WHY PSYCHIATRY ?*

BY

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The question I have posed as the subject-matter of this address is, I believe, of fundamental importance to anyone contemplating a medical career, whether as general practitioner or as specialist. The psychiatric field is one of infinite possibilities. A vast number of problems urgently demand solution, and in the clinical, academic, and research spheres, whether at home, abroad, or in the Services, abundant opportunities arise for all who may feel attracted into such work. It has been stated frequently, and I think with truth, that psychiatry constitutes the other half of medicine, and yet, sad to relate, it continues to occupy a comparatively minor part of the medical curriculum. That should be remedied. It will be as soon as the doctors of the future and the medical faculties of our universities recognize that a new orientation requires to be effected. I say this because there seems to be a distinct danger of medical work degenerating into a job of work—prescription and certificate writing—rather than a calling, a dedication to the service of others, wherein lies something which makes an inspiring appeal to heart, soul, and medical skill.

In order to convey some idea of this field of work, and to justify the statement that psychiatry constitutes the other half of medicine, allow me to mention a few facts. Of every 100 children born, 8 will have a nervous breakdown and 3 will spend some part of their lives in a mental hospital. On January 1, 1950, there were 272,540 persons mentally ill or defective, compared with 230,299 occupied beds in hospital for all other disease put together. The economic burden as represented by such figures is enormous, but the amount of suffering to the individual and his family is something which defies definition. Here is an opportunity for preventive medicine so that countless sufferers may benefit, and great pleasure and satisfaction can be derived from one's work. A far better health organization can be built up than has ever existed. But as prerequisites there must be a comprehensive undergraduate education and an opportunity to have had a good look round, to survey the position carefully before making a final decision on one's future career. To a certain extent, at least, this latter proviso is secured now that a year's work in general or special hospitals is obligatory before registration can be effected.

A New Point of View

There are some students, the precocious ones no doubt, who from their schooldays have decided to devote themselves to a particular type of medical career, and plan their experience accordingly. They feel they have a special bent, or flair, or urge in one direction. These, perhaps, are the fortunate ones. Others may take much longer to decide, and may be influenced by chance or luck, or by association with someone who is regarded as a great example. It has been my experience as a teacher of psychiatry that great numbers of students have found that psychiatry opened up a new point of view, a different type of medical work; it brought them intimately into association with the patients themselves, with patients as individuals, rather than their

diseases, thus constituting a really vital interest. They began to realize that it was not enough to study physical diseases as such, but that the personality and character and emotional level of those who were suffering also demanded investigation. It is that wider appreciation of their medical responsibilities which will enable them to treat their patients more successfully. Such a technique, the understanding of man in relation to his disease, makes it implicit that the interrelationship of mind on body and body on mind must be paramount. That, however, is not a matter which can be determined in a minute, it has to be carefully weighed and evaluated, and may take a longer time than is compatible with certain natures.

During their training most students feel that their mission is to cure physical illness, to relieve suffering quickly, and to see an immediate response to the powerful remedies which they now have at their command. That is what actually happens. The spectacular and often dramatic results that follow the administration of penicillin and other antibiotics, or the marvels of chest, heart, and brain surgery, is work which appeals to practically everyone. And such results are only the precursors of future clinical and experimental research which will lead to marvels of healing which we can but dimly visualize. It is not surprising, therefore, that medicine and surgery, in general, should be dominated by the essentially objective mechanistic approach, which has so much to offer.

But not all the answer is there. We still have to understand the art of living, the ability to adapt harmoniously to the sphere in which we are placed, and how we may effect a better total integration leading to efficiency. That is the reason I have the temerity to ask the question "Why," or, perhaps better, "Why not psychiatry?" I cannot hope to stir your hearts and minds as responsively as the physician or surgeon might do. I cannot promise quick and dramatic results. I can only offer "blood and sweat and tears" and long periods of painstaking work which eventually may bring its due reward. But there is a wide vista in front of you. Before entering into psychiatry ask yourself these or similar questions: Is it worth while? Is it sufficiently satisfying? Am I likely to be happy in it?

The Science of Man

Personally, I have never regretted my choice. I have found psychiatry to be an absorbing, fascinating subject which during the past fifty years has evolved into an orderly body of knowledge that can be specifically applied. It involves the study of constitutional and environmental phenomena leading to an ability to reach an understanding of personality and character by means of a study of the individual's psycho-biological reactions. Psychiatry deals with man himself. It is the science of man; the most backward, the most difficult, but potentially the most fruitful of all the sciences. It requires people endowed with a contemplative, philosophical outlook. But that, after all, is the brightest and highest characteristic of man; a thinking person, one who can take stock and be hopeful of finding an adequate solution to almost any tangle. To be optimistic without being too naive about it. Have you such qualifications? Have you inquiring, questioning minds? Minds that are unwilling just to accept everything at its face value but are happier when they are seeking for causes, asking questions, and above all analysing the interplay of the somatic and psychic reactions. If you feel that you have those greater interests, if the study of the speculative, subjective, emotional, and instinctive appeals to you, then I would suggest that you might find in psychiatry that branch of medical work which will give you entire satisfaction.

Let me hasten to add that psychiatry is not necessarily a subject for the specialist alone. It is much more nearly allied to general practice than any other branch of medical work is. Much of surgery, of ophthalmology, of radiology, and other specialties are essentially postgraduate disciplines and are not especially important in general practice, but

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psychological medicine is part and parcel of the vast majority of all clinical states which present themselves. I have been so sure of this that in teaching psychiatry it has always been my main object to present it in such a way that it might be used by the general practitioner, day in and day out, in the course of his ordinary duties. All good general practitioners will give me their support. They know that their success in practice is dependent on their ability to understand and sense out the psychological background, whether centring in domestic disharmonies or more individual personal problems.

This sort of psychiatry which I am trying to outline, the psychiatry which deals with the interpretation and understanding of the facts of everyday life as led by ordinary people, is very different from the psychiatry which was bounded by the high walls of the mental hospital. That indeed was an intramural age, when the psychiatrist was regarded as just another "mad doctor" who was not in very close touch with his colleagues. At that time body and mind lived in watertight compartments, and the influence of one on the other was sensed by only a few thoughtful physicians. Now the relationship is so close that we have what we call psychosomatic medicine—an awkward-sounding combination, but one which serves to stress the interlocking and transformation of emotional forces into physical symptoms.

I believe, therefore, that the doctor of the future should, in addition to his knowledge of the physical and objective side, be familiar with the more intangible personal, subjective aspects which are closely bound up with social, domestic, marital, and economic problems. It is for that reason that I have welcomed this opportunity of outlining how psychiatry may be advanced, how it may be more freely and expertly practised, and how the mental health organization may be more closely co-ordinated with its sister branches, especially in general practice.

Mental Examination

In his student days the undergraduate should become familiar with the methods of conducting a mental examination. This is as important as to know how to percuss and auscultate a chest. He may not understand the significance of all the sounds he elicits, but at least he will be accumulating data which his experience will teach him to apply. So it is with a mental examination. This can be effected quickly in an orderly manner so that the state of emotional tension, the content of thought, the intellectual faculties, and the degree of judgment and insight can be approximately evaluated. All this information is then correlated with a detailed chronological history, a life study, which pin-points what happened in infancy, in school-days, in work, in marriage, and in domestic relationships. It may seem a formidable programme, but it is not nearly so complicated as it sounds, and it ensures a complete and thorough examination. It is a great saver of time in the long run.

One of the important things to remember is that you must not be afraid to ask questions. Tact, of course, is required; nothing must be said or done which will antagonize the patient, but there is nothing a person likes better, whether he be sick or well, than to talk about himself. This sort of approach establishes a rapport; the patient realizes that the doctor is interested, that he is a good listener, and that he can be trusted. I know that all this is so, because so many patients have said to me—"It is a great relief to talk about the intimate details of my personal life, but the other doctors I have consulted did not seem to regard it as important." Let me be a shade more explicit. We must be quite clear regarding the family relationships, the difficulties encountered by the only child, the problems which may have arisen in relation to sexual development, schooling, the choice of a career, the advisability of marriage. These are some of the matters which arise in the practice of every family doctor, and yet very often he does not feel that he has the knowledge or understanding, or even that it is his business, to deal with them. It is my conviction, on the

contrary, that it is the wise family doctor, the trusted medical adviser, who is pre-eminently suited, by his knowledge of the family circumstances, to guide and protect the respective members of the family in their development. If he experiences any particular or special difficulties then he should call the psychiatrist into consultation early rather than late. Unfortunately this is not the usual practice. Many doctors hesitate to advise psychiatric consultations because they fear the patient may feel insulted, and may transfer his complaints to another doctor. That is much too narrow a view, and is seldom the case, but a change will not be effected until doctors meet their responsibilities more courageously, and with more understanding of the efficacy of the psychological explanation—not necessarily determined by psychoanalysis.

Schooling; Choice of a Career; Marriage

I would like now to justify the position I have taken by making a few comments on the above matters.

Schooling.—Very frequently, schooling is decided in a light-hearted and casual manner, and often with little understanding of the needs of the particular child. The family doctor may never be brought into consultation at all; but provided he is, and provided he is familiar with the consequences which may be the aftermath of injudicious forcing or of unsatisfactory placement, he can be of infinite help in advising the parents and in safeguarding the child. Luckily the majority of children seem to fit into their educational niche more or less securely—at least they get through somehow or other—and, all round, the school system in this country reaches a very high standard. But it is the failures I am concerned with—and these come from certain schools only—and the steps which might or should have been taken to prevent catastrophes that need never have happened. They should be placed in an environment that is suitable to their requirements: not so much their limitations—that is too negative—but according to their available resources. It is really quite a difficult decision to determine whether a day school or a public school is going to be of the greater advantage. Some children do much better in the one than in the other—irrespective of what the family tradition may have been—and certainly it is my experience that the sensitive ones do much better if they are allowed to develop quietly in the shade of the home background rather than in the more intense light of the public school. It is a mistake to try to toughen sensitive people too soon and too quickly. Give them time and probably they will mature satisfactorily enough; but a good many are slow developers, both emotionally and intellectually, and require to be managed with delicacy. It is the emotional development which we want to stress particularly.

Career.—The comments I have made in relation to the choice of school are equally applicable to the choice of a career. There are far too many square pegs in round holes. People who are ill adapted to their work are unhappy, and suffer from an intense state of frustration. In many instances this might be avoided, and I believe that the family doctor's experience might be of immense value in combating the serious wastage turnover which occurs: the tendency to flit from job to job—interest developing only after experience. While there are special circumstances which may require the knowledge and skill of the expert to deal with, yet the doctor in general practice, with his knowledge of his patient's bodily state and nervous potentialities, might do much to assist him in choosing a career which would be compatible with the man's endowment. Hours of work, the adequate employment of leisure, the amount of sleep necessary, are points which may be of much significance, and have to be assessed with care. The success of the measures I am suggesting was well demonstrated during the war years, when every possible effort was made to fit people into those forms of work which were most compatible with their efficiency and their aptitude. They prevented many a serious nervous breakdown—a condition which was all too common during the first world war.

Marriage.—This perhaps is one of the most difficult adaptations of all, and I need hardly emphasize that an unhappy married life is a source of great anxiety which may reflect itself on quite a large number of people. There is no more potent source of mental distress and tension than the broken home, however it may have been caused. It may result in alcoholism, divorce, legal separation, incompatibility of temperament leading often to cruelty and dangerous conduct, jealousy and suspicion, and many other dangerous and disordered states that might possibly have been prevented. My reason for airing this topic is that, in my experience, I have encountered many cases in which young people contemplating marriage, but who have had genuine doubts about its advisability, have been encouraged by their medical advisers to go ahead, with the added statement that it will probably do them all the good in the world. Marriage, in my view, cannot be dealt with in such an optimistic spirit: it is not likely to be a cure for nervous instability; it does not quiet the fears of the young woman who is worried about her heredity and wonders whether she will be the means of bringing other nervous children into the world. On the contrary, it intensifies those fears, the possibility of pregnancy becomes a nightmare, and a childless and unhappy marital situation results. Advice about all such matters, whether by the family doctor or by a Marriage Guidance Council, is very much better and more successful when given before the marriage than after it has been contracted.

These are some of the matters which from the preventive angle are important, and I do not think they overload the plate of the family doctor: they must add considerably to the interest of his work.

Since writing the above comments I was interested to read in the *Scotsman* of December 30, 1954, an account of an investigation which is being undertaken by a social worker, a psychiatrist, and a statistician into the 300,000 letters written each year to newspapers and magazines seeking advice on problems of personal relationships. The problems raised refer to adolescence, courtship, unmarried motherhood, marriage and preparation for it, children, "in-laws," separation and divorce, social isolation, and old age. That statement gives a good idea of the very large number of people who are seeking help and advice about the ordinary affairs of everyday life, and yet they do not seem to know whom to turn to. I submit that a good family doctor could answer their inquiries more fully and thoroughly than can be done by correspondence.

Effects of Fear

If we turn now to the more clinical aspects I would like to emphasize how much the general practitioner with psychological insight can do to alleviate and treat those cases of anxiety and depression which are the most frequent of all forms of nervous and mental disturbance. They are nearly always complicated by the additional problem of sleeplessness, which transforms night into something to be dreaded rather than welcomed. The root cause of all such states is fear—something which is present with us from the cradle to the grave. It pursues us throughout our lives, and may show itself in a multiplicity of forms. We can always side-track it to a certain extent, but yet we long for security, for protection, for a feeling that there is always help at hand.

Fear has its beneficent and malignant aspects. We know, for instance, how in times of stress or danger it may prove, physiologically, to be a valuable self-protective mechanism whereby we can escape from critical situations; while often the fear of public exposure and punishment may enable us to exercise an amount of self-discipline whereby we control those impulses which would result in social misdemeanours. But when it is constantly present, when worry and anxiety are perpetual, then our fear may express itself in the production of physical symptoms—for example, peptic ulcer, palpitation, amenorrhoea, skin disorders—none of which

can be cured by physician or surgeon until the cause of the fear has been elucidated. This is all very familiar, but to none more so than many of the great writers and essayists such as Darwin, Mosso, W. H. Hudson, Conrad, George Moore, Victor Hugo, and Montaigne. All of them recognized the power that fear had in dominating not only the actions but the thoughts of everyone.

Lord Frederick Hamilton, in his autobiography entitled *Days Before Yesterday*, put it quite simply and graphically when he recalled the terrors he had experienced from the age of 6, when he made his way "nightly down the passage of many terrors which lay from the nursery to the other part of the house where the grown-ups lived." A young man who had been referred to me because of his anxious-minded state informed me from what a simple thing it had arisen. He had been playing in a Rugby match, and a friend who had been watching the game shouted out, "Oh, so-and-so is nothing but a funk; he's afraid to tackle his man." That remark entered the boy's mind; it destroyed his confidence in himself, it acted as a minute splinter in his flesh until many years later when he summoned up courage to speak about it. That is not an uncommon occurrence, and can be duplicated in the autobiographies of many famous men, and in the life stories of men I have known who have been decorated for their bravery, and whom I have been privileged to help: people who have feared they might be cowards, people who have frequently had to prove themselves to themselves by going to an extreme limit of over-compensation amounting to exhibitionism. No one ever expressed the position better than a young lady who had suffered much and who embodied some of her feelings in the following letter which she wrote to me:

"I think I understand things in general, as the important point is instead of letting the bats in my belfry loose when they wished to fly around I have firmly locked them in. Now I am to let them out; I can't say I like the idea, but I will try. After all, I didn't like having some teeth stopped, but I always had to go through with it. I wish you had not disturbed so many bats all at once, especially the ones that have grown beards. I see now why I cannot sleep, and why you liken the process to the surgeon and the wound which must have the pus taken out of it before it heals, and it is bound to hurt in the process. Please will you take care of all those bats and some day, if you have time, will you discuss them. The very biggest and the oldest is fear; he is as old as I am, he niggles by day and rules by night and his family is numerous. I will never slay him by myself and I am sure he must be very septic and nasty. I have had to go to such lengths as a child to hide my fears, and I hide them now, but they are all there. When I lay so helplessly ill and was regaining my consciousness all my dreams were of fears I had suffered and hidden as I had carried on with whatever had to be done. I talked to no one of them, and even now I have the awful fear that you might think I was mad. I always think that all the bats spring from this root, fear. Fear of an anaesthetic, of suicide, of doctors, parents, certain teachers, dreams. The suicide fear has a root all its own."

That extract gives a vivid picture of the torment which so many children and adults suffer from, and it is easy under these circumstances to realize how difficult it must be not only to concentrate on one's particular job but even to lead one's life at a reasonable level. But perhaps the most disturbing feature is the feeling or fear of impending loss of control leading to actions foreign to the person's disposition. Under such circumstances it is understandable that the suicidal act may be the final touch.

Sleeplessness

Furthermore, you will appreciate why sleeplessness should be closely linked with such a troubled state. Their minds are filled with morbid thoughts, thoughts which seem to free-wheel, a kind of mental whirlpool which never seems to reach a stage of peace and quietude. To produce sleep mechanically by means of drugs when such states of anguish exist is almost impossible. Some patients frequently say, "If I could only be put to sleep for a fortnight I should then be better," but even when continuous narcosis is used I have never found it to act satisfactorily in such

cases. It is, I believe, essential in the first place to give the person some understanding of how and why their insomnia is present, and to explain that insomnia or sleeplessness is closely identified with the idea of death and the fear of the unknown. Sleep is the symbol of death, and many of these patients I refer to, while they long for sleep, are yet afraid to sleep because they cannot sink back into a state of unconsciousness owing to this fundamental fear. It is the anticipation of sleeplessness which produces it. The same situation is evident, for instance, in those who fear an anaesthetic, and many anaesthetists will tell you how certain people are very difficult to anaesthetize and some even refuse general anaesthesia because of this underlying fear. Although they long for sleep, subconsciously they fight it; they may be on the point of falling over when they will suddenly awake with a start, or they may go to sleep for a short time, in the early part of the night, but they waken suddenly and are unable to get to sleep again.

Antidotes to Fear

These matters I believe are of very great practical importance and indicate the necessity for general practitioners who are dealing with them to understand more than the prescribing of a hypnotic. The essential thing is to have an appreciation of the psychological mechanisms which are causing so much havoc and to be able to keep alive faith and hope, which are the only real antidotes to fear. A good deal can be done by education, discipline, example, the inculcation of the spirit which inspired the soldiers of the *Birkenhead* when they stood at attention while the ship foundered in a shark-infested sea. That is what is meant by morale, which was described by Dr. Edward Glover, in a book entitled *Fear and Courage*, as our most important secret weapon. I have put this matter into the forefront because I can use it more or less as a text on which to emphasize the wide sphere which a doctor with psychological insight can not merely interest himself in but become absorbed in. The concomitants of fear are of serious import and require equal if not even more consideration than the sex problems and difficulties which have been supposed to be at the root of so many types of nervous and mental disturbances. A good deal more could be left to natural development and bringing-up than to the type of instruction which is purveyed in books, in school, and even over the wireless: certain types of health talk are apt to be very much more disturbing than helpful.

Helping the Patient

A point of some practical importance is to prevent the patient from feeling that he must take the full responsibility for helping himself. While he should be informed that his co-operation is essential and that he must contribute from 25 to 50% in helping himself to get well, yet he should always be assured that the doctor can help and is willing to keep in touch with him. Doctors are sensitive about this; many feel, in dealing with nervous patients, that they are not contributing anything, that their visits are of no value, and in consequence they lack confidence in their ability. That is, I believe, always a very serious fault, because the mere fact that the doctor keeps in touch, even although his visits are of short duration, brings an assurance and a confidence that may be of more value than anything else. The art of medicine consists largely in the personal interest and kindness and enthusiasm brought to bear, and these may help more than anything else. While we need the co-operation of the patient, it is equally essential to enlist the co-operation of the relatives. The more they can be kept in the picture and the more they can be given understanding of how they may assist, the greater the encouragement and the quicker the result.

A Rich Fare

If the fly I have cast has attracted your notice you might even have gobbled it up and have hooked yourself to

psychiatry as a specialist. If you have done so, then a rich fare awaits you, and you may partake in the academic, research, and clinical field or in a mixture of all three of them.

Schools of psychiatry, as I have said before, should occupy a much more prominent place in the medical curriculum. A chair of psychiatry should be established in every university centre, and a professional examination in psychiatry should constitute part of the final examination in medicine. A student should be as adequately trained in psychological as in physiological principles. Nor would I confine the study of psychiatric principles to the clinical years only; they require to be inculcated early, and should seep through the whole of one's medical training. I believe that every large general teaching hospital should reserve from 5 to 10% of its beds for psychiatric cases, and that psychiatric units with adequate out-patient departments and with facilities for research should be part of the general hospital organization. This is not a visionary arrangement, because to a considerable extent it is already in being in the United States, in Germany, and in Scandinavia.

From the teaching angle there is a considerable body of opinion opposed to the instruction of students through the medium of the systematic lecture. Many prefer study groups in the form of seminars. There is much to be said in favour of such a plan, but in our Scottish universities, where we require to instruct classes of 150-180 students, such a method is impossible, practically and economically. There is much to be said in favour of systematic lectures. They orientate a student quickly in the history of his subject, they can give him perspective, and they can illustrate the teacher's own experience gained from his close association with the general practitioner. That is why I am inclined to favour part-time rather than full-time professorships where the clinical problems are dealt with in the somewhat artificial milieu of a hospital organization. Furthermore, when we make full use of the out-patient departments we have the finest opportunity for clinical teaching. There we get a good cross-section of the medico-social problems which occur in general practice; we can demonstrate methods of examination; we can elicit the salient features which may require further investigation and treatment under more private and specialized conditions. My experience has been that patients co-operate well in such out-patient work; the atmosphere of the clinic may at times become almost electrified, and the fact that so many students assembled together are seriously interested supports the patient's pride and sense of prestige, and thus assists in his treatment.

Any research unit must be co-ordinated with both the academic and the clinical sides. The answer we are seeking may not be found in the test-tube or the laboratory (biochemical, neuropathological, or psychological) but in the study of man himself in his social relationships. This, however, is only a surmise which constitutes problems to be solved. That was brought forcibly before us at a Conference on Mental Health held at Oxford in 1952. There were gathered together neuro-anatomists, pharmacologists, psychiatrists, biochemists, professors of sociology, psychoanalysts, animal behaviourists, physiologists, and endocrinologists, who for two days discussed "what ignorances principally hamper our understanding of mental illness." There were plenty, I can assure you. It is our aim to eliminate those ignorances, to develop a knowledge which can be applied so that our thoughts and conduct can be sublimated into better and higher channels. We can learn much from the co-ordination of psychological, physiological, and anthropological research through, for instance, electroencephalography, which has already given us so much information of brain functioning; through the improvement in technique in what is called psycho-surgery; through the personality studies postulated by Sheldon, as now being actively pursued at the Warneford Hospital, Oxford; and by the pharmacological studies of Elkes in Birmingham.

These are all spheres in which the clinician and the research worker must be in the closest harmony.

While there are many specialists who may be attracted into the essentially scientific aspects of research, there are many others who find their satisfaction in working clinically in some particular field. I might mention, for instance, psychiatry in relation to eugenics—a grossly neglected subject, but one which is fundamental. I know there are those who blatantly exclaim, "Hereditry is bunk"; but those of us who have experience, who see family groups involved seriously from generation to generation, or who have been impressed by the significance of similar twin studies, or of the spread of various forms of mental deficiency or of conditions characterized by organic brain disease—for example, Huntington's chorea—cannot take such a facile attitude. It is dangerous to accept all such states as a sort of *fait accompli*, but rather must we do everything that is possible to improve the quality of the race. All this work has its place in our mental hospitals and colonies for mental deficiency, which should be live places for clinical research, and not merely custodial institutions.

These hospitals require improvement and modernization both in equipment and in medical and nursing personnel. They are grossly overcrowded, the ward units are much too large, but even with all their defects they constitute important organizations which call for the highest degree of administrative and medical skill. It is intensely disappointing to-day to note that the highest positions in the mental hospital service, posts carrying with them so much responsibility and which were so greatly prized, seem to have lost much of their former appeal and attract comparatively few candidates. I believe that the main reason for this unfortunate state is because at the time of the introduction of the Mental Health Act the special conditions in relation to mental hospital work did not receive sufficient consideration.

Other Fields

If, however, your inclination lies in some other direction, then I might offer you child psychiatry, a subject which is calling out for more workers. Here you see team-work in action. The psychiatrist, the psychologist, and the social worker pool their resources not only in an effort to deal effectively with the child and the conditions surrounding it, but also because the child is much more likely to react to satisfactory treatment than the adult. Childhood, it has been said, is the golden period for mental hygiene; it is the plastic period of development, the time when prophylactic work is likely to prove fruitful. Indeed, the vast majority of the problems of childhood can be dealt with admirably by a modification of environment and social circumstances and by dealing with the particular problem at a conscious level. But again we need the full co-operation of parents, schoolmasters, and all organizations dealing with children. Our aim in all such work is to produce a state of *emotional and social security*, which is the greatest safeguard for all subsequent disorder of health and conduct.

Then there is a great need to improve our relationship to the law, to the Church, and to industry. Each one of these fields is teeming with problems of great significance and importance which would require separate consideration, and which I cannot attempt to deal with here. I feel, however, that I must mention them, because psychiatry has a great contribution to make to each of them. And then when one has accumulated one's experience you may feel that your duty and your inclination is to spread the gospel of mental hygiene so as to educate the public to take a more realistic and more humanistic attitude towards a subject which is vitally concerned with human betterment.

These, then, are some of the reasons which have led me to ask the question, Why or why not Psychiatry? I trust many of you may answer it affirmatively and that those of you who do will find in it work which will prove of infinite value to you personally, and to those whom you may be privileged to help.

THE TEACHING OF DERMATOLOGY TO MEDICAL STUDENTS*

BY

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Of recent years much attention has been focused on the changing face of medical practice. In no field are the changes more pronounced than in general practice, especially since the advent of the National Health Service. In the special subjects there are consultant teachers to keep the curriculum for higher qualifications up to date, but so far as general practice is concerned there is, and always has been, considerable difficulty in placing the right emphasis on the various subjects in the medical course. General practitioners, once they have qualified, usually put examinations and organized learning behind them, and rarely feel strongly enough about any aspect of medical training to give guidance to the bodies who control the qualification of future doctors.

For some time it has been felt that the teaching of dermatology to students has borne no relationship to the amount of skin disease met with in general practice. Most of one's colleagues, regardless of where or when they were trained, will agree that their knowledge of dermatology on qualification was negligible. The following is an attempt to place dermatology fairly on the map of medical education so that in future no newly qualified doctor should be able to claim that he knows "nothing about skins."

Incidence of Skin Disease in General Practice

Within the past few years there have been many surveys of the work involved in general practice. Sir James Mackenzie (1919) found a "high" incidence of skin diseases in general practice. Marien and Ardouin (1954) listed twelve dermatological diagnoses made in a total of 234 cases—that is, just over 5%—seen during a three-week period in 1953. Horder and Horder (1954), in presenting two series of 1,000 diagnoses made in their practice, one in the summer and the other in the winter of 1953, listed 89 skin conditions seen in the summer and 65 in the winter—an over-all percentage of 7.7. Fry (1952) showed that in 1951 approximately 8.5% of his patients had diseases of the skin. He classified his diagnoses into disease groups; skin disorders were fifth in order of incidence, the first four being upper respiratory infections, general respiratory diseases, digestive disorders, and neuroses. Stocks's (1949) list is the same as Fry's with the addition of rheumatic conditions. Backett *et al.* (1954), who described a year's work in a general practice in 1950–1, stated that skin disease was indicated in 11% of all diagnoses and involved between 6% to 12% of their work. A small personal (unpublished) investigation showed that 10.6% of all new cases seen during four weeks in May and June, 1950, were dermatological. The figure for a similar period in November and December of that year was 7.4%—an average of 8.8% over the combined periods.

In a survey of over 17,000 prescription forms issued in a wide variety of areas in England in September, 1949, Dunlop *et al.* (1952) found that 12% dealt with "skin preparations." Presumably these consisted of ointments, pastes, creams, lotions, and powders, and did not include the mixtures, tablets, injections, and dressings which must also have been required. Thus the amount of work involved must have

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