are interested in. It is a difficult specialty. As yet it hasn't changed the scene of medicine. There will be no improvement in its position until the methods are better. Psycho-analysis is the only good technique but it must be made shorter.

Every doctor has a chance to do good psychiatric work but, because of pressure of time, less Psychiatry is being done except by a few with insight. Hostility towards Psychiatry is due to personal factors and problems in the individual doctor.

Psychiatrists annoy dermatologists by going all overboard. The relative merit of various factors in skin disease is unknown but, in excema for example, because the pattern was repeated, they said the primary cause must always be psychiatric. But there is no ergo causation.

OBSTETRICIANS & GYNAECOLOGISTS

INTERVIEW 30

Criticisms of Psychiatry

1. Emergencies are not answered: it's our chief "beef" - many times when we want a psychiatrist we want him in a hurry. It is nice to have a psychiatrist when you can get him.

2. In the majority psychiatrists are a buch of queers; but when met on a shoulder to shoulder basis we found they were wonderful people - on their feet.

3. They give us detailed histories but don't tell us anything; they claim to treat the patient as a whole but often don't. They try to put everything on a functional basis, as we are guilty of putting everything on an organic basis. In Psychiatry, as in Medicine and Surgery, a psycho-somatic approach is needed.

4. Publicity. This has lowered the dignity of Psychiatry and other branches of Medicine; the promised service is not being given. In one way, however, it is good because it is true a lot of diseases are functional and not organic.

5. Medical students are soured by their teachers in psycho-analysis; only a minority are pro-Psychiatry.

6. An increase in psychiatric facilities is badly needed. Psychiatry will then be of more use and the attitude towards it will mellow.

Referral

One per month on an average to the Department generally, but usually through the psychiatric consultant. Gynaecology is well disposed as a body because of the influence of the head of our Department. We are aware of the psyche and of function because we use a lot of medical, as opposed to surgical, treatment.

Psychiatry is on a firm basis - but it will make no more inroads into Medicine.

INTERVIEW 31

Criticisms of Psychiatry

1. It is overplayed at the University; medical students think it has an equal place with the other specialties. They will soon find out what a waste of time it is when they miss the odd gall-bladder in general practice. General practitioners should be able to deal with psychiatric cases.

2. It does more harm than good and causes fixation in patients; minor aberrations become magnified and mountains are made out of mole hills.

3. Physical examinations are lacking.

4. Psycho-analysis is damned tripe.

5. Publicity could have been controlled. Education to an awareness of the problem is necessary, but it has gone to extremes. The public are now mentally- health conscious and must have reassurance. The more they understand the greater the phobia.developed; it is like the cancer drive. Psychiatry should be eliminated from Medicine because it is running a racket; the medical profession generally is running a racket. Psychiatry is now a cult, but will assume a proper perspective. It has its place - busy specialists can't give the intensive treatment required by psychotics. Most of us don't have time to deal with extreme cases.

Referrals

Private patients are referred to the psychiatric consultant, ward patients (about three or four a year) to the Department generally. We get a number of psycho-neuroses and an occasional psychotic. I would want to know the psychiatrist before referring and evaluate his approach towards the patient - there are few sane ones.

Gynaecological personality

Dealing exclusively with women, infinite patience and handling of the patient's emotional side is required. Some feminine vagaries are beyond the realm of decency. Women resent too great a delving into their emotional problems; you have to

assume an understanding and a pose. If you sit back and let it come the flood gates will inevitably burst. Many of the juniors get into hot water by pursuing a psychiatric approach - they make the women break down.

The gynaecologist is a cross between the general practitioner and the surgeon, but he must be more understanding. I echo the words you will hear from the others.

Surgeons have gone too far in their attitude towards Psychiatry, but the surgical internist is more guarded. They have had their troubles too - surgical patients were mistreated in a number of instances by psychiatrists, which annoyed and upset them. Inflammatory processes, tumour growths, constriction of scars, healing of bone can't be treated by psychiatric measures, only surgical.

Criticism of their operations being unnecessary is valid only outside the medical teaching centres and in the States. The honesty of the surgeons is higher here. Psychiatry can't <u>prove</u> that the operations are unnecessary but in the future it will possibly replace those performed for functional disorders.

The attitude of the minor specialties, E.N.T., Anaesthetiology, Dermatology etc., towards Psychiatry is to blow it off.

INTERVIEW 32

Criticism of Psychiatry

1. Patients are "passed on" - bad feet to Orthopaedics, bad backs to Medicine, etc. They won't see them and send them back. I referred a committable woman and was told "We don't see that sort of patient". I was mad because, in my opinion, she could have been treated psychiatrically.

2. They don't do a physical examination.

Sympathy

1. It is such a different thing from all other branches of Medicine - you can't see a mind or cut it up.

2. The Yanks played it up in psychological movies etc., but publicity is good if it educates the public.

3. The city lacks a psychiatric hospital which would put up the prestige of psychiatrists. I feel sorry for those guys - they'll get it some day, I hope.

In Gynaecology, unlike other services, there are more cures than alleviations. 60% of patients have a functional basis to their complaints in general practice, but the psychogenic factors may be overlooked. Most gynaecological disease has a psychogenic overlay, but it is taken care of so it doesn't really matter.

Psychiatry represents no threat to Gynaecology. It is a specialized branch of Medicine but I do superficial Psychiatry myself.

INTERVIEW 33

Criticisms of Psychiatry

1. They suffer from being an isolated unit - as do we. Rubbing elbows at an informal level has a serious reflection on what is done during the day. If we had lunch with them every day they would get more referrals but they eat in their own corner.

2. Perceived as a whole psychiatrists are rather odd in appearance, because they are dealing with things they can't understand and therefore become preoccupied with their business. They are referred to as "nuts", which is only a joke, but they do tend to be a little odd.

3. Psycho-analysis is mystic. I would never send a patient to a psycho-analyst.

4. Their terminology is not too clear but is necessary by reason of the complexity of their work. In a history report from them I don't get it all, but that is my fault. We don't understand their terminology because of our own inadequacies and disinterestedness; they are not guilty. Their terms of reference are part of their business. Our reports are short - a woman is either pregnant or not pregnant - but they can't state their cases as briefly.

Sympathy

1. They are working in a tough field and are the butt of many jokes, which are not taken seriously however. They are compromised in absurd positions because of the actions of their patients.

2. Emergencies are answered well if the patient goes off the deep end, but facilities won't allow Psychiatry to keep them in the Department. This is the gynaecologists' "gripe".

3. Mental disorders and diseases are serious; there are more tied up in mental institutions than in any other. Every effort is required to make the mentally ill useful members of society.

Attitude of other services

Physicians: Quiet and reserved, more used to prolonged treatment and therefore more patient.

Surgeons: Loud and boisterous. If there is an appendix they cut and cure in an hour. Gynaecologists are the same. We don't understand how a treatment can take six months because we deal quickly and successfully with patients. This leads to shortness of patience with

Psychiatry. The group orientation and personality is influential in determining the attitude of the doctor towards Psychiatry, but individuals override the group.

Referrals

Psychiatric treatment is difficult - we don't have to send them over there to tell whether or not a woman is crazy. Psychiatry is used as a last stand because the patient is unwilling to go. Most doctors concede that, if referred sooner, psychiatrists would have a better chance. But we have treated several older women - acute alcoholics - very successfully ourselves.

The younger men are psychiatrically-conscious; they explain everything away by Psychiatry, which is irritating. They tend to label psychiatric cases too soon, which is not necessarily bad because psychiatrists are doctors too, but it is a source of annoyance that they tend to put pressure on the staffmen, who want to find out if there is a physical source before referring.

Public patients are referred to the Department but, if the patient is close to me, I would want to know the specific psychiatrist, because there is a big foreign element and private patients prefer to go to one of their own kind.

Suggested remedies to improve the position of Psychiatry

1. Propaganda to remove the stigma to the patient and to show that the psychiatrist is a doctor too.

2. Increase in the number of psychiatrists and their facilities.

3. The profession at large will become psychiatrically-conscious through the increased teaching of Psychiatry. In the length of time between medical school and specialization, the psychiatric knowledge learned becomes foggy - the doctor's character is moulded into that of a surgeon, for instance, during his post-graduate work. Therefore an increase in psychiatric teaching won't make much difference to the

position of Psychiatry at the time of graduation except that more will specialize in Psychiatry.

4. As its techniques improve, so will the status of Psychiatry. No doubt, when they produce the goods, when they can say: "We can get these patients better", they will get recognition. Apart from E.C.T. they haven't reduced illness on the average. Despite the publicity the number of psychiatric beds hasn't been reduced.

They are doing <u>some</u> good now and are encouraged. I, personally, hope they will do more. Doctors are pretty sober in evaluating the benefits of certain techniques and have faith in the hospital administration for expanding psychiatric facilities and the trend to develop even better ones.

The majority respect psychiatrists - they are fine fellows.

NEUROLOGISTS

INTERVIEW 34

Criticisms of Psychiatry

1. Warring schools.

2. Well established convictions.
   Some claims are justified, others excessive. Proof is often based on one case, not the average.

3. Its foundations are less sure than those, for example, of Surgery. They are unable to use the same measures of weight as other fields.

4. Psycho-analysts are extreme; referral is mainly to the eclectics.

5. Long waiting list for admittance to, and at the expense of, the Department.
   This is unavoidable, but hesitation before referral is only practical politics for the patient.

There is little readiness to use Psychiatry in Neurology. Much of the antipathy is personal; there are some prejudices, some logical grievances.

Medical men want proof of <u>cure</u>. This would legitimise the position of Psychiatry. However, there will be a mellowing of attitude with the gradual recognition of mental illness and the effect of medical training in Psychiatry - as doctors realize that Psychiatry doesn't represent a threat. The younger men are more aware of mental illness.

INTERVIEW 35

Attitude of various groups towards Psychiatry

The internes and residents are most tolerant and broad-minded. The junior staff is more detached; the senior staff is most detached and intolerant.

Individual surgeons are above board and forthright. At all levels there is a tendency to individualize. The relationship of Psychiatry and Neurology is one of sibling rivalry.

The personal element is most important in referral; one gets to know the "easy" people. The personality of the individual and the degree of sophistication in his own and allied fields determines his attitude towards Psychiatry. Many think they can make a psychiatric diagnosis and it is therefore unnecessary to refer. Referral is also conditioned by the help one gets from one's colleagues. For instance, it's no good asking Dr. A..... - he wouldn't help us.

The psychiatrists have the job of sawing wood; let the wood pile speak for itself.

INTERVIEW 36

I am prejudiced because of the man I worked under at Harvard.

There is an old saying that neurologists will only succeed in Montreal if they practice Psychiatry, and it is therefore useful at the moment as a stop gap.

Psychiatry has no place - no answer. They know nothing and will disintegrate as neurologists take over their work and as the organic cause of disease is discovered.

PEDIATRICIAN

INTERVIEW 37

Attitude of other services towards Psychiatry

Surgeons are individualistic and not so well disposed towards Psychiatry. Their attitude is one of rationalization - it wasn't my fault.

There is a distinct cleavage between Neurology and Psychiatry. At first, and to the present day in some hospitals, there were only neuro-psychiatric departments, which were mainly neurological. With the division, therefore, neurologists feel their services are being taken away, and psychiatrists find neurologists doing Psychiatry, which has resulted in this cleavage.

Pediatricians became psychiatrists before we knew the meaning of the word; we knew a child could suffer from "motheritis", and that its behaviour was closely connected with the family situation, but we didn't appreciate the concepts of rejection and over-protection and the importance of the parents' own personality and background until the psychiatrists showed us the way.

We have to understand the real or imaginary illness of children in terms of the family situation, therefore we must have a psychiatric orientation. We can't get on without a training or self-training in relationships - otherwise we are not doing good pediatric work.

Many pediatricians are small in stature and of a mild and gentle disposition.

ANNUAL TABLE OF TRANSFERS

To Psychiatry from:-			From Psychiatry to:-
Medicine	A (General)	23	3
"	B "	3	1
"	C (Metabolism)	2	
"	D (Dermatology)	1	
"	E (Endocrinology)	2	
Surgery		15	9
Neurology		6	4
Gynaecology & Obstetrics		5	
Neuro-surgery9		1	
Opthomology		1	
Urology		1	
	Total:	60	17

Source of referrals to the Psychiatric clinic per year

Referrals from the Department	6
" " Allied Clinics	114
" " Community doctors	23
" " Community agencies	1
Self referrals	24
Total:	168

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