What Should Psychiatrists Do?—A Personal View

By C. M. H. NUNN, Consultant Psychiatrist, Royal South Hants Hospital, Southampton

At one time, I knew what psychiatrists should do and it was very satisfying. They should, so far as humanly possible, restore the mad and the distressed to sanity and tranquillity. Now things are less clear, and there are three main reasons for this. First, many of the incurably mad are distressed because they live in conditions of unspeakable social squalor which one does not have the power to relieve. Second, most of the curably distressed are cured by time or their GPs and we see only a small proportion of them. Third, many of the people referred to us have personality or alcohol problems for which, in most cases, no effective treatment can be given.

So what should an ambitious psychiatrist attempt? The routine that most of us follow has a certain humanitarian value, but we are in a similar position to that of nineteenth-century physicians dealing with infectious disease. We can usually only soothe a fevered brow without affecting the fever, and there are far too many such brows for all to be soothed. Occasionally we make a real difference to some patient, as when a physician gave morphine and fluids to a cholera case or cleared the membrane from a diphtheritic throat. Ambition suggests that we should aim for more than this.

At present, we are not even particularly good humanitarians. Our incurable patients find it difficult to obtain asylum to an extent which would have appeared incredibly harsh to, for instance, chest physicians in the days before tuberculosis could be treated. Instead of running down mental hospitals, surely we should be expanding them to provide pleasant, sheltered homes analogous to Tb sanatoria for all those patients now drifting around common lodging houses whose only occasional break from their dreary routine is to go to prison. No doubt rehabilitation units should be attached to each asylum. It is likely, however, that only small numbers of psychiatrists would be required as consultants to such establishments, since nurses and social workers could probably run them effectively.

There has been extensive, usually abortive, discussion about how to provide an effective back-up service for GPs who deal with the bulk of curable patients. In many areas GPs complain, with justification, that it is difficult to get their patients into acute admission beds and that out-patient waiting lists are too long. Given adequate numbers of acute beds sited near the communities served, the situation could be much improved by quite small changes in our usual practice.

Perhaps GPs could be given direct access to beds, and encouraged to take clinical assistant sessions on acute wards. Emergency clinics with social work and community nurse back-up might be more widely established. Maybe psychiatric out-patient sessions should be held in surgeries instead of at hospitals.

Although steps like these might make present-day psychiatry a bit more effective and human, it will remain largely ineffective until we know as much about the subject as physicians know about fever. Research should therefore be our most important function. There are all sorts of obstacles to this, including financial and organization difficulties. My own view is that lack of promising hypotheses to test is no longer a problem, since these are generated in profusion by all sorts of scientists (and even a few psychiatrists). One of the major stumbling-blocks is lack of agreement about the most important direction of inquiry, with an over-emphasis on the sociological aspects of psychiatric disorder. There is ample evidence that human brains can develop normally and remain sane under social conditions far more stressful than any to be found in this country at the moment. Therefore, we should surely concentrate on the biological deficits which cause some people to fail.

Research programmes are needed on a far larger scale than we are accustomed to considering, but there is a growing awareness of this. For instance, a programme is being organized in America (NIMH collaborative study on the psychobiology of depression) which will examine most of the scattered information about biochemical changes in depression in order to relate them to specific depressive syndromes and to try to ascertain which are primary and which predict response to antidepressant treatment. This requires, however, the collaboration of six major centres and over a hundred researchers. Equally large programmes are needed in many areas. The success of the international pilot study on schizophrenia provides an encouraging example.

Even in the field of personality disorder, generally thought to be both confused and confusing, promising steps have been taken. For example, EEG power spectral analyses have been shown to correlate well with a battery of psychological tests in defining discreet areas of brain dysfunction in a number of personality-disordered populations. Obviously the ability to define separate personality disorder syndromes by objective criteria of this sort is a first step on the road to searching for cures. Again, the resources needed for research like this are very considerable and most of it is going on in North America (particularly Alberta). However, it probably costs less than premature and apparently unsuccessful attempts at treatment in some psychotherapeutically-orientated hospitals such as those represented by Grendon Underwood Prison or the

Henderson Hospital in this country.

Perhaps we should leave humanitarianism mainly to social workers and nurses, help GPs to apply current treatments, and organize ourselves to undertake effective research into the biological causes of mental disorders and their cure. Maybe we could learn how to do this from the example of the physicists. They have been triumphantly successful in elucidating the structure of matter, and the structure of mind is no less important a problem, but the timescale needed, judging by their experience, should be measured in decades rather than years. Quite fundamental changes in the ways in which we usually think and organize ourselves would be needed for success. It is often said, with some truth, that small scale research habitually undertaken by psychiatrists produces results that are either trivial and believable or surprising and unacceptable. The College and each Region should appoint full-time research co-ordinators to ensure that we examine non-trivial problems in a believable way and that continuity of research effort is maintained for whatever time may be necessary.

Foreign Report

On Finding a Place in the Sun

By GORDON PARKER, University of New South Wales, Sydney

Issues of identity and contemplation of the future have been preoccupations of Australian psychiatry recently and will be identified and contemplated in this report. While aware that to direct attention to such issues is *ipso facto* evidence of insecurity about identity, and is certain to be a relatively unsubtle exercise in convoluted nationalism, your reporter suggests that jingoism, if properly defined as 'love of Australia', is an adequate defence.

Issues affecting the profession have a wider context which should not be ignored. It was Donald Horne who, in 1964, described Australia as 'the lucky country'. Specifically, he said: 'Australia is a lucky country run by second-rate people who share its luck'. He developed the view that Australia was a 'derived society' whose prosperity came mainly from the luck of its historical origins (with overseas innovations and the results of the manufacturing age imported), while it lacked any capacity for originality. Following one generous generalization with another, Horne described the élites as second-rate self-congratulatory, provincial minded, and lacking any ideas as to how to give definition to any unique Australian identity (Horne, 1976).

While Horne's allegiances were clearly not with the Conservative party of that day, they did reflect the stirring within some of a national consciousness, an intermittent exercise that has occurred since a flag was raised at Botany Bay. In 1972 those stirrings were definable and were encapsulated in the momentum that elected the Labor Party to government.

If one has ever believed that psychiatry, as against the political process, has some influence on social change, it would be a dispiriting task to seek confirmation in Horne's book on the Labor Government. For in the early 70s '... it was Whitlam who defined new realities, expressed new values and seemed to reach out for the new creative moods of the age ... He was concerned with the cultivation of an Australian sense of excellence' (Horne, 1976). In those heady days the exodus by the Australian intelligentsia (whose ambition it had been to grow up to become expatriates) was reversed. A thousand symbolic flowers were ready to bloom. The Whitlam government engendered a decidedly creative mood.

Further, it created Medibank.

Medibank, Labor's 'most visible single measure' (Sexton, 1979) was, in essence, a health insurance programme providing access to health insurance for people previously unable to afford private insurance. Its introduction was opposed by a medical profession that saw it as the first step toward nationalization of health services. While the profession did not fear that Medibank would result in loss of income, it also did not anticipate that the early years of Medibank would be associated with a doubling and tripling in medical incomes. That result, and the effects on the practice of medicine, deserve a volume in any history of Australia.

In November 1975, Whitlam was given his marching orders, and in the ensuing election the Liberal Party was returned to power. Since then Medibank has been cut, pruned, and reshaped, and it is likely to be ring-barked shortly. Medical costs, which escalated dramatically in the years of, and in part as a consequence of, the Labor government, have still increased (although less alarmingly) during the years of the ensuing Liberal governments. The politicians now chant increasingly that social and medical