By Albert Deutsch

New Federal Mental Health Program Gets Off to a Good Start

The groundwork for a co-ordinated, nation-wide drive against mental disease—America's health problem No. 1—is being laid rapidly, following Congressional passage of the National Mental Health Act. Just before adjournment, Congress appropriated $5,200,000 to the U. S. Public Health Service to get the Federal program started. Of this amount, $850,000 is earmarked to begin construction on a National Mental Health Institute at Bethesda, Md., which will serve as a center of psychiatric research and training. The building of the Institute will ultimately cost $7,500,000, it is estimated. It will include a 200-bed hospital for the study of nervous and mental ills. The rest of the initial Congressional appropriation will be spent in financing psychiatric research and training projects and in Federal grants to states to stimulate establishment of more mental hygiene clinics throughout the land. It is hoped that 100 of these clinics will be organized during the next year.

Surgeon General Thomas Parran, moving swiftly upon Congress's favorable action, has appointed a six-man National Mental Health Advisory Council consisting of outstanding psychiatrists. Their job, as defined in the Act, is to help plan and develop the mental health program and to recommend research projects.

The Council includes:

¶ Dr. David M. Levy, distinguished child psychiatrist of New York City.

¶ Dr. William C. Menninger of the famed Menninger Clinic in Topeka, Kan., who was chief of the U. S. Army's neuropsychiatric division, with the rank of brigadier-general, until his return to civilian life last month.

¶ Dr. John Romano, professor of psychiatry at the Rochester University Medical School.

¶ Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene.

¶ Dr. Edward A. Strecker, chief of service at the Pennsylvania Hospital's Mental Hygiene Institute in Philadelphia and ex-president of the American Phychiatric Association.

¶ Dr. Frank F. Tallman, Ohio State Mental Hygiene Commissioner, who has played an outstanding role in bringing to public attention the shocking conditions in many of our state mental hospitals.

The Advisory Council will hold its first meeting Aug. 15 in Washington.

In charge of the over-all program is Dr. Robert H. Felix, chief of the Public Health Service's mental hygiene division, who has experienced a rather meteoric rise to a top psychiatric post. Chubby, genial and earnest, Felix was born in Downs, Kan., 42 years ago. His grandfather was a physician; so was his father. Felix describes the latter as a "saddle-horse doctor who graduated into the horse-and-buggy class."

Felix got his M.D. degree at the Colorado University Medical School and later got a master's degree in public health at the Johns Hopkins School of Hygiene. He was awarded psychiatric research and training fellowships from the Commonwealth Fund and the Rockefeller Foundation. In 1933 he entered the Public Health Service, rising to clinical director at the Medical Center for Federal Prisoners at Springfield, Mo., and later serving as clinical director of the Federal Narcotic Farm at Lexington, Ky. At the latter institution, he completed several research projects on the personality of drug addicts.

Surgeon General Parran ran into the young psychiatrist in 1940 during a visit to the Lexington narcotic farm, and was favorably impressed by his unusual grasp of administrative detail. When Dr. Lawrence Kolb retired as head of the Service's mental hygiene division in 1944, Dr. Parran named Felix to the post. Felix is a diplomate of the National Board of Neurology and Psychiatry, and is considered a progressive eclectic in his specialty. He is completely wrapped up in the job of organizing a national mental health program, regarding it as a God-given duty. He is married, has an eight-month old daughter, and collects classic-music records and reads philosophy in his off-hours.

Don't expect any sensational results from this new Federal set-up for some years to come. The organizing job, in the face of critical shortages of psychiatric personnel and facilities, is a tremendous one. But the program is off to a good start, under splendid auspices. In time, I am confident, it will serve as an effective spearhead in the war against mental disease and the promotion of sound mental health.

P.M. New York

1946

UR PROFESSOR ATTENDS MEET

Dr. John Romano, professor of psychiatry at the University of Rochester School of Medicine and Dentistry, is in Washington attending the first meeting of the National Mental Health Advisory Council, appointed by Surgeon General Thomas Parron.

Dr. Romano is one of six outstanding psychiatrists named by the surgeon general to carry on the work of a co-ordinated, nationwide drive against mental disease. Groundwork for the program was laid with the recent Congressional appropriation of $5,200,000 for the U. S. Public Health Service to get the federal program started. Of that amount, $850,000 is earmarked to be used to start construction of a National Mental Health Institute at Bethesda, Md., which ultimately will cost $7,500,000.

Dr. Romano, who served as visiting neuro-psychiatric consultant for the Eighth Service Command and psychiatric consultant to the Army in the European theater in World War II, will head the $3,000,000 new psychiatric clinic, the Rivas Clinic, being built at the UR.

Dem. & Chronicle

Aug. 15, 1946

Rochester

1946

By Albert Deutsch

Atomic Pile Seen as Nucleus Of U. S. Health and Medical Center

WASHINGTON, Aug. 16.—Surgeon General Thomas Parran, of the U. S. Public Health Service yesterday revealed plans for the creation of a three-pronged research project to apply at atomic energy "for the greater health and welfare" of the civilian population. The plan, which has not yet gone beyond the "scientific discussion" stage centers around an atomic pile that would be located at the Public Health Service's research headquarters in Bethesda, Md., just outside of Washington. (An atomic energy pile consists of normal uranium and a graphite-like material which slows down neutrons, thus permitting the normal uranium to produce a chain-reacting system without being processed into U-235 or plutonium.)

Dr. Parran

On one side of the proposed atomic pile would be built a center for atomic research from the angle of physical science; on the other would be a research center for the application of atomic energy in the biological sciences, including medicine.

A third building erected around the atomic pile would house research scientists, such as chemists, whose investigations would be pertinent to both the physical and biological sciences.

The proposed research center oriented around the atomic pile would be connected with the National Institute of Health, operated by the Public Health Service at Bethesda. One of its primary goals would be the application of atomic energy to the cure, and perhaps the prevention, of cancer and other human diseases. The atomic pile would permit extensive research into the inner life of the human body, in health and in illness, through the use of isotopic tracers which, by irradiation, make it possible to follow the course of food, blood and other substances as they pass through the human system.

Dr. Parran observes that the development of these isotopic tracers may prove to be "the greatest aid to medical research since the invention of the microscope."

The proposed atomic pile research center at Bethesda would be operated jointly by the U. S. Bureau of Standards and the Public Health service. The project already has won the approval of Secretary of Commerce Henry A. Wallace and Federal Security Administrator Watson Miller. Dr. R. E. Dyer, director of the National Health Institute, estimates that the center would cost about $15,000,000. Final approval would have to be obtained from the Congressional Committee on Atomic Energy before it could be launched.

The plan was announced at the first meeting of the newly-created National Advisory Mental Health Council, a six-man board appointed by Dr. Parran to help develop policy and supervise research under the National Mental Health Act passed last month by Congress. Dr. Parran, who presided over the meeting, was outlining plans for a new health and medical center at Bethesda —including research hospitals for cancer, tuberculosis and mental disease—when he slipped into a discussion of the atomic pile project.

The Mental Health Council consists of Doctors William C. Menninger, John Romano, George S. Stevenson, Edward A. Strecker, Frank F. Tallman and David M. Levy—all outstanding psychiatrists. Dr. Parran announced the appointment of four consultants to the council—Dr. F. Alan Chalmers of Minneapolis, Dr. Frank Fremont-Smith of New York, Dr. Nolan D. C. Lewis of New York and Dr. William Malamud, of Boston.

In an earlier column, I stated erroneously that Congress had appropriated $5,200,000 to the Public Health Service for the administration of the National Mental Health Act. I learn that this sum was stricken out of the act at the last moment, leaving the set-up without funds at least until next January, when Congress reconvenes.

PM- New York

THE WASHINGTON POST
Friday, August 16, 1946

Increase in Mental Illnesses for People Over 65 Predicted

A prediction that mental illnesses among Americans 65 years and over will double in the next 40 years was made yesterday at the first meeting of the National Advisory Mental Health Council.

In a statement issued at a meeting of the council, whose six expert members will assist the Surgeon General of the U. S. Public Health Service in administering the National Mental Health Act, the PHS declared:

"An increase of cases out of proportion to the increase of total population is forecast since the incidence of mental disease rises with age, and the number of Americans aged 65 and over is expected to double in the next 40 years."

The statement estimated that eight million Americans now suffer from some form of mental or nervous disease, said that the "blueprint" for a broad drive against such afflictions is provided in the new law, and added:

"Through the investment of our wealth in human resources as authorized under this law, we can make this a happier and healthier nation, hold together homes that would be broken because of mental illness, return many of those suffering from these diseases to productive citizenship, and protect our younger generation in their right to grow up as healthy, happy, useful human beings."

Congress has authorized, but not yet appropriated, $7,500,000 for construction of a national institution of mental health for research and the training of technicians, and has authorized, but not yet appropriated, 10 million dollars annually for grants-in-aid to States for attacks on the problem of mental illness.

The two-day meeting of the advisory council will end this afternoon with PHS and Federal Security Agency officials analyzing the law and discussing proposed policies with the council.

At yesterday's session, Representative J. Brown (R., Ohio) said that Congress, in passing the measure, did not intend that the States' obligations in caring for mental patients be removed.

The acat, he declared, is designed to promote Federal initiative in research and training of competent personnel so that all the States may benefit.

Dr. Edward A. Strecker, head of psychiatry at the University of Pennsylvania and a member of the newly formed council, praised Congress for its progressiveness and courage in enacting the legislation.

Other members of the council, all psychiatrists, are Drs. David M. Levy, Columbia University; William C. Menninger, Topeka, Kan.; John Romano, University of Rochester; George S. Stevenson, medical director of the National Committee for Mental Hygiene; and Frank F. Tallman, Ohio State Commissioner of Mental Diseases.

All attended yesterday's opening session with the exception of Dr. Levy.

The welcoming address was given by Miss Mary E. Switzer, assistant to the administrator of Federal Security Agency. Council members and guests were introduced by Dr. Thomas Parran, Surgeon General of the United States Public Health Service.

Other speakers were Mrs. Albert D. Lasker, secretary of the National Committee for Mental Hygiene; Dr. Robert Felix, chief of the Public Health Service division of mental hygiene, and Dr. Dale Cameron, assistant chief of the division.

Washington D.C.

ENQUIRER AUGUST 30, 1946 Frid

Former UC Teacher Named To Mental Hygiene Board

Dr. John Romano, Rochester, N. Y., former professor of psychiatry at the College of Medicine, University of Cincinnati, and Dr. Frank F. Tallman, Columbus, Director of Mental Hygiene for Ohio, have been named members of a six-man commission to assist Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, in administration of the National Mental Health Act, it was learned yesterday.

Bleecker Marquette, Executive Secretary of the Cincinnati Public Health Federation, said that the federation gave active support to the measure, which was passed by Congress this summer.

"Ohio will be entitled to a substantial allocation under the terms of this act, which provides for research, for mental hygiene education and for the training of personnel, all of which are vitally needed," Marquette said.

"The act authorizes two appropriations. One of them is for $4,500,000 to erect and equip a hospital and laboratory building in Washington, to be known as the National Institute of Mental Health. The other is an increase of $10,000,000 over the present $20,000,000 available annually for grants to states for the establishment and maintenance of public health services.

DR. ROMANO. DR. TALLMAN.

"Money is also made available for the training of personnel. This is one of the greatest of all needs. Nearly 2,000,000 men were rejected from military service for psychiatric reasons. Most of them could benefit by treatment. At present, there are not anything like enough trained psychiatrists, psychologists and psychiatric social workers to treat returned veterans and others who need care."

Cincinnati - Enquirer

By Albert Deutsch

Experts Chart Federal Program To Help Combat Mental Disease

Plans for a Federal attack on the Nation's Number One Health Problem, mental disease, were drafted last week in Washington by a group of high-ranking psychiatric experts called together for the purpose by the U. S. Public Health Service.

The plans include Federal aid to help break the critical bottlenecks in psychiatric research, trained personnel and mental health facilities. If Congress comes across with the appropriations needed to put these plans into effect, it would make possible the greatest single advance of our generation in American mental hygiene.

Deutsch

Last Summer, Congress passed the National Mental Health Act; authorizing an annual appropriation not exceeding $10,000,000 to the Public Health Service for waging a Federal campaign against mental disease. Unfortunately, no appropriation was made at the time. President Truman, in his recent budget message to Congress, recommended a total of about $6,000,000 for next year's administration of the Mental Health Act. The National Mental Health Advisory Council, consisting of six topnotch psychiatrists, met last Friday and approved a three-pronged offensive for the first year, conditioned on favorable budgetary action by Congress.

Here's how the Federal plan shapes up for the next year:

Research: $500,000 is set aside (if Congress makes the money available) for Federal grants to non-profit institutions and agencies, public and private, to stimulate and conduct scientific studies on the nature, cause and treatment of mental ills. The Advisory Council, at its meeting, considered 32 research projects that had been submitted in anticipation of Federal grants. The Council gave outright approval to nine projects, costing $100,000, rejected 15 and deferred the rest for further investigation. The Council's recommendations must go to Surgeon General Thomas Parran of the Public Health Service for final approval.

Training: $2,000,000 has been requested of Congress for Federal grants to aid in the training of desperately needed psychiatric personnel for the care, treatment and prevention of mental illness. The Council approved, as a starter, grants in aid to medical schools and centers for the training of 150 psychiatrists, 150 psychologists, 150 psychiatric nurses and 150 psychiatric social workers.

Community Services: The National Mental Health Act authorizes the Public Health Service to make grants to the States on a matching basis—two Federal dollars for every state dollar—to be used mainly in setting up mental health clinics. No Federal money is to be used for operating mental hospitals, which is considered to be a state or local responsibility. President Truman has asked for $3,000,000 for this purpose and for setting up Federal-financed demonstration projects in strategic areas. Part of the $3,000,000 can be used to prepare publications on mental health for the professional and lay public.

There isn't a state in the Union which isn't terribly short of mental health clinics, where people with emotional or mental disturbances can obtain psychiatric advice or treatment without being hospitalized. Experts tell us that at least one such clinic is needed for every 100,000 people. Many states haven't a single fully staffed mental clinic. The Federal program seeks to help set up about 100 clinics during the next year. While local public and private non-profit psychiatric projects can be supported by Federal funds, they are eligible only when submitted by an authorized state agency as part of a state plan. In other words, the local agency in each instance must submit its request for financial aid to the appropriate state authority, not directly to the Public Health Service.

The National Mental Health Advisory Council, appointed by Surgeon General Parran to shape policy and approve projects, includes Drs. Edward A. Strecker, William C. Menninger, John Romano, Frank F. Tallman, George S. Stevenson and David M. Levy. Dr. Robert H. Felix, head of the Public Health Service's mental hygiene division, administers the program set up by the National Mental Health Act.

Citizens interested in the Federal mental health program might write their Congressmen and/or Rep. John Taber, chairman of the House Appropriations Committee, in support of President Truman's budget recommendations.

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

IN REPLYING
ADDRESS THE SURGEON GENERAL
U. S. PUBLIC HEALTH SERVICE

April 3, 1947

MEMORANDUM

TO: Members of the National Advisory Mental Health Council

SUBJECT: Appropriations Bill as Passed by the House, March 25, 1947 for Fiscal Year 1948.

I am sure you will be interested in knowing the results to date of the 1948 Appropriations for mental health.

$4,000,000 was appropriated by the House for these activities exclusive of grants to states. The budget included an estimate of $5,108,000 to carry out provisions of the National Mental Health Act. The House, however, appropriated $1,108,000 less than the Budget requested, because it felt that since the program is a new one it would be wise to proceed on a moderate basis during the first year. In this $4,000,000 is to be included the maintenance of hospitals at Fort Worth, Texas, and Lexington, Ky., research, training, and administration. It will now be necessary to review and critically appraise the appropriations for research grants so that those with the greatest potentialities will be awarded the aid.

Besides the $4,000,000 appropriated, the Committee has specifically earmarked $3,000,000 in grants to States to be used solely for mental-health activities.

It will be a source of gratification to you to know that the Report of the House Committee contains the following statement: "The Committee is mindful of the great good to be derived from this program and expects to make adequate provision therefor".

The appropriation must next be acted upon by the Senate.

Thomas Parran
Surgeon General

COPY

Federal Security Agency
U. S. Public Health Service
National Institute of Health
Bethesda 14, Maryland

January 8, 1947

Dr. William C. Menninger
General Secretary
The Menninger Foundation
Topeka, Kansas

Dear Doctor Menninger:

I should like to acknowledge receipt of your application for a grant in aid in the amount of $18,130 submitted in behalf of Doctor George S. Klein's proposed research on "A Clinical Study of the Personality and Psychiatric Diagnostic Correlates of Certain Perceptual Effects."

This application is being prepared for presentation at the next scheduled meeting of the National Mental Health Council, January 24, 1947, and notification of the action taken by the Council will be forwarded immediately thereafter.

It is noted that the proposed budget includes two items which are usually disapproved by the National Advisory Councils in making grants-in-aid. It is the policy of the Councils that principal investigators with tenure shall not receive salary reimbursements from grant funds. It is also contrary to policy to grant funds for indefinite items such as your request for $800 for "Miscellaneous (to provide for price changes and other unforeseen equipment needs)." We would suggest that, if this item cannot be deleted, some definite type of equipment should be specified.

Clarification of the questions raised, and your authorization for the Research Grants Division to amend your application to make any necessary changes, will facilitate the processing of the application for presentation to the Council.

Sincerely yours,

Ernest M. Allen
Assistant Chief
Research Grants Division

cc: Dr. George S. Klein
Dr. Kolb (2)

COPY

January 13, 1947

Dr. Lawrence Kolb
U. S. Public Health Service
Washington 25, D. C.

Dear Doctor Kolb:

Thank you for your suggestions in our phone conversation today.

It was my intention to indicate to you over the phone that where we have listed a half-time salary as the co-director of the three research projects which we submitted we did so on the basis that someone would have to be employed to do the clinical work which these persons are now doing. In other words, in contrast to a state institution or university and despite the fact that we are a Foundation our chief source of income has been and must continue to be from clinical work. Therefore, if we relieve someone from clinical work to do this research we must of necessity either forego that income or, as is our intention, employ someone else to do the work. Consequently, it is my feeling that this particular situation, which I assume would apply in other private institutions, involves a principle for which some policy should be considered by the Research Committee.

It was my understanding that you had encountered the same situation in some other requests and that a policy would have to be worked out to cover such situations. It is implied in paragraph II, A 1 of the Agenda for the meeting. Since Doctor Rapaport will be present at the meeting you felt it was not essential to revise our statement but as I indicated I do not want to put Doctor Rapaport on the spot in defense of our own particular requests. Therefore we will be sending a slightly revised first page of our requests, indicating that the amount of money requested for the Director or the co-director does not accrue to the salary of the worker and will be used to employ a substitute to carry on the clinical work now being carried by the person designated.

If there is anything further we should do about this please let me know. We are grateful to you and to Docotr Ellis and to Doctor Felix for including these projects in the Agenda and hope that this slight conflict can be cleared up.

Sincerely yours,

William C. Menninger, M. D.

WCM-n

THE MENNINGER FOUNDATION
TOPEKA, KANSAS . . . . . .

FOR PSYCHIATRIC EDUCATION
. . . . . AND RESEARCH

January 15, 1947

Dr. John Romano
University of Rochester Medical School
Rochester, New York

Dear John:

I want to apprise you of the situation we encountered when submitting three projects for consideration to the Research Grants Division of the Public Health Service. The enclosed copy of the letter from Dr. E. M. Allen is a sample of the letters I received in wake of our submitting the projects. To gather some information I telephoned Dr. Lawrence Kolb. The copy of my letter of January 13, which I also enclose here, records his suggestion for coping with the situation. It is also in keeping with the policy recommendation that appears on the first page of agenda of the Committee on Research of which you are the chairman under II, A, 1. In another letter to Dr. Kolb accompanying a revision of our budget sheet I wrote, "the footnotes we incorporated on these pages are meant to explain that these people (that is, the directors of the projects) have been engaged in performing clinical duties and the amounts requested are to pay for substitutes to do their clinical work and not to supplement their salaries".

I believe that many institutions, and certainly all private institutions which want to do research and want to make sacrifices for it, will be faced with the following situation:

(a) They will devote the time of some of their best men to research, giving up the income-producing, teaching, and administrative time of these men which is of crucial importance to the institution. This will be the case in all those institutions where endowed research positions are not extant (and I want you to count on your fingers how many institutions there are where such positions do exist).

(b) If these institutions will be supported to the extent that at least the salaries of men whose services they give up for the

sake of research will be paid so that some kind of substitutes can be hired to carry on the routine work, these institutions will be encouraged to make the sacrifices for research described under (a).

I feel that a policy-making board should seriously consider this situation. I regret only that I have to bring up the problem in connection with the institution with which I am associated. I trust that you, who can see the situation in several other institutions, will be in the position to put this issue in general terms. As for me, I feel that the policy we choose to follow in this respect may make the difference whether mature men steeped in clinical work will do research or whether all the mature talent will be absorbed in routine and administrative work and the research will be done (under more or less supervision from these mature men) by "beginners". At least this is how the situation looks to me.

I hope you will be able to give consideration to these matters before the meeting of the Committee.

Sincerely,

William C. Menninger, M.D.
General Director

WCM:el

THE MENNINGER FOUNDATION
TOPEKA, KANSAS . . . . . .

FOR PSYCHIATRIC EDUCATION
. . . . . AND RESEARCH

January 15, 1947

Dr. John Romano
University of Rochester Medical School
Rochester, New York

Dear John:

I just finished writing you a letter when it occurred to me that it might be well to bring to your attention another policy problem which might well deserve your consideration before the meeting.

I think your Committee on Research might consider not only grants for research projects but also issues of training for research. It goes without saying that no regular training of psychiatrists, graduate or postgraduate, amounts to a training in research and that such training can be accomplished only by apprenticeship in research institutions. I therefore wonder whether or not your Committee should consider the establishment of research training fellowships and junior research fellowships and the ways and means provided for such fellowships within the framework of the present legislation.

Looking forward to seeing you soon,

Sincerely,

William C. Menninger, M.D.
General Secretary

WCM:el

THE MENNINGER FOUNDATION FOR PSYCHIATRIC EDUCATION
TOPEKA, KANSAS . . . . . AND RESEARCH

March 5, 1947

Dr. John Romano
University of Rochester School of Medicine
260 Crittenden Boulevard
Rochester 7, New York

Dear John:

Like yourself, I too was deeply shaken by the passing of Dr. Kurt Lewin. Particularly those of us who knew his broadminded, non-partisan character experienced his passing as a very great loss. Even though this certainly is outside of what I consider my responsibilities on the Advisory Council, I could not help but give some thought to what losing him will mean to your Committee. I thought you would not mind if I dropped you a note on the ideas I had.

Psychologists like psychiatrists are a sectarian lot; they have many factions. Lewin somehow stood above these factions and had the respect of all. I imagine you would want to find somebody in his place who could fill this bill to some extent. In rummaging through my memories and in talking to a few people, two names stand out: one of them is Dr. Gardner Murphy, the head of the Psychology Department of City College. He is a past-president of the American Psychological Association and a man of high ideals, integrity, and general recognition. The other is a younger man, Dr. Robert White of the Harvard Psychological Clinic, who happily unites an academic background and clinical interest.

These are my ideas; take them for what they are worth.

Yours,

William C. Menninger, M.D.

WCM:el

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

IN REPLYING
ADDRESS THE SURGEON GENERAL
U. S. PUBLIC HEALTH SERVICE

May 20, 1947

Dear Doctor Romano:

I have read with much interest your thoughtful letter of May 14th concerning policies to be followed in giving grants for training. I agree fully with your point of view that training grants should be given to as large a number of qualified institutions as possible even though no one institution during this first year will have an adequate amount.

Our Committee on Psychiatric Training was working under tremendous pressure and in my opinion were seeking to apply an exact measurement to the problem which was not susceptible of such measurement.

I am sure Dr. Felix has sent or will send to you suggestions which were developed after the Council meeting which had for their objectives a more satisfactory appraisal of the several training projects.

If we should have the good fortune of getting additional funds for training as a result of the action of the Senate in increasing our mental hygiene appropriation by $500,000 it should be possible to spread much more widely our grants for this purpose during the next year.

I assume that Doctor Felix will be discussing the matter with you this week at the American Psychiatric meeting.

With kind regards, I am

Sincerely yours,

Thomas Parran

Surgeon General

Dr. John Romano
Professor of Psychiatry
The University of Rochester
260 Crittenden Boulevard
Rochester 7, New York

cc Members National Advisory Mental Health Council
Dr. Felix

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

IN REPLYING
ADDRESS THE SURGEON GENERAL
U. S. PUBLIC HEALTH SERVICE

June 19, 1947

MEMORANDUM

To: Members of the National Advisory Mental Health Council

Enclosed is a copy of a letter from Dr. Edward A. Strecker commenting upon the correspondence with Dr. John Romano, which was sent you under date of May 20, 1947.

If members of the Council wish to comment further upon this or other subjects relating to the Mental Health Program, I shall be glad to see that the correspondence reaches the entire group if that is agreeable to the writers.

/s/ Parran

Surgeon General
Chairman, National Advisory Mental Health Council

Enclosures

May 14, 1947

Dr. Thomas Parran
Surgeon General, United States Public Health Service
Washington 25, D. C.

Dear Dr. Parran:

If you remember, I had to leave before the end of business late Wednesday afternoon, April 23. I left during the final deliberations of the Council with you as to actions which the Council was to take on the report of the Training Committee, and, more particularly, on the grants for clinical psychiatric training. Frankly, I was somewhat concerned by this report of the Training Committee. Perhaps it was my fatigue, perhaps we were trying to compress matters of major policy and decision into too small a segment of time.

I can understand that there may have to be some type of priority rating on the part of the committee in order to determine relative eligibilities and urgencies of grants to certain training areas. I was not clear as to all of the criteria of priority, nor how uniformly the criteria were used for final judgments. Having had the opportunity in the past fourteen years to have worked in a number of clinics in various parts of the country and to know intimately men who are currently working in other clinics, I was somewhat surprised at the priority listing. To be specific, I was shocked to find the University of Cincinnati number 23, and below a number of other clinics which I think are distinctly inferior to it. The first question I should like to ask is should the Training Committee consult the members of the Council for their opinions concerning priority? I know that this brings up the question as to the relative responsibility of the committee. If I remember correctly, our Research Study Section is open to suggestion from all members of the Council and invites their opinions as to the validity and pertinence of any project. Further, we welcome suggestions and opinions from them before we make our final decision.

If certain schools such as Cincinnati get nothing at all under the appropriation, a considerable amount of damage will have been done. It is possible that there may be an inference that the department did not measure up to the standards of others. This could not fail to react against a department when it attempts to raise money locally or obtain money through foundations. One cannot escape the fact that the Committee on Training, by the fact that it will give to some and not to others, unfortunately has the power to produce the impression that there are two types of departments--acceptable and non-acceptable. In view of this power I think it should be exceedingly careful to see that all first-rate places get a grant, no matter how small. Even an open expression by the committee that some schools which deserve grants did not get them because of the limited money will not counterbalance the effect of being grouped with inferior training centers.

I should like to take a definite stand as a member of the Council that schools having really good programs be given a grant no matter how small. For the reasons noted above, the situation of these schools--even though they be granted smaller amounts of money--would be helped to a degree far greater than the actual amount of money received.

An objection may be raised that this may violate the principle that all schools that are given money should be given enough money to benefit them. I have serious doubts about the necessity of such a policy. So far as I know, all of the grants to go to the first sixteen are to be made to centers which already have some money. My fundamental premise is that the money at present should be granted to the best places so that they can produce the greater number of trained people so urgently needed. I don't believe that wearing wishing caps, even though they may be stuffed with bank notes, is going to solve the problem of an inadequate number of skilled and trained people. I can't see how allocating money to inferior places is going to improve matters significantly, particularly when this is done in preference to choosing superior programs.

I use the example of Cincinnati as I probably know as much about it as anyone does. I have also had occasion to know something of Colorado, Yale, Harvard through long-term personal experience, and of others through visits and through staff. In my opinion the set-up in Cincinnati is excellent. They have a group of very well-trained young psychiatrists headed by Levine and Rosenbaum; they have good working relationships in medicine and in pediatrics; a group of top-notch investigators like Mirsky and Ferris, and a long-time productive relationship with the health and social agencies of the community. In addition, they have begun a tie-up with the United States Public Health Service in Lexington. I hope that this liaison will grow, as I am sure it can be made mutually beneficial.

As I have told you on previous occasions, I am deeply and sincerely interested in doing whatever I can to help you and the others administer and initiate this very important program of national mental health. I am thankful for your broad vision and for your wisdom, and hope sincerely that you will find it possible to be with us in New York at the time of the meeting.

I am sending a copy of this letter to Dr. Felix.

Sincerely yours,

John Romano

JR/MS

(Copy sent to Dr. Felix)

COPY

EDWARD A. STRECKER M.D.
111 North Forty-Ninth Street
Philadelphia 39, Pa.

May 28, 1947

Dear Dr. Parran:

Thank you for the copy of the communication from the Chairman of the Committee on Research, which has been circulated to the members of the Council. Speaking for the members of the Committee on Training, I would like to say we welcome constructive criticism and help. I am glad to communicate my reactions and, were I less than frank, I would be rendering a disservice to the carrying out of the Mental Health Act.

At the meeting in New York of the Council, some of us were troubled at what seemed to us to be a personalized and non-objective attitude on the part of the Chairman of the Research Committee concerning the rating given by the Committee on Training to the Medical School of the University of Cincinnati. Some of us felt that it was not an attitude which contributed to satisfactory progress. It would have been just as logical for me to have expressed my dissatisfaction because in my opinion the Committee on Research failed to approve several projects, and notably one which in my own personal knowledge and judgment is definitely better than some of those which this Committee did approve. Even though the Committee on Research made its mistakes both of omission and commission, I felt it did a reasonably good job, as did the Committee on Training, and therefore, I, along with the other members of the Council, respected and accepted the final decisions.

I believe the argument I quote: "If certain schools such as Cincinnati get nothing at all under the appropriation, a considerable amount of damage will have been done. It is possible that there may be an inference that the department did not measure up to the standards of others. This could not fail to react against a department when it attempts to raise money locally or obtain money through foundations. One cannot escape the fact that the Committee on Training, by the fact that it will give to some and not to others, unfortunately has the power to produce the impression that there are two types of departments - acceptable and non-acceptables. In view of this power I think it should be exceedingly careful to see that all first-rate places get a grant, no matter how small. Even an open expression by the committee that some schools which deserve grants did not get them because of the limited money will not counterbalance the effect of being grouped with inferior training centers.

"I should like to take a definite stand as a member of the Council that schools having really good programs be given a grant no matter how small. For the reasons noted above, the situation of these schools — even though they be granted smaller amounts of money — would be helped to a degree far greater than the actual amount of money received."

is quite illogical. It is obvious that not all the projects either in Training or Research can or ever will be accepted. It would be just as logical to say that since several good projects were not acted on favorably by the Research Committee, that the departments from which they originated are inferior. Clearly often this is not so.

The matter of granting small amounts of money to a large number of institutions was thoroughly discussed in Council and the opinion was so solidly against it that I am surprised to have it crop up again. Very valid arguments as to the lack of wisdom of such a course were presented by Alan Gregg and others and personally I am convinced there is no surer way of destroying, or at least seriously jeopardizing the proper functioning of the provisions of the Mental Health Act than to give small sums of money to a large number of institutions.

I shall be glad to discuss any of these issues at the next meeting of the Council.

I trust, too, that this communication, along with others you may receive, will be circulated to the members of the National Advisory Mental Health Council. It is a good way of striving for that cooperation which is a hallmark of the maturity needed to attain our objective.

I repeat, speaking for the Training Committee, that we welcome sound criticism and help. However, after all things are weighed, the Committee will make the decisions. If the time ever comes when the decisions of this or any other committee approved by Council and the Surgeon General are not accepted, then I would no longer wish to participate.

Sincerely yours,

/s/ E. A. Strecker
Edward A. Strecker, M.D.

Dr. Thomas Parran, Surgeon General
Chairman, Nat'l Advisory Mental Health Council
U. S. Public Health Service
Washington 25, D. C.

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

IN REPLYING
ADDRESS THE SURGEON GENERAL
U. S. PUBLIC HEALTH SERVICE

July 21, 1947

MEMORANDUM

To: Members of the National Advisory Mental Health Council

There are enclosed for your information copies of self-explanatory letters received from Dr. John Romano and Dr. George S. Stevenson.

Thomas Parran

Surgeon General
Chairman
National Advisory Mental Health Council

Enclosures

June 23, 1947

Dr. Thomas Parran
U. S. Public Health Service
Washington 25, D. C.

Dear Dr. Parran:

Thank you for sending me a copy of Dr. Strecker's letter. As I have had a chance to think of the first work of the Advisory Council there are some general things that I feel should be taken into account.

First of all it seemed to me that the work of the three committees has proceeded too independently, and in view of that I would like otomodify the viewpoint expressed by Dr. Strecker in his last paragraph to the point that the decisions of the Committee should stand. It seems to me that it is the job of the Council to see that the decisions of the Committees dovetail with each other in order that they may be mutually supporting. I believe the ultimate test of the effectiveness of this Act will not be the number of research projects turned out or the number of psychiatrists trained, but the amount of good work that is done for the people of the United States who are in need of mental health services.

If this is true, then, the grant-in-aid program, coupled with the independent activities throughout the country, should give the lead to both training and research. It should show where training is needed, what kind of training, and also where our researchhgaps are. I must admit that while acting as a member of the Council this was not quite so clear to me as it is now, and the other members of the Council have had much less opportunity to secure this over-all perspective in their daily work than have I. Most of them are academically focused and think in terms of academic strenghtening.

At our very first meeting, for example, it was pointed out that we have a shortage of training facilities and that every effort should be made to utilize what we have and to focus training in such a way as to augment our training facilities. In the allocation of funds, however, there was no effort to clarify the critical points of shortage of personnel, and I am afraid that the way grants were made is almost certain to tie up the funds in such a way that changes in allocation will be difficult to bring about. As a result there are training centers to which no attention has been paid and which are likely to go unused whilethe inexperienced centers are being strengthened.

There are some thirty vacancies for psychiatrists in the children's field, which is more than anything else the field represented by the grants-in-aid. Unless these vacancies are filled the whole grant-in-aid program is threatened with the use of inferior personnel. In compensation for this I have been able to secure $15,000 this year from the Commonwealth Fund, contrary to their decision more than two years ago that they would not make grants for

stipends for the first year's training in child psychiatry, This will make it possible for us to "save" the above mentioned experienced centers, but I believe in the future the Council should take seriously the fact that it has a job over and above and sometimes contrary to that of the individual committees.

I believe that the Council should in the future decide the type of help that it wants from the committees and not allow them to move along independently. For example, it might ask the committees to review the country with the possibility of building up areas in which there is no center of psychiatric teaching. It might ask them, on the other hand, to build up four or five top ranking places in which our future professors could be trained. It might ask them to build up centers for training child psychiatrists or for training personnel for research, depending upon what happens to be the need from time to time.

I feel most comfortable that you have put Dr. Alan Gregg on the Council for his work has brought him into the broader perspective.

Sincerely yours

S/ George S. Stevenson

Medical Director

June 24, 1947

Dr. Thomas Parran
Surgeon General, United States Public Health Service
Washington 25, D. C.

Dear Dr. Parran:

Thank you for sending me a copy of Dr. Strecker's recent letter to you, in which he indicated his reactions to the points I presented in my earlier letter to you and to the discussion which took place in the Council meeting in New York City. You ask if it would be agreeable to the writers if this and other correspondence dealing with Council matters should be sent to the entire group. Not only do I have no objection, but I think it an excellent idea. You will remember that my earlier letter to you was in the nature of unfinished business, as I had to leave the Council meeting in mid-afternoon and was asked by you to send my thoughts on the discussion which had to do with the last order of business, namely, the Report of the Training Committee.

As I left, it was my understanding that the Council had approved the Report of the Training Committee but that, if there were to be any changes in the amount of money to be expended by the Training Committee, the existing order of priority and assignment of stipend would be open to review. When I learned that the latter was the case and that there was to be a change in the amount of money available for the Training Committee, I presented my suggestions to you and in the New York meeting presented them to the Council as a group.

Essentially my motive in presenting the points was the following. I believe sincerely that American psychiatry is in urgent need of skilled leaders and teachers. Therefore, I feel that the wisest plan would be to see to it that those schools and institutes which currently are the best prepared to teach because of men and facilities should be underwritten to insure the training of as many skilled persons as possible. I chose to speak of the University of Cincinnati particularly because of my intimate knowledge of the men and the facilities in this school. In instances like this I prefer to speak of particulars so that I may illustrate and defend my point of view rather than deal in abstractions. At the meeting it was the Council's decision that we retain the original approval of the committee report. Naturally, as a member of the Council, I accepted this majority decision.

However, as I read Dr. Strecker's letter, I sense that there is another matter which is perhaps more fundamental than the specific instance of which he spoke and of which I have just written. It has to do with the zone of responsibility of the Council. Perhaps it will be possible at our next meeting to place this matter and two others which follow on the agenda, so that we may discuss them in detail. The first question is what is the fundamental responsibility of the Council? Is it essentially a Council which should accept without comment the various committee reports, or is it invested with the responsibility and privilege of expressing opinions, offering suggestions and criticism on the reports which

are submitted to it by each of the committee chairmen? In other words, is it proper for me or for any other member of the Council to question, offer suggestions, or criticize a committee report? I must confess that this has been my understanding. If I am in error I would appreciate your telling me, so that I may know the facts correctly.

A second matter concerns the time interval between the preparation of the committee reports and the review of the committee reports by the Council. In the times that we have met the Council has met on the third day of a three-day session. The first twodays and two nights for the committee chairmen are filled with the major responsibility of directing the committee's work and of preparing a report to be presented to the Council on the third day. Each of us who is a committee chairman, therefore, is so engrossed in the preparation of his own report and in presenting it to the Council that he has little time to study and digest the reports of the other committee chairmen. My question is this--would it be advisable to have a period of time elapse between the work of the individual committees and the meeting of the Council? As I understand it, this is the way in which the other Councils operate. It would give the Council an opportunity to study and digest more thoroughly the work of the committees, so that it may be in a better position to give an opinion. I believe we have discussed this before, and there may be many reasons why it has been arranged in the way it has. Certainly one reason has been the tremendous pressure of time and of multiple demands made on those of us who serve on the Council. The present method saves time. I believe a second reason was the matter of expenses for travel and of administration of the meeting. There may be other reasons.

A third question which I should like to have the Council discuss at the next meeting is the matter of having members of the Council act as chairmen of the committees. I don't know if this procedure is followed in the other Councils, nor the reasons for its operation in our Council. As it now stands, three members of the Council are chairmen of the committees and the remaining three are members of one or the other committee. Actually, then, when a chairman presents the committee report to the Council, he is actually presenting it to four members and not to six. Would it be proper to discuss this matter at our next meeting, namely, the double assignment of Council members?

I look forward eagerly to meeting with you and the members of the Council at the next meeting. I hope we shall have an opportunity at that time to discuss these matters in detail.

Sincerely yours,

S/ John Romano

John Romano, M.D.

February 16, 1948

Dr. Thomas Parran
Surgeon General, U. S. Public Health Service
Washington 25, D. C.

Dear Dr. Parran:

I read with sincere regret the announcement of your retirement. I have looked forward eagerly to the meetings of the Mental Health Council in Washington for a number of reasons. One very important reason was the opportunity of meeting and sharing with you the responsibilities of long-term planning in the field of mental health. Although I have known you a very short time, I have been sincerely impressed with your qualities as a leader and as a creative thinker. I have been impressed by your courage, intelligence, and wisdom in dealing with others.

Your record in the past twelve years is concrete evidence of your courage in facing and your ability in planning for the real and urgent health needs of our nation.

Cordially yours,

John Romano

JR/MS

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

OFFICE OF
MEDICAL OFFICER IN CHARGE

Quarantine Station
Miami Beach, Fla.

March 2, 1948

Dear Doctor Romano:

Your kind letter has been forwarded to me here, where Mrs. Parran and I are getting a brief vacation.

I want you to know how deeply I appreciate the kind sentiments which you express. It has been a great pleasure to know you during these last two years and particularly to see the way your mind works.

Some time ago, a leading American educator was telling me how much he admired General Marshall. He said, "Of all the men whom I have known, General Marshall, more than any other, has the ability, in dealing with a complex situation, to define the important variables and to keep them constantly in equation."

One of my pleasant tasks has been to participate in the sessions of our several councils. There are some of the best medical and scientific minds in the country. May I tell you that in my judgement you have the same quality of mind as that which my friend has attributed to General Marshall?

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

OFFICE OF
ICAL OFFICER IN CHARGE

I hope our paths will cross often in the days ahead.

With all good wishes, I am,

Cordially,

Thomas A. Ratcliffe

John Romano, M. D.
Psychiatrist-in-Chief
The University of Rochester
260 Crittendon Boulevard
Rochester 7, N. Y.

C O P Y

THE MENNINGER FOUNDATION
TOPEKA, KANSAS

April 26, 1948.

Dr. Robert H. Felix
Room 3018 Railroad Retirement Bldg.
4th & D, S. W.
Washington, D. C.

SUBJECT: Comments on the Reports of the Sub-committees for the Mental Health Advisory Council.

Dear Bob:

It is with a great deal of regret that I cannot possibly be with you on May 14 and 15 because as I indicated in previous letters these dates conflict with the American Psychoanalytic Association meets of which I am president. The Council Meeting and Committee on Standards and Training meet on the 14th with the standing committees meeting that evening and the first day of the Association meeting is on the 15th. May I make a plea that we do not conflict with any national psychiatric meetings hereafter as dates set for the Council. I am aware of the fact that this saves two days for most of the rest of the members but with a six man Board it seems to me rather important that a date be chosen in which at least at the time that it is chosen it is acceptable to all members of the Board.

1. General Comments

A. Sub-committee meetings. The Board, I think should consider ways and means of advising you as to how the Sub-committee meetings can be less intense, less strenuous and demand far less of those persons whom we ask to assist us. I have only the Training Committee meeting on which to judge but it was far, far too strenuous to expect people to continue with such service. This may be an administrative matter but it seems to me it is of primary importance. We cannot expect people to work until two or three o'clock in the morning on this job. It is highly commendable that we do but something is just cockeyed in the system. Therefore, I recommend:

(1) That ways and means be devised to prevent excessive demands on our consultants.

(2) That official thanks go from the Council to every member of every Advisory Committee expressing our recognition of the tremendous effort they have invested and our deep appreciation to their guidance and counsel to us as the Council. I think we should indicate that we could not possibly function without their help and are taking steps to make this demand less intense upon them.

2. Recommendations from Consultants: I am convinced that if we give people an opportunity to express their opinions we could learn a great deal. Therefore, I would recommend that the Council adopt a policy of asking every consultant on everyone of these three general advisory committees to give us their opinion and advice as to how we can do the job better, how we can make their work less strenuous and yet just as effective and any other suggestions they would have to us as the Council. I think it would be well worthwhile to point out to them our responsibility and why we want their advice.

3. Integration: I am not at all convinced that we have as yet begun to achieve the desirable integration between the committees on training or between the three areas of training, research and community service. Specifically, this letter is dictated on April 26. The meeting of the Council is two weeks hence. I have no idea whatever, as a Council member, of what is recommended from research or from community service. I appreciate that this may be an administrative problem within your own division and yet I don't see how we can act intelligently without throughtfully considering these three areas and our responsibility for allotting money between the three.

Integration within the Committee on Training seems to me to still be lacking the ideal. While we have the various disciplines represented on the Nursing, Psychology and Social Work Committees, we have not as yet had those disciplines represented in the Psychiatric Committee. We can go on giving lip service to this business of "The team" but I am quite certain that the committee for instance on Psychiatry has no really adequate conception of what went on in the other three divisions. I believe this is an administrative problem and I don't know how to solve it but I certainly want to emphasize and point out that we are not as yet meeting our responsibility.

For instance, I am sure that we ought to be favoring those institutions that have a sufficiently adequate psychiatric program to conduct, for instance, an adequate psychiatric nursing program. We do have two psychiatrists on the Psychiatric Nursing section but I don't know whether they even have the data as to what kind of a psychiatric training program is currently going on in the institution nor what the Public Health Service, through this Mental Health Act, is providing in funds to augment it. I think one could duplicate this throughout. It doesn't make any sense at all to me to make a terrific grant in one area, say psychiatric nursing, if we have a weak psychiatric department in the school where we are making a grant. How can we integrate that? Isn't that our responsibility? Shouldn't this be done at the time we are making the grant?

4. Money Available: At the moment I dictate this I have no idea and I presume you don't either of how much money is to be granted. I am impressed at least in the psychiatric committee of how we whittled grants right and left. Again and again I was impressed, as an on-looker, of the number of grants from very superior institutions in which we whittled off twenty percent, fifty percent, seventy-five percent in a hasty sort of a fashion. If there is enought money I hope that these will all be reconsidered. In fact, as a member of the Council, I insist from my single vote that they must be reconsidered. I make this recommendation because in my testimony before Mr. O'Keefe's committee he asked whether we were going far enough and fast enough. I regretfully admit that I couldn't answer that or didn't answer it adequately but I wrote him subsequently to the effect that I thought we were not going fast enough or far enough whenever we had to cut down the grants from excellent training institutions to one-half or one-third or even one-fourth of what they requested.

A. Comments on preliminary report of the Sub-committee on Psychiatric Social Work: This committee ought to be commended on its report. I think it is excellent. Again, obviously they have had to try to create a minimum and optimum grant and I would so hope that we can have the money to make the optimum grant. I don't know whether it is the Council's job to review these applications

"rejected" and I wonder about the advisability of having somebody from this committee present to explain these details if and when the Council meets.

This committee discusses the point of support from USPHS funds to maintain in-service training programs within clinical field work facilities. They specifically cite the situation at the Menninger Foundation, recommending a grant for the coming year but none hereafter.

Although personally involved, I want to raise the question as to what is the institution providing field work to do about administrative problems in relation to managing this field work facility? I think the Council ought to specifically instruct the Social Work Committee, that if we follow their recommendation then the institutions who are to supply the students should include in their grant such administrative funds as are necessary for the field work facility to carry out the training. In simpler terms, I wonder what their thinking is as to who is going to pay the bills for keeping the records, for the office space, for the stenographic work. This becomes somewhat personal in my illustration but five of us from the Menninger Foundation went back to Pittsburgh to sit with them at their faculty meeting in March and while the University, I believe, paid the expenses of four of the five it nevertheless cut out considerable time, effort and work in the Foundation. None of that is paid for by merely paying railroad expenses. Field agencies can't carry on this work unless they are remunerated and it is not clear from this report how they will be.

What are we going to do about the professional coordination at the federal level, between the requests and the functions of the training program and the Community Services program of the Mental Hygiene Division? I ask this hoping that the Council will give it earnest consideration.

B. Sub-committee on Psychiatric Nursing: Quite frankly this report somewhat distresses me. Seventeen of nineteen applications were approved in contrast to at least ten, fifteen or perhaps twenty psychiatric training grants which were disapproved (I don't know what percentage of the whole number); only fourteen of the sub-committee on clinical psychology out of approximately forty-two were approved and eleven out of thirty-seven of the social work were disapproved. In other words, the very high percentage of acceptance for approval of the Psychiatric Nursing Committee makes me wonder about their standards.

Review of the recommended grants for nursing seem totally out of line to me, based on the experience in the psychiatric training plan. I personally just cannot conceive on the basis of the psychiatric training how the Council can approve grants of eighty-nine thousand, fifty-five thousand, sixty-seven thousand, seventy-eight thousand, fifty-one thousand, fifty-three thousand and many other sums over thirty thousand to training in nursing when we have given none in psychiatry, to my recollection (I do not have the figures in front of me) of over forty or fifty thousand. Something is totally out of line in this and I think it is the Council's responsibility to find out where and how. I personally cannot approve of these enormous grants for the training in nursing when I have no indication as to what the coordinated programs are in psychiatry, clinical psychology and psychiatric social work. If the latter three are weak, then it doesn't make any sense whatever to me to give an enormous grant in nursing.

Personally, may I make myself clear that I am extremely sympathetic with psychiatric nursing and I recognize a great need for it. Their grants, however, are totally out of line with everything else in the amount of money, and I would feel it a very great responsibility of the Council to check these as to the coordinated programs in psychiatry. I would urge detailed investigation to find out how much psychiatric guidance is given to the course in psychiatric nursing at Columbia University which is supposedly recommended for eighty-nine thousand dollars, at the University of Minnesota where it is recommended that we give seventy-eight thousand dollars, at the Catholic University for fifty-three thousand dollars, at the University of Washington in Seattle for fifty thousand dollars where I know we don't even have a Professor of Psychiatry appointed.

C. Report of the Sub-committee on Training in Clinical Psychology: This seems to me a very excellent report. I have no suggestions or criticisms. I do feel that if we have the money that by all means we should give the "desirable grant." I think also we should give the "desirable number of stipends." This report impresses me with its great care but this care is obviously emphasizing the importance of scaling down the amount available to meet the minimum needs. If we are going to do the job, then I would hope that the Council gives, if at all possible, the "desirable grant" and if not at least the "minimum grant." This report illustrates again the fact that we don't have anywhere near enough money to do our job and must curtail the program proportionately in every area because we don't have available funds.

D. Research Grants: I have no data on this subject and have not had a report from this Committee so I have no comments. I caution our Council on the necessity to integrate the work of this committee with Training and with Community Services.

E. Community Grants: Again I have not the slightest idea nor have I even seen a report from the Public Health Service as to how much money has been given for community grants under this general category. I feel at a loss as to my responsibility on the Council because, except for the state of Kansas, which I happen to know incidentally, I do not know what this Act has provided in the way of help to states in terms of money. Perhaps this information has been sent me and I just have not seen it. There is no way I can judge without such information.

This long memorandum is in lieu of my inability to attend the Council Meeting. I hope it may be helpful and I do feel adeep sense of responsibility for our actions as an advisor to the Surgeon General.

Sincerely,

WCM/lf
dfs

William C. Menninger, M. D.

THE UNIVERSITY OF ROCHESTER

School of Medicine and Dentistry and Strong Memorial Hospital

260 CRITTENDEN BOULEVARD | ROCHESTER, NEW YORK 14642

JOHN ROMANO, M.D.
Distinguished University Professor of Psychiatry
(716) 275-3047

March 25, 1977

Eli A. Rubinstein, Ph.D., Scientific Director
Brookdale International Institute
P. O. Box 801
Stony Brook, N. Y. 11790

Dear Eli:

I had copies made of the enclosed two prints. The Fellowship Grant Committee photograph is completely legended. It was the last year that I chaired the Committee (1960-1961). The other picture is that of the National Advisory Mental Health Board. It is the 3rd year of the Board's existence. Carlyle Jacobson, Karl Bowman, Alan Gregg and Leo Bartemeier have replaced Frank F. Tallman, George S. Stevenson, David M. Levy, and Edward A. Strecker. This is the 1948-1949 year.

You may keep these. I hope you may find them of some help.

Cordially yours,

JR:jw
Encs.

The Teaching of Psychiatry to Medical Students: Past, Present, and Future

BY JOHN ROMANO, M.D.

The author, after paying tribute to the late chief of the NIMH training branch, describes past and current psychiatric education. Among the contributions he believes psychiatry has made to medical education are its emphasis on methods of observation and on understanding the personality. However, he believes current psychiatric training has neglected contributions from the biological sciences and fails to completely recognize the importance of the entire life cycle. He also assesses recent changes in medical school curricula.

I AM HONORED in being chosen to give the first Vestermark Memorial Lecture and pleased to be able to pay public tribute to a friend and colleague of many years. We met in Denver in 1936. "Vesty" was the first of a series of Public Health Service physicians sent to Colorado by Walter Treadway and was succeeded by Edgar Lindlay, John Cronin, Victor Vogel, and Terrell Davis. After 1938, others were assigned by Treadway's successor, Lawrence Kolb. The administrative officers of the Colorado Psychopathic Hospital were Franklin Ebaugh, Charles Rymer, and Clark Barnacle. The Commonwealth Fund Fellows included Jack Ewalt, Henry Brosin, Phillip Heersema, Herbert Parry, John Evans, and me. In the next two years, Marion Durfee, Jules Wallner, Bill Shanahan, and Phil Franklin joined us.

But there were others. John Benjamin was freshly arrived from Zurich and from his association with the Bleulers and with Emile Oberholzer. He shared with us his interest and knowledge of psychoanalysis and the Rorschach. He spoke to us of cognitive disturbances of schizophrenic patients and about the general temper of continental psychiatry.

Ed Billings had just launched, with the generous help of the Rockefeller Foundation, the medical psychiatric liaison program in the Colorado General Hospital. Tony Cheavens and Martin Towler came up from Galveston; Davidson and Gee from Essondale, British Columbia; Paul Wolfe and others from the state hospital in Pueblo. At that time there were only a limited number of resident programs in the nation, and for that time the number of us brought together in one program was considerable. It was a motley group, less homogenous than the composition of present resident populations. While we may have drawn together for different reasons, one important reason was the opportunity for graduate study in the field of clinical psychiatry in a major university department, housed in a psychopathic hospital, woven into the fabric of a medical school, with the then rare support of fellowship stipends—modest as they may seem ($100 a month)—to us in our affluent present.

As Robert Felix(4) has pointed out, while

Read as the Seymour Vestermark Memorial Lecture at the National Center for Mental Health Services, Training, and Research, Washington, D. C., September 29, 1969.

Dr. Romano is distinguished university professor of psychiatry and chairman, department of psychiatry, University of Rochester School of Medicine and Dentistry, and psychiatrist-in-chief, Strong Memorial Hospital, 260 Crittenden Blvd., Rochester, N. Y. 14620.

Amer. J. Psychiat. 126:8, February 1970

the major thrust of the program was our daily engagement in the study, care, and treatment of patients. Ebaugh and others made possible our involvement in health services, not only to our patients and their families, but also to the community in which we existed and which we served. We were exposed to and involved in medical legal issues, occasionally with dramatic climax; in consultative services to courts and social agencies; in demonstration child and adult clinics in Greeley, Ft. Collins, and Grand Junction; in diagnostic and treatment services to a nearby institution for delinquent boys; in three- to four-month assignments to the state hospital in Pueblo; in numerous public educational lectures to parent-teacher and lay organizations in Denver and throughout the state.

There was little or no formal instruction, as we know this today, in the form of tutorials, seminars, conferences, and lecture series. We taught and learned from each other; and at times long and heated were our debates about the study, understanding, and most appropriate care for our patients. We vied with each other for assignments in the teaching of medical students, and interest in and concern about teaching were enhanced by the fact that Ebaugh and Rymer were in the midst of their survey of psychiatric curriculum content in a number of American medical schools(3). As I remember it, there was little formal investigative work, although a number of us did become involved in certain clinical case studies, including prognostic studies in schizophrenia. We were involved in the enthusiasms of the time --with *dauerschlaf*, insulin, the use of the Kettering hypertherm in the treatment of patients with syphilis, as well as with the more traditional psychotherapeutic techniques of the day. Sulfa had arrived but penicillin was yet to come, and we would wait another 20 years before chlorpromazine was available. Later in our stay Metrazol was tried and ECT was on the horizon.

We seem to have had an endless number of acutely disturbed patients, and we would respond to their emergency needs, together with our nurses and attendants, with the prompt devotion and gusto of seasoned firehorses. Psychology and social work were represented by only a few valiant souls, who served principally as handmaidens. It was a far cry from the rich and profitable interchange that exists today in most of the university departments.

This was the setting to which Vesty and Lucille and their son, Buddy, came in 1936. Although his earlier life in Illinois and Iowa should have prepared him for landlocked Colorado, he missed the sea and ships and tugs and ferries with which he was surrounded at Ellis Island, from which he had just come.

Vesty told me often how important the influence of Sam Wortis and Paul Federn had been to him in the Ellis Island assignment, but he felt the Colorado experience most influential. Perhaps this was because of the informality, intensity, and intimacy of our work together. As young men, we dreamed young men's dreams. However, I doubt if any of us, even the most prescient, could have predicted the changes that have taken place and more particularly the rate at which the changes have occurred. We must not delude ourselves by forgetting or minimizing the major political, social, and economic forces that played an important part in the overall development of mental health education, research, and services in our nation; yet there are and there have been those who played a significant role in initiating, enabling, and implementing those changes. Vesty was one of those. He was an important member of that group of men and women brought together by Thomas Parran and Robert Felix in the remarkable venture of our federal government in the field of mental health.

After Vesty left Colorado he was assigned to Lexington, where he took part in a number of pioneer epidemiologic studies. He returned to the U. S. Marine Hospital at Ellis Island in 1939, where he became chief of the neuropsychiatric service; he remained there until 1945. Robert Hewitt served with Vesty at Ellis Island. Jacob Arlow and John Train were residents, and Paul Federn and Sam Wortis were major consultants.

In 1945 Vesty was assigned to the U. S. Public Health Service Hospital at Ft. Worth, Texas. William Jenkins writes of this period: "Vesty came there as executive officer and director of training when Dr. Grover Kempf was medical officer in charge and Robert

Hewitt was clinical director. Some of the people on the staff then, and arriving from time to time with some or no experience in psychiatry, included Knight Aldrich, Curtis Southard, William Rosanoff, Thomas Dorr, Marion Richmond, Ralph Coltharp, Bill Lewis, Louis Gottschalk, David LeGrand, Ted Becker, Eugene Nininger, John Nardini, and others. Vesty taught and carried out a major executive function in the operation of the hospital. He encouraged the young staff to learn and to teach, which many did."

In 1948 he was called by Robert Felix to become chief of the training branch of NIMH. He was the first chief officer in this division, as in the preceding period (1946-48) Lawrence C. Kolb had served as administrative officer to both the research and training programs. It was my privilege in the next 11 years to meet often with Vesty as we participated in the affairs of the Council, in the meetings of the research and training sections and later in those of the Career Investigator Selection Committee. While my memories of these meetings are full and vivid, they have been reinforced and extended by the remarks of a few of Vesty's intimates, to whom I wrote and talked. Their responses, immediate and warm, are in themselves clear evidence of the high esteem and deep affection each had for Vesty: Robert Felix, Lawrence C. Kolb, S. Bernard Wortis (with whom I talked the day before he died), William Jenkins, Robert Stubblefield, Jose Barchilon, and Raymond Feldman. There could have been a legion of others equally as intimate, as Vesty's life and career touched many.

Portrait of a Man

It is remarkable how consistent and faithful is the portrait of the man drawn by each of our colleagues. From their vantage points they speak first of his gentleness, kindness, and integrity and also of his extraordinary ability to see the good in people.

They speak of his devotion to his assignment and his remarkable capacity, through his example, to obtain the utmost efforts of those with whom he was associated, including both professional and secretarial staffs. He was innovative and imaginative in conceiving and launching many new educational ventures with schools of law, theology, and public health as well as with the traditional disciplines. He championed the idea of basic science departments of behavioral sciences.

They speak of his modesty and absence of pretension, of his never assuming a posture not genuinely his own. They speak of his loyalty to the Public Health Service, to which he gave generously of himself. A number drew attention to the daily lunch meetings held most often in his office attended by Bob Felix, Jim Lowry, John Eberhardt, Joe Bobbit, Milt Whitman, Bob Stubblefield, Phil Sapir, John Clausen, Bill Jenkins, Bob Hewitt, Ken Little, Esther Garrison, Eli Rubinstein, Ray Feldman, and many others. Bill Jenkins writes of this: "Sometimes the talk was about the work, but often there was good-natured joshing and humor and verbal competitiveness, and Vesty was often a central figure in the give and take of these sessions, which he liked very much." This was Vesty's Village Green, a place and a time for the meeting of friends and co-workers. But he had another Village Green, one that extended far beyond Bethesda—actually from coast to coast—made up of the faculties of our universities. He visited and guided and comforted and stimulated each of us in his unswerving commitment to promote, nourish, and strengthen our educational programs. And he did all of these things with limited assistance. It is in this regard that he has been called generative, an advocate, a champion, and an enabler. This is where one saw the dimensions of his rich parental qualities.

Vesty, like most of us, had his problems. He weathered successfully and with grace an endless number of administrative crises relating to funding and to personnel. He was disappointed to witness the seemingly petty and childlike splits that occurred in several psychoanalytic institutes, and he made several efforts to approach individuals about attempts to resolve the schisms. He continued to believe that schools of public health could do much more to influence public health teaching in the medical schools. What seems extraordinary is the fact that although Vesty's actual personal experience as a teacher was quite limited, he was able to understand and to promote, in their essence, educational programs in many disciplines,

and he seemed, perhaps intuitively, to sense the basic need of the university to be free free to explore the unknown and to be innovative. His role was as an enabler and one who did not become intrusive in the affairs of the university. He was able to distinguish between craftsmanship and profession and recognized that the latter must attempt always to use intelligence in new ways. He responded to the immense challenge of the task and grew with his experience.

A Wide Repertory

He who is chosen to give the Vestermark Memorial Lecture on matters relating to psychiatric education has a wide repertory from which to choose, as Vesty's career touched many disciplines. I have chosen to speak on the teaching of psychiatry to medical students since I am fully aware of Vesty's sustained and vigorous support of the undergraduate program in medicine. He clearly understood the strategic importance of the education of the physician for tomorrow. Regardless of his eventual special skills, interests, and occupations, the physician remains a significant social instrument in promoting mental health at various levels of health services throughout the nation.

What I shall have to say about the teaching of psychiatry to medical students will be based in great part on personal experiences. I shall not present an exhaustive survey of the relevant literature. Most of the time in the past 35 years in five of the six medical schools with which I have been associated I have been engaged full-time in teaching, patient care, clinical investigation, and administration.

Early Psychiatric Teaching

It is believed that medical schools existed in connection with the temples of ancient Egypt. There is firmer evidence that medical education took place in various forms in ancient Greek medicine and later in Arabic medicine. More systematic teaching was begun in the early Middle Ages in Salerno and grew further during the Renaissance. However, the teaching of psychiatry to medical students was indeed a latter day accomplishment. Sir Aubrey Lewis(8) reminds us that the most convenient date at which to begin the history of psychiatric education in Britain is in 1753, when the governors of St. Luke's Hospital, London, authorized William Battie, physician to the hospital, to take pupils. It is true that this permission was rescinded 50 years later, but it was a straw in the wind. By the time the governors of St. Luke's in 1843 authorized a resumption of teaching, others had instituted something of the kind namely Alexander Morison in Edinburgh (1823) and John Connolly at Hanwell (1842). In 1848 Bethlehem admitted a few pupils, and from 1848 onward there were regular courses, lasting for four months and held twice a year.

The first chair of psychiatry designated as such was that occupied by Heinroth in Leipzig in 1811.

American psychiatric teaching had its origin in the work of Benjamin Rush(2). In 1821 Rush published his *Medical Inquiries and Observations Upon the Diseases of the Mind*(14), which was the first American general treatise on the subject of mental diseases. Based on his 30 years' observations of mental patients at the Pennsylvania Hospital, for many decades this remained a primary textbook for American students of mental diseases. It was the only text of its kind until 1883, when William Hammond (7) and E. C. Spitzka(16) published textbooks on insanity, followed by E. C. Mann (10). However, there was a prevailing indifference to the subject of mental disorders in all but a few of the medical schools in this country.

Pliny Earle was appointed visiting physician to the New York Asylum in 1853; during this year he delivered his first course of lectures on mental diseases at the College of Physicians and Surgeons. Later he was appointed professor of materia medica and psychological medicine in the Berkshire Medical Institute at Pittsfield, Mass. regretfully a short-lived institution. Later developments occurred in New York City, Philadelphia, Boston, Albany, and Baltimore. But it can be said that until the 1870s even occasional lecturers on mental and nervous diseases, not to speak of systematic courses, were rarities in our medical colleges. The appalling lack of psychiatric instruction was formally recognized in 1871, when the Association of Medical Superintendents

of American Institutions for the Insane at its annual meeting adopted a series of resolutions vigorously recommending the need for lectures and clinical experiences. Subsequent statements were made at the end of the 19th century and into the 20th.

Meyer's Influence

Perhaps not sufficient tribute has been paid to Adolf Meyer who, more than any other person, persisted in pointing out deficiencies and the urgent need to develop a systematic curriculum of psychiatry in the medical schools. In 1909 the Council on Medical Education of the American Medical Association published a model medical curriculum that included a total of 30 hours for psychiatry, all in the fourth year. In 1912 the Association of American Medical Colleges set a minimum standard of 20 hours of psychiatry teaching in medical schools. Largely through Adolf Meyer's efforts a number of surveys were undertaken: in 1914 by Graves(5), in 1933 by Noble(12), and the survey by Ebaugh and Rymer in 1942 referred to earlier.

These surveys were followed by conferences supported by the National Committee for Mental Hygiene. The first was called in 1933 to consider the formation of the American Board of Psychiatry and Neurology; the second, in 1934, discussed the psychiatric curriculum for psychiatric teaching; the third, in 1935, discussed psychiatry and pediatrics; the fourth, in 1936, discussed the methods of teaching psychiatry. The Commonwealth Fund supported one conference, which took place during the war (February 1945).

The two Ithaca Conferences were held in the summers of 1951 and 1952. The significance of these two conferences is well-known. Whatever success has followed the Ithaca Conferences depended in great part on what had preceded them, but there was one difference that distinguished them from previous ventures. The Ithaca Conferences and the recommendations that ensued from them were generously nourished by federal funds, available for the development of both undergraduate and graduate teaching programs. So far as I know, this had no precedent. Vesty served as the liaison officer from the U. S. Public Health Service to each of these conferences and participated actively in their design and execution. The World Health Organization in 1962(18) submitted an additional report on the teaching of psychiatry, and the most recent conference was held in 1967(17); the working papers have been distributed, and I believe the report is to appear soon. For the 1967 conference Thomas Webster prepared a most useful and detailed statement about psychiatry and behavioral science curriculum hours in U. S. schools of medicine and osteopathy(19). He pointed out significant trends in the increase in behavioral sciences during the first two years of medical school, the increase in elective curriculum hours, and in interdepartmental teaching.

While the amount of psychiatry and behavioral science teaching in U. S. medical schools has been increasing for over 50 years, the greatest development has occurred since the end of World War II. There are numerous references to this in the professional literature. Most of us acknowledge that the single most important determinant of change in the departments of psychiatry in the United States since the end of World War II resulted from the enactment of the National Mental Health Act, passed by the 79th Congress in 1946, which made possible the allocation of funds for education and research. Other determinants that have brought about changes in the teaching of psychiatry to medical students included the establishment of psychiatric services in general hospitals. It is important to realize that over 80 percent of existing general hospitals with psychiatric units have opened their doors since 1947. Other factors include the expansion and liberalization of health insurance programs under public and private auspices and the Hill-Burton Act, which provided federal matching funds for the building of psychiatric services in general hospitals.

There have also been significant changes in the perception of the hospital by the public, as exemplified by the growing use of ambulatory services, particularly the hospital emergency room, as a primary source of medical care. The psychiatric service in the general hospital has made possible the study and care of patient populations, which, in addition to persons suffering from

traditional mental illness, include others not ordinarily seen or cared for by psychiatrists. However, the general hospital movement also brought with it restrictions in the care of the chronic psychotic patient, the mentally retarded, the delinquent, the alcoholic, the addict, and the psychotic child. It is hoped that the community mental health center movement, with its concern about continuity of care and the delivery of health services to all our citizens, may help correct this deficiency.

The objectives in the teaching of psychiatry to medical students were clearly outlined in the first Ithaca Conference and since then have been stated by a number of us. I shall not at this time outline in detail all of the objectives, but I would like to point out that the object has not been exclusively to prepare those who will become psychiatrists, or even to point especially to the family doctor of tomorrow to the exclusion of the surgeon, internist, radiologist, and others.

Today, in many Western countries the doctor has an unusual opportunity to obtain sound scientific training, to develop attitudes of clinical perceptiveness, and to become informed. His basic medical education allows him to bring to the patient-physician relationship an attitude of affective and moral neutrality. Using his knowledge and skill as well as his insight and sympathetic understanding, his role is to study and help his patient without becoming a censor or judge. We have learned that if he is to deserve this position in society and if he is to fulfill these responsibilities, he must have the preparation appropriate to his work. If he perpetuates the dichotomy of current belief and practice in medicine if he tries to deal systematically and scientifically with the body but remains content to be intuitive and artistic in dealing with the mind and emotions he will be found wanting.

The department of psychiatry has been the principal agent responsible for the introduction into the medical school of the behavioral sciences. This is most clearly manifest with the growth of psychology, not only within the department of psychiatry but throughout the medical school in the departments of pediatrics, preventive medicine, neurology, anatomy, physiology, pharmacology, and the dean's office in terms of student selection and assessment. The sociologist has become a familiar figure, and there are overtures from political science, economics, education, and history. It is also clear that psychoanalytic psychology has had a greater impact on psychiatry and general medical education in the United States than in other countries. Not only has this provided a set of notions concerning the nature of mental illness and of treatment procedures to correct illness, but it has also provided an opportunity to learn more about normal behavior and to accumulate data toward a general human psychology.

Psychiatry as Leavening Agent

Psychiatry has been one of the significant leavening agents in bringing about a greater intimacy between the medical school and the university-at-large. This, or course, also includes the liaison established with biology, chemistry, physics, biostatistics, and with the recent uncanny development of mechanized intelligence. Psychiatry has also been an important agent in bringing about a greater intimacy between the medical school and the community in the region in which it exists. Many university psychiatric departments survived their early years principally through funds provided by Community Chest and public tax sources for the continuing services of the department members to the community.This was the case in Cincinnati when I went there in 1942 and in Rochester in 1946. Much of this has "growed like Topsy." Much of it, too, has been community crisis oriented, unrelated or isolated from other health services and subject to the whims and vagaries of personal interests and disinterests and short-lived budgetary commitments. Only recently has there been clearer awareness of the need for more systematic knowledge of the community in terms of health facilities and plans for the extension and coordination of services to all citizens in the community or region.

In the following section I have selected certain areas of concern that I believe have led to real contributions to the education of tomorrow's physician.

Observation in Psychiatry

First, and perhaps most important, is concern with methods of observation. We are indebted to David Shakow(15) for clearly delineating the distinctions between objective observation, participant observation, subjective observation, and self observation. From the student's traditional experience in his study of the physical and biological sciences, he has become familiar with objective observation. From the social sciences and the humanities and in particular as a sentient human being, the student has some awareness (but less systematic knowledge) of participant, subjective, and self-observation. The world of things is much more orderly than the world of persons.

It has been principally through the teaching of psychiatry that the student has the opportunity to learn how to evaluate himself as a participant in a group and to make evaluations separate from those connected with participation in the group; he learns how to understand the feelings of his patients about themselves and the impact of illness on them and on their families; he also acquires a capacity for self-observation and may begin to understand something of his own feelings as he is involved with others. With this, he becomes acquainted with the complexity and difficulty in validating his observations, and he is deeply impressed with the remarkable variability of human conduct.

This concern with methods of observation is central to the understanding of the patient-physician relationship. I believe this to be a phase-specific task and that learning this role is dependent upon and emerges from the student's basic capacity for human intimacy. It is generally agreed that this capacity does not appear fully formed, nor is it ever completely achieved. Individual successes and failures as infants, children, and adolescents in our interactions with parents, family, friends, teachers largely determine our basic capacity for interest in and involvement with ourselves and others. When we have acquired this capacity, we are capable of interpersonal intimacy. We can avoid becoming isolated or needing to dehumanize our relations with others because of fear of being injured or destroyed.

For the clinician, this capacity for human intimacy is a necessary but not a sufficient condition. It must be adapted to specific needs. He must learn a new role, constituting a means to an end, not an end in itself. It is a role that requires interest in and capacity for involvement with self and others. Also necessary is the conscious awareness of the implicit mutual expectations and emotional attitudes of the clinician and his patient. The role must be learned through example and precept. The clinician must acquire compassionate objectivity in order to observe clearly and reliably and to record accurately, so that the inferences from his observations may be valid and his decisions wise. I believe that during the growth of the medical student there is a critical period – a point in time when the learning task must be joined, when basic patterns are set down that determine the future mode and course of conduct for the student physician. I believe it takes place in the student's initial engagements with his patients in the teaching hospitals during his student clinical years and internship.

Understanding of Personality

Another area of concern is the general notion of personality and the basic principles that underlie the understanding of personality. Here again we are grateful to Shakow for his clear review(15). Students come to the medical school today much better informed than their predecessors, undoubtedly due to the major improvements that have taken place in the undergraduate teaching of psychology, biology, and the social sciences and perhaps also due to the pervasive ambience of psychology in our time. Basic principles of personality include consideration of genic and ontogenetic factors in growth, development, and decline; the recognition of unconscious and preconscious factors as determinants of behavior; the notion of drive-derivative behavior; the idea that the personality is integral and indivisible; and the psycho-social principle that recognizes that man is a social animal and that the emerging stages of the life cycle must be understood in terms of the crucial coordination between the developing individual and his social environment.

This concern with the principles that underlie understanding of personality has

also led to a clearer concept of health and disease. Medical students become aware of the speciousness of the single cause and more cognizant of multiple causes and effects, of open rather than closed biological systems, and of dynamic steady states rather than fixed, immutable equilibria. As clinicians, students learn that their material is that of the whole of living organization. They become aware of their Tower of Babel and ask how sufficient is the language learned of the body as a machine, of the language of small parts learned by microscopy, of the language of physics and chemistry, of the language of the mental apparatus, of the language of social systems. Students become aware that we have yet to acquire the full and proper language that describes the whole of living organization—that is, a satisfactory basic science of human biology.

The relevance of this to psychopathology is apparent. Students learn that psychopathology survives and regretfully prospers under many flags. They learn to recognize the multiple determinants of the behavior of emotionally and mentally sick persons. They learn, too, that the distress of their patients may be manifested in physical, psychological, or social symptoms, or in an infinite number of combinations of these. All this, as I have already noted, requires mastery of appropriate methods of observation. It also requires learning more about the zones of healthy and sick behavior in our society and the information necessary to distinguish among normal, neurotic, psychopathic, psychotic, and intellectually defective behavior. Students learn that the clinician is no longer an isolate. He shares with nurses, preclinical scientists, medical specialists, psychologists, social scientists, social workers, administrators, and others in the prevention of illness and in the study and care of the sick person. Students learn, too, that those who care for the sick find that they are concerned not only with disease but increasingly with the patient and his disability, with the members of the patient's family, and with the community to which they belong.

These, then, are the areas of concern in which I believe that psychiatry has played a significant part. While our sister disciplines in the medical school have shared in these contributions, I believe it has been psychology, particularly as it has become intimately interwoven into the fabric of the department of psychiatry, that has assisted us more than any other discipline. Whatever success has been made could not have taken place without the intimate reciprocal contributions of research and clinical service assignments. And in the tradition of American medicine, our residents from the beginning have assumed important responsibilities in the teaching of our medical students.

Areas of Neglect

There may have been successes, but there is much still to be done. There have been areas of neglect. I will draw attention to one of these and speak to two areas that require further exploration and to certain current trends in curriculum planning in medical education, with particular reference to the teaching of psychiatry.

I believe that we have neglected to include relevant contributions from the biological sciences in our teaching program. At least, the teaching in this area has been uneven and usually uninspiring. As John Nurnberger(13) has noted, this would include behavioral genetics, functional neuroanatomy, neurohumoral and hormonal chemistry, and behavioral neurophysiology. Nurnberger points out that in spite of the substantive advances in these areas, contributions from these fields are generally neglected in the teaching of our students. He believes the biological roots of behavior are sunk as deeply and explored as fully as are the social science roots but still do not command their appropriate place in a teaching program and curriculum. While relationships have been established between analytically trained psychiatrists and social scientists, he notes the lack of such relationships between psychiatrists and biological scientists.

This has been a matter of concern to us for some years, and in our department Robert Ader(1) is offering opportunities to first- and second-year medical students to undertake short-term animal research projects as part of their preclinical work in psychiatry. The immediate goal is to demonstrate the influence of experiential factors

in the development and behavior of the organism and on its susceptibility to organic disease. He believes, as do I, that for a student to observe directly the effects of his manipulating the experiential history of a living animal is a far more effective teaching device than any number of didactic or reading assignments. Ader writes:

> Such an exercise would help to accomplish two other goals in general medical education (and in psychiatric training in particular). First, the student would participate in the formulation of a meaningful problem or question in a form which is amenable to experimental analysis. Second, such an exercise could foster an appreciation of the nature of the relationship between biology and behavior. It has been said that to speak of biology and behavior is to be redundant, for the complete understanding of one must encompass the other. The behavior of man is not qualitatively different from that of other organisms, but represents the result of an evolutionary process and should therefore be studied in this context. This is not to advocate a reductionistic philosophy. On the contrary, it seems evident that there is no one-to-one relationship between physiological or biochemical states and a given behavior. Psychosomatic medicine, for example, which many still think of as a study of the effects of the mind on the body, has become translated into the study of the interaction between psychological and physiological processes; in short, to understand the behaving individual [patient], one must understand that his behavior is the result of complex interaction of biological processes, genic and experiential history, and the cultural and social environment in which his behavior takes place.

Work in Ader's laboratory and in those of others shows that individual differences can be traced to the biological and experiential history of the organism. It can be demonstrated that prenatal or early life experiences are capable of influencing developmental processes (maturation of behavioral and physiological rhythms); behavioral (perceptual and learning performance, emotional reactivity); physiologic function (adrenocortical activity); and susceptibility to a variety of disease processes (gastric erosions, tumors, alloxan diabetes, viral disease). Ader has shown that the prevailing psychophysiological state of the organism will determine its response to the superimposition of pathogenic agents (susceptibility to immobilization-induced gastric erosions as a function of the individual's daily activity cycle); or that a biologic predisposition is not necessarily sufficient in itself to result in manifest disease (the interaction between plasma pepsinogen level and the severity of the "stress situation").

With Ader I believe the active participation of the student in the type of short-term experiments referred to may assist him to obtain a better understanding of the relationship between biology and behavior.

There is one other area that requires further exploration. The reading of a critical review(11) of a recently published text(9) on the human life cycle reinforced my impression of many years that what most of us have been trying to teach in this regard is far from satisfactory.

Importance of Life Cycle

While we have added Erikson and Piaget to Freud and have included cognitive and physical sequences of development in our consideration of human infancy and childhood, our treatment of the human life cycle in its totality is foreshortened, or, as the reviewer called it, truncated. Perhaps because of the influence of psychoanalytic psychology with its emphasis on early life and on the human dyad, perhaps because we have been more concerned with intrapsychic than with interpersonal events, perhaps because our interest in the affective life has diminished our concern with cognitive and physical aspects, or perhaps for other reasons we are apt to resort to stereotyped patterns and to neglect significant aspects of the learning process, of the influence of multiple family members and of social class and ethnic differences and current belief systems of social morality. Most of us seem to be exhausted by the time we have dealt with childhood and adolescence and are apt to give short shrift to young, middle, and late adult life, to occupational choice, parenthood, and retirement. Perhaps our traditional and pervasive concern with morbidity—that is, with illness, loss, and disability—has dulled our means to recognize the successes, freedoms, and gratifications of middle and late life.

Studies of patients recovering from serious injury, such as those conducted by David Hamburg(6) of severely burned patients,

may help us to distinguish between coping and the traditional mental mechanisms or defenses. "Coping" is an old word that is being put to new use. Coping devices, unlike the traditional defense mechanisms, are more apt to be conscious than unconscious, more interpersonal than intrapersonal, more involved with shame than with guilt. They are more future-oriented and are information-gathering, rather than information-reducing. We look to our psychologist and sociologist colleagues to assist us, inform us, correct our present short-sightedness, and add to our understanding of both psychology and psychopathology.

Another area already being explored is the future design of the university medical center. It is predicted that this center will become a community health center and in so doing will become intimately intertwined into the fabric of regional health services. As a school of the university, our central objective is the education of tomorrow's physicians. We know that we cannot accomplish this in the sense of a profession unless we retain the freedom to pursue new knowledge, wherever it may take us. We know also that medicine is not a spectator sport and that the student learns how to study and care for the sick by doing so—in the proper setting and with regard to social needs.

For centuries the hospital has been the environment in which the medical student has learned—through example and precept and through a series of graduated assignments of personal responsibility—how to apply the basic information he has acquired in physics, chemistry, biology, psychology, and sociology to the tasks of the physician. It is at the bedside and in the clinic that the medical student learns to discipline his capacity for human intimacy in his encounter with his patient and the patient's family. It is here where he learns of those events of human interaction that are specific to the doctor's job. But the new generation of students also must learn, as we must learn, how to provide health care to the patient and his family before he comes to the hospital and after he leaves it. There will inevitably be changes in our curriculum to meet these needs. At the same time the teaching hospital will be responsible for designing patterns of education for new kinds of paramedical professionals.

Our unique contribution as a university is to undertake systematic studies of a broad range of health services that may clarify and objectify issues relating to medical needs, but not to adopt, wittingly or unwittingly, a priori commitments to particular solutions. As must be evident, this matter is centrally related to the community mental health center movement and to the attempt to become responsible for systematic studies of health care and delivery of services to all of our citizens. It relates, too, to the need to become responsible for the study and care of many who have been neglected—the chronic psychotic, the addict (including the alcoholic), the delinquent, the aged, and the psychotic and brain-damaged child.

Changes in Curriculum

Current trends in undergraduate medical education include a reduction in the time of basic core assignments; an increase in the time for elective assignments; a proliferation of interdisciplinary courses; provision for early commitments of students with special interests, with the establishment of multiple tracks of curriculum; and active participation by students in determining individual choice of curricular pattern. Are there hazards associated with requiring early commitment and thus reducing options early in the intellectual and professional life of the student, making more difficult the possibility of intelligent choice from the wide range of opportunities throughout the undergraduate period? It is a rich and varied menu. Are there hazards for the students who do not choose the psychiatric track? Will they be short-changed in their exposure to the impact of psychiatry on all of medicine? Will the department of psychiatry continue to consider one of its major responsibilities helping prepare all medical graduates, regardless of their eventual destinies, to become informed of the basic emotional and cognitive aspects of human interaction and of the significance of the effects of psychosocial events as these influence the lives and health of patients and their families? We believe that equally important to any contribution we may make to the education of the psychiatrist of tomorrow is the contribution we make to all

physicians, whether or not their major concern later in life is in patient care.

We have not been impressed with any contrast in the interest in psychosocial matters between students who do and those who do not wish to become psychiatrists. In our samples of medical students and medical school applicants, we see large numbers of young men and women who have given serious attention to social and behavioral sciences in their collegiate experience, who have traveled, engaged in a wide range of life activities, are sensitive to the acute problems of our world and its people, and are far from the stereotype image of the narrow biologic scientist who sees little beyond his test tube or counter. For many of our students we see the psychiatric education we give them as providing some basic concepts and tools with which they can apply the human sensitivity and awareness of life problems that they already have to their work with patients. Perhaps the alternate track for medical students may turn out medical students more informed in psychiatry than is currently possible in many cases.

Given a student with a clear, firm decision to become a psychiatrist, my tendency would be to encourage him to obtain as broad an experience as possible in general medicine before entering the field. Moreover, I would be concerned about what is lost for the student who does not take the track in psychiatry. I would also be concerned about the potential change of interest and investment of the department faculty in working with elite and nonelite groups of students. We have sufficient experience to indicate that even as much education as our first- and second-year courses in psychiatry and a limited four-week psychiatric clerkship are inadequate to prepare a physician fully for the psychiatric background he needs in his professional work, whatever his eventual career choice.

Would we not agree that today's medical curriculum is becoming quite liberalized? It is much more flexible than it ever was previously, and much of the rigidity of the convoy system has been diminished. Preparation for medicine is much better today than it was 25 years ago—not only in mathematics, physics, biology, and chemistry, but also in psychology, the social sciences, and the humanities. Nor must we minimize the significant effect of the improvement in secondary education.

Intelligent and sensitive admissions committees are now able to identify differences among students and to respect such differences. Medical faculties are now in a position to provide variations on the theme of traditional courses to meet more appropriately the interests and needs of the student at the level of sophistication with which he comes to medical school. Furthermore, experiments in innovative changes are rampant in medical schools, particularly in providing generous chunks of elective time. This has gone so far that we must make sure that the notion of the elective does not become a sacred cow, and we must be on the alert to examine the effects of some of these departures from traditional curricula. I believe there will be experiments by many of us to introduce the student early in his career to certain types of clinical experience. But from our limited experience I do not consider this an easy task. While it is relatively easy for preclinical students to assume objective observational roles (that of spectators of human behavior), it is more difficult for them to become participant observers in the professional role because of their still limited tool kit of information and knowledge and because they have not had sufficient experience to prepare them emotionally for the task.

One fundamental issue that each school must face clearly and honestly is what is to be considered basic and fundamental in the medical curriculum for the preparation of the undifferentiated physician. There may be (and probably should be) variations as to how this may be defined. But given this basic or core curriculum, I believe many of us will provide a large range of elective opportunities for our students within the medical school, in the university-at-large, and in the community. I also believe that with proper guidance through faculty tutorial supervision, some of these electives may be framed toward specific ends. These may point toward molecular biology or the psychosocial set. As you can see, I am not of the opinion that the medical school as a professional school is equivalent to a traditional graduate school. I think there are certain im-

peratives in the professional school that are necessarily not present in the graduate schools. One should also remember that many schools have conducted fairly liberal programs. In our own school, approximately ten to 20 students in one year use one-year fellowship periods to work in the several departments of the medical school, and well over 75 percent of the student body is currently involved in summer fellowships of one type or another. Up to the present these have not been called electives and are dealt with outside of the traditional school year.

The traditional instrument to effect change in the preparation of tomorrow's professional person is the curriculum. However, one must remember that it is an instrument, a means to an end, not an end in itself. And like theoretical beliefs or notions, it should command loyalty only as long as it is useful and germinal—that is, capable of leading one to use intelligence in new ways.

The burden of our task as teachers is to create the proper instrument and use it wisely, to constantly test its usefulness and appropriateness to the times, and to venture courageously toward new and better ways.

But there are certain matters quite independent of curriculum, course schedules, and content that constitute the essence of the educational process. These are values that Vesty understood, respected, and held dear. They are the traditions of our individual schools; the skill and devotion of senior and junior teachers; the insistence on integrity and on the maintenance of standards of conduct; the ever-present curiosity and restlessness about existing beliefs and practices and the pursuit of new knowledge, even for the sake of the search; the mutual respect of a community of scholars; and the compassionate objectivity of the clinician in his care of the sick and the family of the sick in the communities in which they live.

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Supp. Am. J. of Psychiat. 122: 1966

(3)

sidering what roles professionals may play over and beyond that of delivering traditional direct services and toward enriching and supplementing traditional community mental health programs.

Psychiatrists who are developing these training programs do not have an easy task. As I have said, some of our colleagues have been critical of the introduction of an additional area of training into an already overcrowded professional training curriculum. They believe that such a program pushes the psychiatric resident into areas that are not the true province of the specialty.

I firmly believe that residents properly selected in the first place and sufficiently grounded in well-planned psychotherapeutic experiences will mature personally and professionally more rapidly with the additional training and experience in community roles.

These are questions that must be resolved, but to me it seems logical that students of psychiatry who receive this training would be better prepared to practice—whatever their roles—after having experienced this orientation to the community. This attitude of mine no doubt springs in part from my training and background, and, I think, is in the Ebaugh tradition.

The men who are developing these curricula are convinced that, in the face of the psychiatric and mental health needs that exist and in anticipation of the roles in which psychiatrists will and should be functioning in the future, training in community psychiatry should be required in the residency curriculum.

Since all psychiatrists do not accept this view—in fact, since there is a rather sharp division in point of view—is it not the obligation of all of us to take a thoughtful and searching look into training and retraining procedures for ourselves and for those who will follow us? Those now in training and who will enter training in the next few years will be the leaders and consultants for challenging new comprehensive community mental health centers, with all that they promise for the future. Out of devotion to the best interests of the mentally ill who are our primary responsibility, and out of regard and concern for our psychiatric colleagues of tomorrow as well as of today, it seems to me we have no choice but to examine and experiment with our psychiatric curricula.

This field of medicine which is our special trust, this psychiatry which we try to understand and to apply, is so important to the physical, social and psychological welfare of mankind that our best efforts and our most statesman-like thinking and planning are the minimum we can offer.

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TWENTY-FIVE YEARS OF UNIVERSITY DEPARTMENT CHAIRMANSHIP

JOHN ROMANO, M.D.

An advertisement in the *New York Times* dramatically calls our attention to the events of the second third of the 20th century, which is now drawing to a close. It is claimed that more basic and far-reaching changes have taken place during the last 30 years than in the 300 preceding them. Historians may call it "The Age of Change," not only because there have been many changes, but because the rate of change

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itself has accelerated faster than men have ever dreamed possible.

The advertisement enumerates the major and publicly visible events of the past three decades—the Great Depression, the Second World War, Korea and now Viet Nam, the rise of new nations, the struggle for power, the spread of affluence, the technological revolutions in making and building and distributing, and vividly at this moment the serious attempts in our own nation to ensure full measure of civil rights and living opportunities for all of our citizens.

From demographic and statistical studies, we learn that today about one out of every 25 human beings who ever lived is alive. And 90 percent of all the scientists who ever lived are alive. The rate of the world's population increase has doubled in this center third of the 20th century. There has been the most enormous knowledge explosion in history. Four times as much is known now as in 1935, and in the next 15 years scientists will learn as much more as in all previous history. As many scientific papers have been published since 1950 alone as were published in all the centuries before(10).

Small wonder, then, that there have occurred in the past 25 years and, more particularly, since the end of World War II, immense changes in our nation's health services, including, of course, the conduct of affairs in university medical centers. In my view, the changes have been greater and more dramatic in the past 20 years than they were in the two decades which followed the publication of Abraham Flexner's "Bulletin No. 4 of the Carnegie Institute for the Advancement of Teaching," published in 1910, which played such a tremendous part in effecting changes in medical education and indirectly, but to a lesser extent, changes in the health services of our nation.

Multiple determinants since the end of World War II have intensified interest in medical education. Many, if not most, of our medical schools, both public and private, are in the midst of active expansion in space and structure as well as in function. We have added materially to the number of full-time faculty members and, in some schools, to the number of students in class. Research activities on the part of our faculties and increasingly on the part of our students have expanded. We face today many problems—the subsidy of medical education and of medical research, the costs of patient care, the growing relation between the medical school and community, the increasing dependence of the medical school on state and federal government support.

Faculties of our medical schools are engaged in studies of the preparation of students for medicine and of the selection procedures for admission to medical schools. Medical school faculty committees throughout the nation are studying the curriculum, particularly as it relates to the integration between the teaching of disciplines. There is interest in studies of the assessment of students in operational as well as in traditional examination procedures.

There are studies into teaching practices and into the characteristics of successful and unsuccessful teachers. There have been a few bold persons who have tried to measure the success or failure of the medical schools in learning what it is that the physician does—when, where and how effectively he does it. We have become aware of the differences in the physician's work, sectionally, within a nation, as well as the differences which exist between nations. We are learning that political and social attitudes inevitably and significantly influence the model or image of a physician in a society(13).

That changes have occurred is evident in the medical schools and their teaching hospitals, in their relations to their parent universities, to their communities and to the nation at large.

Changes have also taken place in the departments which constitute the university medical center, including the operating functions of the department chairman. It is to these last two points that I wish to draw your attention. I intend to select certain experiences which I have encountered as a university department chairman over the past 25 years, something less than five years in Cincinnati, something more than 20 years in Rochester.

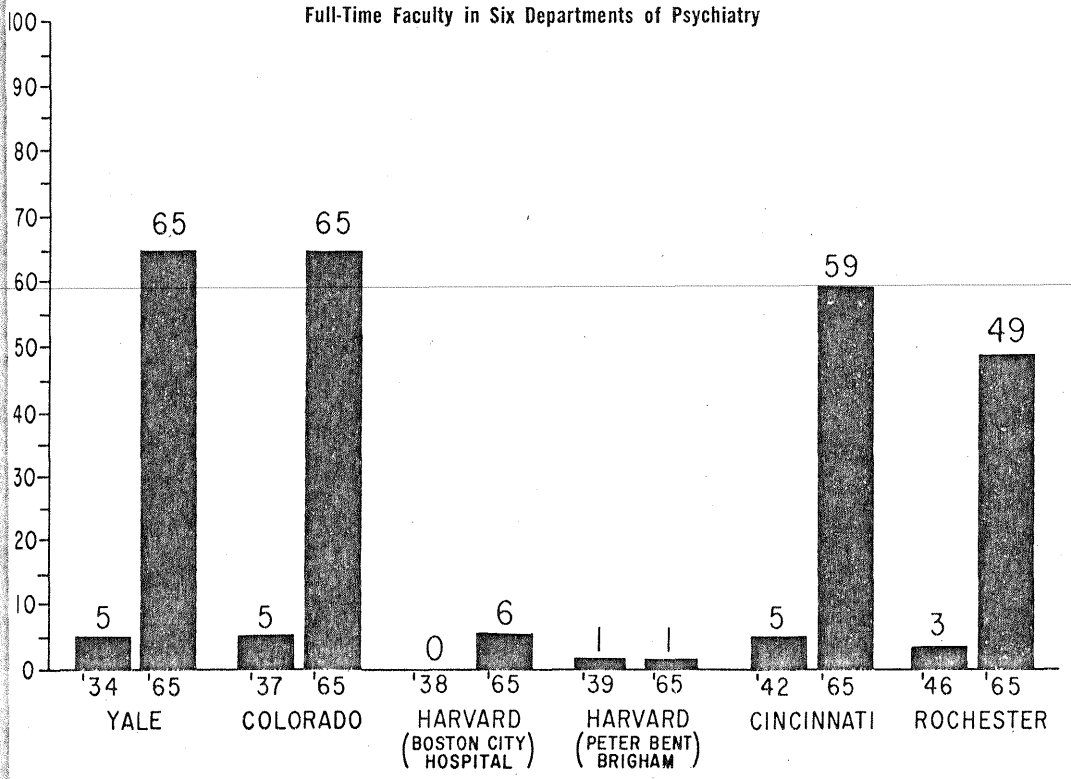
Notwithstanding the hazards of personal selective history, it may be likened to a window through which one may look out upon our concerns and responsibilities. And like the special windows with which we equip our clinics and laboratories, it may also enable us to look in upon ourselves, on who we are and what we may become. It may help us to examine the basic patterns of current organization of the department and of the medical school and hospital. Have our current patterns outlived their usefulness? Must we consider new and different patterns, hopefully more appropriate and useful to the tasks which lie before us?

As you will learn, this is not an exhaustive treatment or survey of the issues noted or a systematic documentation of the relevant literature. It is not based on any consensus of my colleagues or fellow chairmen. It is just what I have said it is, a personal selective history of the changes in the form and function of the university clinical department of psychiatry and of the responsibilities of the department chairman. To what extent the experiences I recount are representative of fellow chairmen in other schools, I do not know.

Let me add another reservation: this is not meant to be an evaluation of our successes or of our failures, of what we believe we've done well or what we believe we've done poorly or, for that matter, what others believe we've done well or poorly. This is altogether another matter, which certainly deserves separate treatment fully and frankly. It should be done, perhaps together, by a number of us who have shared in the common venture, but if not, then independently by each of us. It should be done, too, by external, interested, informed persons from their stance of neutrality and objectivity.

One great weakness of my argument is that I do not have a very clear or informed baseline from which to make comparisons. Before my appointment as department chairman in Cincinnati in November 1941, I did have certain preconceptions of the role of a department chairman and of the

FIGURE 1
Full-Time Faculty in Six Departments of Psychiatry



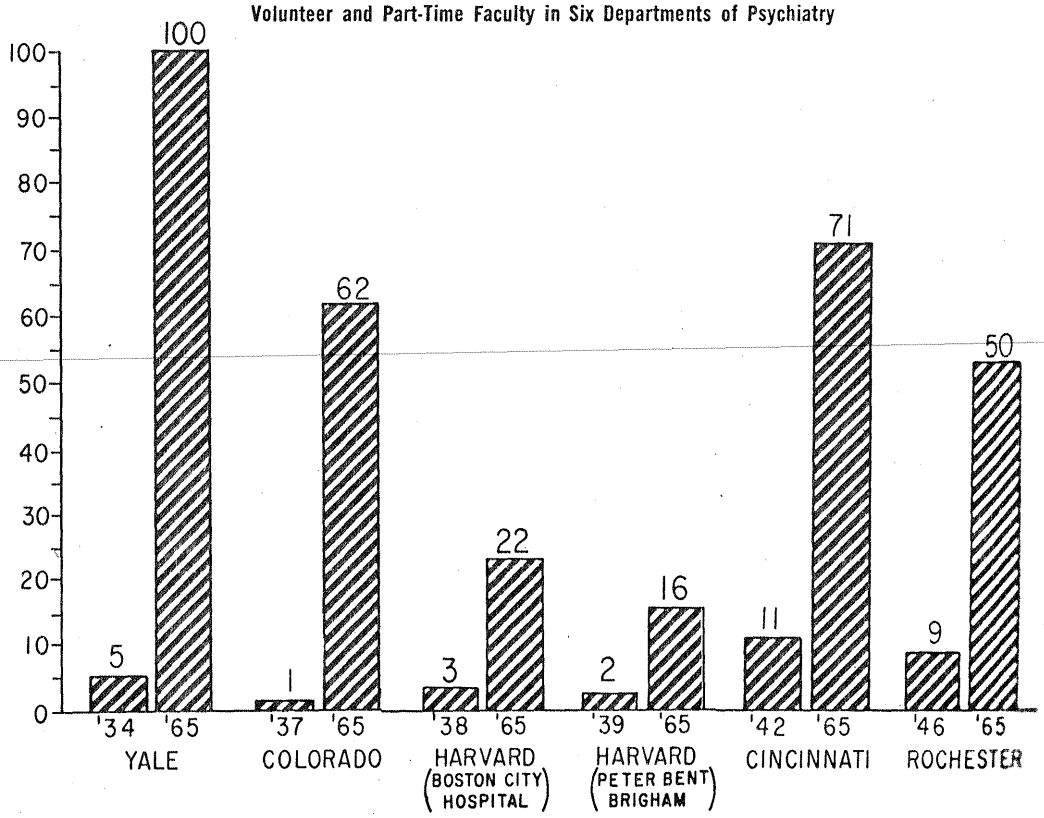
form and function of a department. At Marquette, Yale, Colorado and Harvard, I knew, had studied and worked with a number of part- and full-time professors and department chairmen in anatomy, biochemistry, medicine, neurology and psychiatry and knew something less about surgery, pediatrics and obstetrics.

As for 30 years ago, we must remember that only a few schools had any full-time clinical faculty, that many department chairmen were sometime or part-time participants(5). Most deans were part-time officers, many with considerable laboratory or clinical assignments. However, from the samples available to me, I gathered an image of the role of a full-time professor and chairman, at least as it appeared to me, and from conversations with my peers, as they, too, thought it would be. It was not a very clear image, but it did contain generous portions of time and leisure for thinking, reading and writing; for scholarly pursuits; for the education of the young; for individual investigative work; for the germination of new and hopefully creative ideas; for responsibility in the selection and promotion of faculty and career residents; for the opportunity of continuing clinical experience; and, above all, for the parental or generative responsibility of professional leadership in the conduct of the department.

To what extent this was illusory and wishful, based on insufficient information as is a child's view of his father's work and life, I cannot tell. I do know that soon after my initiation as a department chairman in Cincinnati, many matters requiring decisive action were brought forcibly and vividly to my attention—matters about which I had little previous awareness, much less preparation. Since then, these matters have not only increased in number but in complexity and significance.

In the following I outline briefly what I consider to be areas of significant change in the form and function of a department.

FIGURE 2
Volunteer and Part-Time Faculty in Six Departments of Psychiatry



hey are not ordered in importance. Finally, I shall make certain general remarks.

CREASE IN PERSONNEL

This is perhaps the most visible change. igures 1, 2 and 3 show quite graphically e changes over the years in numbers of ll-time, part-time and resident and fellow ppointments in five university departments th which I have been associated.

Consider the changes in Yale from 1934 the present; in Colorado from 1937 to e present. (I chose 1937-1938, the third ar of my fellowship in Denver.) During 38-1939 while I was serving as a Rockeller Fellow in neurology at the Harvard it in Neurology at the Boston City Hosal, there was no established psychiatric rvice. As you will see, there were no fullme faculty appointments in psychiatry, designated psychiatric house officers, o part-time appointments of psychiatrists d one of a clinical psychologist. Hower, the "nerve resident" always had had me type of psychiatric training and rved not only as a neurologic house officer consultant to the hospital but saw about eight to ten psychiatric patients daily in consultation. Today there is a full-fledged psychiatric service.

In the period 1939-1942, while my appointment was in medicine, I served as psychiatrist and neurologist at the Peter Bent Brigham Hospital. I compared the roster in 1939 with the present one at the Peter Bent Brigham Hospital, where there never has been established a separate inpatient psychiatric service. In Cincinnati, 1942 is compared with the present and in Rochester, 1946 with the present.

Tables 1 and 2 show the increase in faculty appointments in Rochester at five-year intervals over the past 20 years, including those with academic tenure.

These appointments include psychiatrists, psychologists, social caseworkers, nurses, social scientists, statisticians and colleagues from our fellow clinical disciplines.

There are comparable increases in the number of nonacademic professional, technical, secretarial, clerical and administra-

FIGURE 3
House Officers, Residents and Fellows in Six Departments of Psychiatry

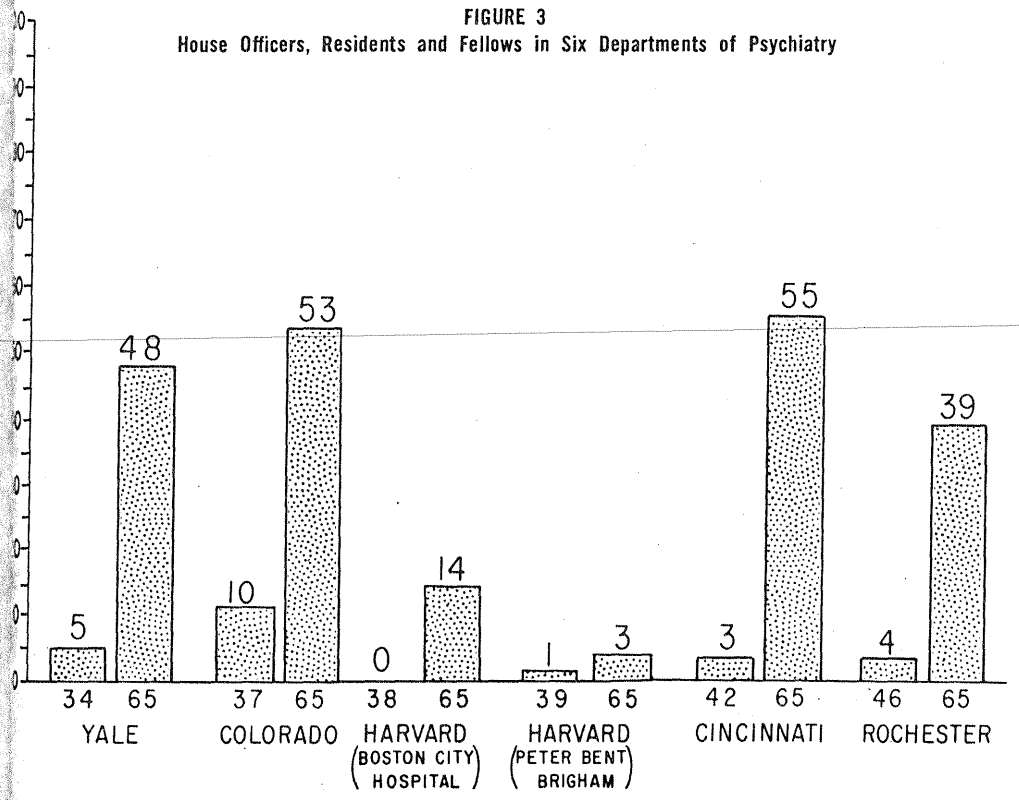


TABLE 1
Full-Time Faculty Members at the University of Rochester Medical Center Department of Psychiatry, by Year

YEAR	PSYCHIATRY		PSYCHOLOGY			TOTAL
	TENURE	TOTAL	TENURE	TOTAL	OTHERS *	
1946-47	1	3	0	0	0	3
1951-52	3	13	0	1	0	14
1956-57	5	17	0	2	0	19
1961-62	7	21	1	10	5	36
1965-66	10	29	4	11	9	49

* Social casework, nursing school, sociology, statistics and biochemistry.

TABLE 2
Part-Time Faculty and Residents and Fellows at the University of Rochester Medical Center Department of Psychiatry, by Year

YEAR	PART-TIME FACULTY				RESIDENTS AND FELLOWS		
	PSYCHIATRY	PSYCHOLOGY	SOCIAL CASEWORK	TOTAL	PSYCHIATRY	PSYCHOLOGY	TOTAL
1946-47	7	2	0	9	4	0	4
1951-52	12	4	0	16	16	0	16
1956-57	24	6	0	20	20	0	20
1961-62	34	5	1	40	32	1	33
1965-66	36	9	5	50	36	3	39

FIGURE 4
Total Membership of the American Psychiatric Association for the Years 1928-1965 Inclusive

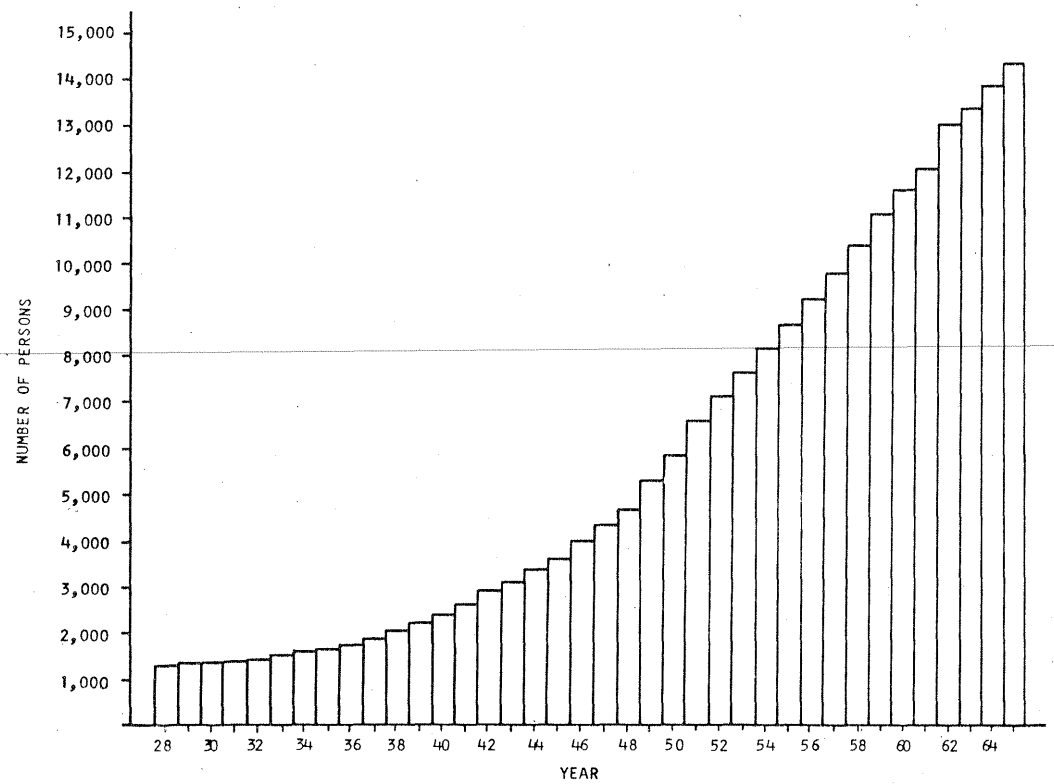


TABLE 3
Membership of the American Psychiatric Association for the Years 1928-1965 Inclusive

YEAR	TOTAL MEMBERSHIP	PERCENT YEARLY INCREASE	YEAR	TOTAL MEMBERSHIP	PERCENT YEARLY INCREASE
1928	1302	—	1947	4341	8.3
1929	1325	1.8	1948	4678	7.8
1930	1346	1.6	1949	5276	12.8
1931	1393	3.5	1950	5856	11.0
1932	1416	1.6	1951	6581	12.4
1933	1517	7.1	1952	7125	8.3
1934	1604	5.7	1953	7608	6.8
1935	1676	4.5	1954	8149	7.1
1936	1749	4.4	1955	8673	6.4
1937	1889	8.0	1956	9247	6.6
1938	2053	8.7	1957	9801	6.0
1939	2235	8.9	1958	10420	6.3
1940	2423	8.4	1959	11037	5.9
1941	2667	10.1	1960	11637	5.4
1942	2913	9.2	1961	12161	4.5
1943	3125	7.3	1962	13001	6.9
1944	3387	8.4	1963	13396	3.0
1945	3634	7.3	1964	13853	3.4
1946	4010	10.3	1965	14341	3.5

tive persons. Currently in 1965-1966, this number is 175 persons.

Nursing personnel	59
Technical, secretarial, clerical	92
Housekeeping	15
Dietary	7
Grounds men	2

All this has quite understandably brought with it issues of recruitment, selection, funding, evaluation, promotion and competition for skills and experience. However, the design of organization to meet and deal with the issues has been for the most part Topsy-like, "We just growed."

Consider, too, the growth of professional personnel in national terms. Figure 4 and Tables 3, 4 and 5 show the total membership of the American Psychiatric Association for the years 1928 to 1965 inclusive(4). My colleague, Charles Odoroff, has indicated in Tables 3, 4 and 5 the rates of growth and comparisons of membership of the American Psychiatric Association to physician population and the national census.

In the period 1950-1960, the number of psychiatric social caseworkers rose from about 3000 to 7200—far more rapidly than the total number of social welfare personnel. It is stated that between 1950 and 1960, the four core mental health professions (psychiatrists, psychologists, social caseworkers, nurses) increased far more rapidly than all health professions and this trend is expected to continue(8).

FINANCES

Quite predictably, increases in operating costs of the university department are comparable to increases in personnel. Table 6

TABLE 4
American Psychiatric Association Membership Compared to Physician Population for Selected Years

YEAR	PHYSICIANS PER MILLION U.S. POPULATION	APA MEMBERS PER MILLION U.S. POPULATION	PERCENTAGE APA MEMBERS IN PHYSICIAN POPULATION
1931	1260	11.2	0.9
1940	1326	18.3	1.4
1949	1349	35.2	2.6
1955	1319	52.3	4.0
1957	1324	56.9	4.3
1959	1334	62.1	4.7
1960	1326	64.4	4.8
1962	1324	69.6	5.3

TABLE 5
Growth Characteristics of American Psychiatric Association Membership Compared to the Population of the United States

YEAR	APA MEMBERSHIP	AVERAGE ANNUAL GROWTH RATE PRECEDING DECADE (PERCENT)	UNITED STATES POPULATION	APA MEMBERS PER MILLION POPULATION	AVERAGE ANNUAL GROWTH RATE PRECEDING DECADE CORRECTED FOR POPULATION GROWTH (PERCENT)
1930	1,346	—	123,100,000	10.9	—
1940	2,423	6.1	132,600,000	18.3	5.3
1950	5,856	9.2	152,300,000	38.5	7.7
1960	11,637	7.1	180,700,000	64.4	5.2
1965	14,341	—	194,000,000	73.9	—
1970	17,700 *	4.3 *	206,000,000 †	85.9 *	2.9 *
1970	19,400 **	5.1 **	206,000,000 †	94.2 **	3.9 **

* Estimated from 5 years 1961-1965.
** Estimated from 10 years 1956-1965.
† Projected using smallest expected growth rate.

shows changes in the budget in Rochester for the medical center as a whole and in the salary budget of the Department of Psychiatry.

There are separate and multiple accounts for research, education and clinical services; for contractual agreements with local, state and national agencies, with private foundations, corporations and individual donors, with local and national insurance companies. In Rochester in 1946, the Department of Psychiatry had four accounts; in 1965 there are 84.

The time spent in learning about available funds for which one is eligible to apply, not to speak of preparing, defending and resubmitting grant proposals, is considerable. A business manager has been appointed to which much of this has been delegated but, quite properly, the major decisions and the substantive material submitted come from the professional staff and the chairman. The major source of external funds, of course, is the National Institute of Mental Health. On other occasions I have indicated that the single most important determinant of change in the departments of psychiatry in the United States resulted from the enactment of the National Mental Health Act, passed by the 79th Congress in 1946, which made possible the allocation of funds for research, teaching and certain community services. Tables 7, 8, 9, 10 and 11 indicate the amount and changes in federal funds for National Institute of Mental Health training grants in the period 1948-1965(6).

PLANNING AND BUILDING

Much time has been spent on planning, drawing, supervising, constructing and equipping hospital floors, clinics, emergency units, day and night care facilities. Provisions have been made for offices, conference and interviewing rooms, patient activity centers, special electronic sound, visual, photographic and data processing facilities and for animal quarters as well as

TABLE 6
University of Rochester Medical School and Department Budgets

YEAR	TOTAL BUDGET OF MEDICAL SCHOOL AND HOSPITAL	DEPARTMENT OF PSYCHIATRY SALARY BUDGET
1946-47	$ 4,000,000 (approx.)	$ 35,894
1965-66	30,265,000	1,303,083

TABLE 7
Number and Amount of Mental Health Training Grants Awarded and Average Amount per Grant

FISCAL YEAR	NUMBER OF GRANTS	TOTAL AWARDS	AVERAGE AMOUNT PER GRANT
1948	62	$ 1,140,079	$18,388
1961	907	28,423,534	31,338
1965	1,816	75,523,250	41,588

TABLE 8
Graduate Mental Health Trainee Stipends Awarded, Average Number of Stipends per Grant and Average Amount of Stipend

FISCAL YEAR	NUMBER OF STIPENDS AWARDED TOTAL	NUMBER OF STIPENDS AWARDED AVERAGE PER GRANT	AMOUNT OF STIPENDS AWARDED TOTAL	AMOUNT OF STIPENDS AWARDED AVERAGE PER STIPEND
1948	219	3.5	$ 401,268	$1,832
1961	3,372	4.7	13,021,466	3,862
1965	7,548	5.7	32,809,595	4,347

laboratories for both animal and human experimentation. It has been an extraordinary time of expansion, both exciting and enervating and, as is well known, the expansion has been not only for clinical services but for educational and research facilities, both desperately needed in the university hospital.

In turn, all of this has meant numerous conferences and discussions with one's colleagues in other departments, with administrative officers, architects and builders. It has also necessitated deciphering and eventually submitting endless forms, questionnaires and proposals about such buildings to local, state and national planning and funding bodies. The significant assistance of the Hill-Burton Act making possible matching funds for the building of psychiatric services in general hospitals antedated the recently enacted provisions for community mental health centers.

Our experience in building actually dates back to the late war years (1944-1946) when plans were being made for a university-affiliated psychiatric service at the Jewish Hospital in Cincinnati. From 1946 to 1948 in Rochester we obtained as much information as we could about buildings before we built our own, and some of the most imaginative and helpful ideas came from modern hotel rather than hospital personnel. We were one of the first to use studio beds, wallpaper, individual toilets in rooms, combination desks and chests and other innovations in a psychiatric unit

TABLE 9
Some Institutions Receiving More Than $500,000 in Total Mental Health Training Awards During the Period 1948-1961

RANK (OUT OF 71)	TRAINING INSTITUTION	TOTAL AWARDS
4	Yale	$3,204,132
8	Harvard	2,733,392
13	Cincinnati	2,031,257
15	Colorado	1,958,697
22	Rochester	1,675,213

TABLE 10
Some Institutions Receiving More Than $250,000 in Mental Health Training Awards During the Years 1962 and 1963

1962 RANK (OUT OF 40)	TRAINING INSTITUTION	TOTAL AWARDS
8	Yale	$721,834
10	Harvard	693,770
15	Rochester	566,806
23	Cincinnati	435,777
29	Colorado (Medical Center)	370,670

1963 RANK (OUT OF 58)	TRAINING INSTITUTION	TOTAL AWARDS
10	Yale	$822,748
12	Harvard	795,517
18	Rochester	596,863
24	Cincinnati	506,321
33	Colorado (Medical Center)	438,565

TABLE 11
Some Institutions Receiving More Than $500,000 in Mental Health Training Awards During the Years 1964 and 1965

1964 RANK (OUT OF 36)	TRAINING INSTITUTION	TOTAL AWARDS
11	Yale	$964,820
12	Harvard	935,046
18	Rochester	767,811
22	Cincinnati	713,296
28	Colorado (Medical Center)	604,146

1965 RANK (OUT OF 39)	TRAINING INSTITUTION	TOTAL AWARDS
17	Rochester	$823,563
18	Yale	823,387
24	Cincinnati	709,979
26	Harvard	673,834
29	Colorado (Medical Center)	649,758

in a university teaching hospital. We made the initial decision to weave the psychiatric unit intimately into the fabric of the whole university hospital and medical center. The alternative was to build a separate, autonomous unit. Although we met and have dealt with the inevitable issues which result from the introduction of psychiatric services into a traditional set previously without any established service, there is little question that the decision was wise. We have had the unusual privilege of being within bareheaded distance of our colleagues, providing intimate interrelations for our students, staff, faculty and patients.

PATIENT CARE

Earlier and separately, I considered in some detail the changes which have taken place and continue to occur in the nature of the care and study of psychiatric patients(16). I drew attention to the current social movement with its objectives of reducing the size of public mental hospital services, of increasing general hospital services and of promoting greater community participation in preventive, reconstructive and rehabilitative measures. I commented, too, upon the truly prodigious increase in the number of psychiatric units in general hospitals and of outpatient clinics and the increasing attention paid to emergency services, to first aid and to helping patients at points of crisis.

Liberalization of insurance, increasing numbers of psychiatrists in the general practice of psychiatry, the very considerable successes of milieu and other psychotherapeutic modes, of ECT and of the use of psychotropic drugs have contributed to changes in length of stay and in general procedures. Currently, there is need for scrutiny of the operational identities of the roles of professional and paraprofessional groups in the study and care of the psychiatric patient. I also expressed concern that the social objectives cannot become exclusively service oriented and that there should be a full measure of support for continuing researches at basic as well as applied levels in the field.

Since the inception of this department 20 years ago, we have been intimately involved and engaged in services to our community. Our 24-hour emergency service has grown tremendously and currently we have about 4,000 patient visits a year. A small percentage are true emergencies in the traditional sense. Most are social and personal crises requiring and responding to immediate attention and care. This has become an important service to the community. It has enhanced our teaching and research programs. It has also introduced new problems in terms of staffing and interrelating the service with our colleagues in our sister clinical disciplines.

DEPARTMENT ORGANIZATION

Departments have grown with an increase in their component divisions. We have divisions of inpatient care, outpatient care, emergency service, children's service, liaison services (medicine, pediatrics and obstetrics), preventive psychiatry, student health, clinical and experimental psychology, social casework, nursing service and education and activities program. Each has a division head to whom are delegated proper responsibilities. Competition and rivalry abound for funds; for professional, technical and secretarial personnel; for space and equipment needs; for assigned time in the undergraduate and graduate curricula; for research projects; for house officer and fellow assignments; for student fellows; and for travel funds.

Much of this is vital, vigorous, healthy, as well as inevitable. However, at times parochial and selfish interests and personal ambitions restrict one's views, leading to conflict, envy, jealousy and petty intolerance. Frequent and regular department staff meetings, executive councils, ad hoc and standing intradepartmental committees, an avalanche of memos, white papers, blue papers (dittoed, thermofaxed and xeroxed) and occasional cries of alarm do not completely solve the problem of ensuring primary loyalty to the department as a whole and sharing responsibilities for its over-all objectives.

One learns that the chairman's role may be a lonely one, not only because of the inevitable and necessary loneliness of the parental figure entrusted with decision-

making but also because of this moment in academic history. Those who follow us may find, among their fellow chairmen, colleagues more informed than those of our generation because of the changes in medical education and because of the growing awareness and acquisition of knowledge of matters psychological. My interests and talents being what they are, I have seen to it that I continue to take an active part daily in teaching, in the care of the sick and in the pursuit of new knowledge. Daily rounds with students and house officers, continuing care of the sick and an open door policy have enabled me to be intimately involved in these matters for many years. I can assure you that this has clearly impressed me with the limits of our knowledge and skills.

I have commented on chairmanship in the modern medical school(12). May I say again that if he is to succeed, even survive, the chairman must have some capacity for parental generativity. That is, he must have the quality of feeling rewarded (without becoming masochistic) in providing optimal situations for others to do what he would have liked to have done himself.

The chairman should also have some capacity for bipolar citizenship. His more obvious citizenship is as protagonist of his department in over-all school matters. It is his responsibility to explain, to defend, to initiate, to stimulate and to support the special interests of his department. The other, more difficult to come by, is that of the citizenship of the school as a whole in which he may have to support, at times initiate, certain ventures for the benefit of the school as a whole, even though it may not help his department directly or immediately. It may even cause it to make sacrifices. Medical faculties, like other faculties in a university, are apt to be confederations of more or less hostile states. Obviously a school can neither prosper nor grow unless support is obtained from its faculty for the objectives of the school as a whole.

EDUCATIONAL PROGRAM : GRADUATE LEVEL

As indicated earlier, we are now dealing with an increase in the number of residents, that is, from two or three residents per year to 12, exclusive of liaison, child and research fellows. Here again it is important to project this onto the changes which have occurred nationally. George Mixter of the Council on Medical Education of the American Medical Association and Robert Lockman of the Manpower Department of the American Psychiatric Association have generously submitted information about this (6, 11).

Briefly and in general terms, one finds there are four times as many programs in psychiatry in 1965 (328) as there were in 1927 (80), more than twice as many in 1965 (328) as there were in 1946 (155). In terms of numbers of residencies offered, there are 13 times as many residencies offered today (4,627) as in 1928 (360) and about six times as many as were offered in 1946 (758). At the present time, of the 328 programs, 86 are child programs. The total number of residents for the year 1964-1965 is 3,624. This is 78 percent of the total number of residencies offered—4,627.

There are the problems of selection. For example, each year we have about 130 inquiries, about 60 of these candidates are considered seriously by us, 40 are interviewed and we choose 12.

We have chosen not to adopt any formal or systematic type of psychologic questionnaire for purposes of selection. We do obtain information, with the candidate's knowledge and approval, about his college and medical school records, and internship performance when available, from persons who know him intimately and with whom he has worked. We insist on personal interviews during which time he visits us and meets with three or four senior members of our faculty and at least one member of the psychiatric house staff.

From the beginning, we have taken part in the Gentlemen's Agreement Plan and have pledged our participation in the Residency Matching Program which may be initiated in the next year.

There are problems of financial support, of assignment, of supervision, of evaluation, of participation in ongoing or independent researches, of providing individual therapeutic, economic and intellectual assistance

and guidance. Pedagogic patterns, traditionally preceptoral and apprentice-like, have become more formal and systematic, with an increase in the number of courses and seminars and with the increasing participation of psychologists, biologists, social scientists and statisticians as well as clinical psychiatrists.

And what of substance, of the content of our educational program? I have chosen to show you the following table (Table 12) which indicates the major headings of current research activities of the National Institute of Mental Health(23).

I draw your attention to it to point out that each subject mentioned satisfies certain criteria of relevance for our educational program. Obviously over the years the content has been expanded. It includes many areas not dealt with earlier in our careers. Whether all individual departments can expect to do justice to all of these areas and, if so, how they are to do so are matters for serious consideration by all of us.

We have attempted to avoid fragmentation and discontinuity in our teaching programs. We have not adopted an extended colonial pattern of short-term assignments to many areas beyond the university hospital. We have tried to remain intimately involved in our teaching programs with our residents, and our senior faculty have devoted much time, thought and energy to the teaching-learning processes in our work with our residents. We have also made possible an intimate exchange between residents of first-, second- and third-year standing and have maintained the chief resident position in the third year for six-month blocks of time on the inpatient and outpatient divisions, the emergency division and more latterly in assignments to community psychiatry. These are assignments with considerable responsibility and with opportunity for initiative and leadership.

TABLE 12
Research Activities of the National Institute of Mental Health, December 1964

Biological factors in mental health and illness
Drugs and the treatment of mental illness
Psychophysiology and psychosomatic illness
Neural mechanisms and behavior
Developmental factors in mental health and illness
Psychological and interpersonal factors in mental health and illness
Effects of social change and cultural deprivation
The community and its mental health resources
Surveys of mentally ill populations and treatment facilities
International research programs

While we have maintained adequate tutorial and supervisory relations with our residents, we try in many ways to provide an optimal climate both intellectually and emotionally for them to assume responsibility. This is particularly so in their assignments to the teaching of medical students and their fellow residents. Career teacher fellows and others are given many opportunities to learn at firsthand basic principles of pedagogy and to gain experience in the teaching of medical students, residents and others. Our stipends have been set at U. S. Public Health Service levels. We have not had the advantages of some who have added considerably to these stipends with obvious recruiting attractions.

It may be of historical interest to realize that professional medical education in the United States provides for greater individual variations from school to school than does medical education in a number of other nations. At least this is my view after visiting and examining a number of medical schools and graduate institutes in various parts of the world. Perhaps the fact that half of the medical schools in the United States are in part supported privately, the other half through tax funds, contributes to a greater degree of freedom in exploring new ways of doing things and not necessarily being committed to a national stereotype. Therefore, one would anticipate that there will continue to be individual variations in all phases of medical education, including graduate teaching in clinical psychiatry.

These variations will depend upon the nature of the physical facilities; upon the clinical services, both obligatory and elective, upon the faculties recruited, their intellectual interests and objectives; and perhaps on other matters relating to the com-

munity in which the university graduate program exists. Much would depend, too, on what are the basic perceptions of the responsibilities of the conduct of a university department in its multiple functions of teaching (both undergraduate and graduate) to the teaching of ancillary persons, to clinical services, to pursuit of new knowledge, to the opportunities to work intimately with persons with different backgrounds and objectives such as biochemists, social scientists and mathematicians.

In my view, the objectives of a university department cannot be fixed at a point relating to the current usefulness of knowledge and skill. Certainly, it should not be fixed at this point exclusively. Rather, the department in a professional school of the university, like departments in all branches of the university, must constantly be restless in its search for higher levels of conceptualization of the data with which it is concerned. It cannot remain content to be empiric.

At the same time, it cannot give up skills, empirically arrived at, which are currently useful in the practical understanding and management of the sick for whom one is responsible. Isn't this actually a reflection of what has happened in the historical development of all professional education? One is seeing this in engineering and in business schools, perhaps in law schools—that is, the emergence from apprentice preceptor methods of instruction to search for basic knowledge and techniques which underlie that which earlier had been accumulated empirically.

We do not provide opportunities for psychoanalytic training during the residency period, nor do we permit residents to participate in any professional work outside the department unless the assignment is relevant to his scholarship, needed by the community, approved by the department and the medical center as a whole and leads to no neglect of his primary responsibility. Those members of the department who are invited to remain with faculty appointments beyond the residency and who wish to pursue psychoanalytic training have been assisted materially by the department. Tandem psychoanalytic training has brought with it, unlike any other discipline, issues of time away from university duties, need for special financial support, varying relations and agreements with psychoanalytic institutes and competing loyalties with the primary university assignment. Earlier and separately in my discussion in the proceedings of the first and second Onchiota Conferences, I have considered past, present and future relations of university programs with psychoanalytic institutes(14).

I believe it is generally understood and accepted that in many, if not most, of the university graduate teaching programs in clinical psychiatry at this time in our nation, certain basic psychoanalytic ideas and notions have been incorporated and utilized in the general body subsumed by clinical psychiatry and also, I believe, in much of what is called general psychology. I speak of ideas of psychic determinism; of the dynamic unconscious mind; of individual differences among persons explicable in terms of ontogenetic growth and development; of the multiple person set; of the ideas of critical phases of such development; of the recent reintroduction of epigenetic concepts (Erikson) as determined by laws of individual development and laws of social organization.

More controversial, I believe, is the evidence for a drive-derivative hypothesis including concepts of conflict, anxiety and symptom formation. Less clear, too, is the evidence for specificity of past life experience in predictive terms of specific neuroses, psychosomatic illnesses and psychoses. In this regard I believe that there is urgent and imperative need for the arduous collection of empiric data to support or refute the inferences about human behavior heretofore reached on what are limited primary data.

Furthermore, in the field of psychotherapy, there has been an acceptance of many of the general issues relating to human interaction, of knowledge of the affective life of the patient and his family and of the matters of transference and countertransference. That there is need here, too, to examine the effectiveness of various therapeutic approaches to patients' needs, in-

cluding the approaches of formal psychoanalytic treatment, and to compare the effectiveness of various approaches with each other is again, in my view, urgent and imperative.

I believe there is need for a more explicit statement of the basic issues which are currently utilized and incorporated from psychoanalysis into the general body of clinical psychiatry. Is there a true consensus? Furthermore, there will be a need for us to examine pedagogically not only the substance but the methods used by us to teach others. What are the values of the supervisory or tutorial system to the young psychiatrist treating his patients? What are the values of the small group seminar or the larger lecture hall? What are the values of demonstrating through certain experiments the validity of the basic issues: for example, hypnosis in terms of unconscious mentation or the collection of empirical observations concerning short- or long-term separation of children from significant parental figures?

I believe there is not only need for experiments in teaching the substance of psychoanalytic ideas and notions but also need for experiments in the learning process of technique. Should we remain content to accept the traditional pattern of psychoanalytic training for those who wish to become psychoanalysts in terms of the established institute pattern of personal analyses of so many years' duration, of seminar and control supervision of so many years' duration? Can we not experiment to learn what can be gained by the candidate both in terms of substance and technique from shorter (that is, six months', nine months', 12 months', 13 months') participation in personal psychoanalysis together with parallel didactic and supervisory experiences?

I believe the days of the independent institutes are numbered. There appears to be evidence that the number of applicants to these institutes is reduced. There is also some feeling that the quality of the candidates has diminished. It may be that the principal motivation for many applicants in the past has been that of acquiring therapeutic skills with less attention to the furtherance of critical scholarship. The fact that the therapeutic skills acquired with the necessary expenditure of time, energy and money over many years have not been found to be as effective as was once hoped may contribute further to the decrease in numbers.

There is also evidence that in many of the current university psychiatric residency programs there is ample opportunity to learn basic techniques of psychotherapy which have been found to be useful and effective in the care of the sick. There is evidence, too, that the general practice of psychiatry has reached a higher degree of maturity in many communities, and it is found by many of the newly graduated residents to be intellectually, emotionally and financially attractive to them.

The long period of apprenticeship in psychoanalytic training may prevent young physicians interested in clinical investigative work from engaging in such work because of the considerable demand on their time and energy. This has made more difficult their participation as teachers and clinical investigators in university departments and has made more hazardous their future as academicians. Furthermore, young persons find more attractive the traditional set of the university in its community of scholarship and in the broader market place of ideas. In the university there is apt to be less of an investment in the status quo and of belief systems. Perhaps also there is a greater opportunity to be stimulated by persons whose belief systems differ from theirs.

I believe also that the psychoanalytic practitioner will less likely be an experimentalist. I have the impression that he may one day become more useful as an experimental subject. Wise, seasoned, skilled psychoanalytic practitioners have acquired certain types of data processing operations which in themselves may be highly relevant and significant to examination by others.

Will the basic design, objectives and operations of the traditional independent psychoanalytic training institutes change with serious attempts to make of them research institutes? I have questioned whether or not this can take place outside the university scene except perhaps for one or

possibly two research institutes which would have to assume the proportions of something like the Rockefeller Institute for Medical Science if they were to survive.

Over the years, we have tried to remain true to our basic identity as a department of psychiatry. We have not become a department of psychoanalysis nor of molecular biology, nor do we intend to become a department of social psychiatry. Our eclectic point of view permits us to examine and to look for new knowledge and skills from physical-chemical biology, including genetics, from psychology and its various branches, from the social sciences, from the use of mechanized intelligence, as well as from our more traditional clinical operations as physicians and psychiatrists.

What is primary and not derivative in our work as clinicians is our ability to discipline our capacity for human intimacy and to apply it in obtaining the data of human interaction between us, our patients, their families and our coworkers.

EDUCATIONAL PROGRAM : UNDERGRADUATE MEDICAL STUDENTS

A major concern and interest of our work over 25 years has been the teaching of undergraduate medical students. Over the years, we have had increasing interdepartmental activity with biology, biochemistry and physiology, with psychology, education and the social sciences and with our fellow clinical disciplines—medicine, preventive medicine, pediatrics, obstetrics and surgery. New courses transcending traditional department boundaries have been established in which the department of psychiatry often has played a germinal role. In our preclinical teaching, we continue to work towards the establishment of a basic science of human biology.

We are aware that our material is that of the whole of living organization and we ask how sufficient for our purpose is the language learned by us of the body as a machine, of the language of small parts learned by microscopy, of the language of the mental apparatus, of the language of social organization. We are keenly aware that we have yet to acquire the full and proper language that describes the whole of living organization.

In our teaching, major consideration has been directed to concepts of health and disease, concepts of growth and development, concepts of the social matrix of the patient and his family and concepts basic to the idiosyncratic human interaction between patient and physician and to the disciplined capacity for human intimacy basic to the physician's role. Beyond this, our students have ample opportunity for intimate and responsible engagement with patients on hospital floors, in the clinics and emergency division and through them with social and health agencies of the community. Each student has the opportunity to become engaged with the more significant and representative types of human psychopathology in the patients assigned to them.

For many years we have made provisions for summer student assignments, both research and clinical. This past summer we had 13 students, one from abroad, one from another school and 11 from our school. Summer fellowships, like other student assignments, carry with them problems of selection, funding, supervision, special assignments and evaluation. The nature of our school permits us and our students to know each other well. The size of the class, the setting and our traditional informality contribute to this. Our considerable successes in the liaison programs between us and medicine, obstetrics and more recently with pediatrics reinforces this relationship. An experimental two-year internship (1959-1961) which provided for service assignments in medicine, surgery, pediatrics, obstetrics and psychiatry also contributed to productive interrelationships between the clinical disciplines(15).

My colleague, Hilliard Jason, has prepared a table (Table 13) from his study of our medical school graduates who are choosing psychiatry as a career which illustrates certain changes over the years.

Department members have been active and have shared generously in the process of selection of students admitted to this school. In our own work we have paid particular attention to the evaluation of students assigned to us, particularly in the clinical setting, and have made many

TABLE 13
Survey of University of Rochester Medical School Graduates

CATEGORY	DECADE OF GRADUATION 1929-38 NUMBER	1929-38 PERCENT	1939-48 NUMBER	1939-48 PERCENT	1949-58 NUMBER	1949-58 PERCENT
Those taking first or first and second residency	276		562		673	
Those in above group taking one or other in psychiatry	11	3.9	31	5.5	48	7.1
Full-time academics	18		92		131	
Full-time academics with training in psychiatry	0	0	4	4.3	16	12.2
Part-time academics	73		160		163	
Part-time academics with training in psychiatry	2	2.7	13	8.1	16	9.8
Those reporting specialty practice as a major professional activity	164		350		361	
Those reporting psychiatry as their specialty	9	5.5	28	8.0	34	9.4

experiments using different types of examinations.

RESEARCH

There has been a truly amazing change in the research activities of the university department. Currently in our department there are about 50 major and minor research projects covering a wide array of subject matter and using an equally great number of techniques. Robert Morison in his recent critique reminds us of the contributions of the Rockefeller Foundation in the period before the establishment of the National Institute of Mental Health(7). He points out how small the amount of money was :

> . . . a little over $16,000,000 in 20 years for Psychiatry and related disciplines. The related disciplines (Neurology, Neurophysiology, Neuroanatomy, Neurochemistry and Psychology) absorbed nearly two-thirds of the funds. Virtually all of the research supported during this period was in the related disciplines and not in Psychiatry per se. Help to Psychiatry, itself, went largely for the development of full-time teaching departments in medical schools, with smaller portions to training fellowships and some experiments in the application of Psychiatry as in mental health and child guidance clinics. Emphasis in the teaching departments was on bringing this specialty more fully into the mainstream of Medicine.

The magnitude of the change in the number and amount of research grants is made more understandable when one examines the increase in the number and amount of research grants made by the National Institute of Mental Health for the nation at large in the period 1948-1965(17, 22) (see Table 14).

In addition to funds from the National Institute of Mental Health, we have had assistance principally from the Commonwealth, Rockefeller and Ford Foundations and from individual donors, for which we are most grateful. Some of this has made possible the exploratory research activities of students and of residents.

Career investigators have been supported in the attempt to create scholars and scientists in the field of clinical psychiatry. Considerable time is devoted to correcting and editing manuscripts, supervising the conduct of research and submitting reports. Increase in technical, secretarial and clerical assistance has followed, as has the need for additional space, equipment and supporting funds.

Although there have been differences of

TABLE 14
National Institute of Mental Health Research Grants

FISCAL YEAR	NUMBER OF GRANTS	AMOUNT
1948	38	$ 373,225
1961	1,286	30,492,081
1965	1,770	60,176,125

1949-58 NUMBER	PERCENT
673	
48	7.1
131	
16	12.2
163	
16	9.8
361	
34	9.4

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TS	AMOUNT
	$ 373,276
	30,492,081
	60,176,175

view within the department, we have tried to maintain a fairly informal set for the purpose of research training among our students, residents and special fellows. We have had a minimum of formal systematic courses in research methods. Rather, we have attempted to introduce material in a systematic fashion when it appeared relevant and timely to the special pursuit of the investigator. Above all, we have attempted to establish a climate of curiosity and questioning in our daily work and have afforded the young opportunities to know and to be exposed intimately to models of clinical investigators. The following illustrates the number of scientific publications by the members of the department at five-year intervals over the past 20 years:

1946-1951	44
1951-1956	89
1956-1961	130
1961-1965 (four years)	179

MILITARY

Since the Draft Act of 1940, through World War II and since, we have been concerned and involved with the military. O.S.R.D. researches during the war, consultant posts to the Army here and abroad, consultant and dean's committee programs to Veterans Administration hospitals, the coming and going of junior and resident staff to the armed forces, U. S. Public Health Service and the National Institute of Mental Health clearly attest to this. The present Viet Nam crisis will undoubtedly draw further upon us for needed military service.

VISITORS

During the past academic year we had 74 visitors to the department, 24 of whom came from abroad. Most remained with us for a few days to learn something about our activities in teaching and in clinical services or were particularly interested in specific research programs. This did not include about ten site visitors from the National Institute of Mental Health or ten additional persons invited by us to spend a few days in the department as visiting scholars and scientists to present formal lectures and engage in seminars. The pleasure and profit in being host to our visitors is apparent; however, the time and effort of meeting, of arranging travel schedules, conferences and lectures, housing, entertainment and avoiding conflicts with other lecturers in the school at times present quite a problem.

MEDICAL SCHOOL, HOSPITAL AND UNIVERSITY SERVICE

As indicated earlier, the ferment of change is apparent in all the departments of the medical school and hospital. As a department chairman, one is not only an active member of the major policy and operating standing committees of the school and hospital but may be called upon to lead and serve on many ad hoc committees, committees on tenure, on interdisciplinary studies, on faculty salary scales, on faculty rank and organization, on the curriculum, on planning and building, on bed utilization and patient care, on promotion and on the search for new chairmen of other departments.

Regardless of how the dean's office may be expanded, the department chairmen are called upon to give fully and generously of their time, effort and skill to the affairs of the medical school and its teaching hospitals. Similarly, the medical school has become more intimately involved with the university at large. Membership in the senate of the faculty, campaign fund committee, honorary degrees committee or presidential search committee may be illustrative of these engagements.

Representative, too, of the increasing intimacy and involvement of the department of psychiatry with university departments outside the medical school are our associations with biology, psychology, the social sciences, education, statistics and with the ever-burgeoning growth of data processing facilities.

COMMUNITY LIAISON

As I indicated earlier in this report, our department of psychiatry, like many, has traditionally been more extramural and related to various community services than many of its fellow clinical departments. For reasons outlined earlier, we anticipate

an increase in the demand from the community for direct clinical services, for consultant posts to agencies, courts, schools and for participation in community service planning. It is evident that with increasing size and complexity of communities, health service planning is no longer elective. Planning has become obligatory in order to avoid unnecessary duplication of services and to establish proper regional distribution of such to serve the needs of all persons.

NATIONAL AND INTERNATIONAL ACTIVITIES

My personal experiences, I believe, may be quite representative of my generation of department chairmen. A number of us have been seriously engaged in national planning for health services in our field. The burden of our assignments has led some of us to consider ourselves an expendable generation in terms of our individual scholarship.

I had the privilege of participating in the beginnings of the National Institute of Mental Health. In 1946 I served as a member of the original Council and as chairman of the first research study section. For the succeeding 15 years, I served on various National Institute of Mental Health committees, including the Career Investigator Selection Committee. In addition, I have served on various advisory groups to the Ford Foundation assigned the task of allocating funds for research programs in psychiatry and related disciplines both here and abroad.

Other assignments have included service on editorial boards of scientific journals. Other members of our department have served on National Institute of Mental Health committees and have acted as site visitors and consultants. All of this has required time, effort and study to do full justice to this truly remarkable venture of our federal government in the field of mental health.

A generous fellowship from the Commonwealth Fund made possible for me a year of sabbatical study (1959-1960) in which I made comparative observations of teaching, research and clinical services in the United Kingdom, continental Europe, the Soviet Union and the Middle East. There is little question that more of us will be taking part in various international studies from which comparative data will be obtained about morbidity, health services, epidemiology, treatment procedures, etc.

GENERAL REMARKS

Thirty years ago a number of us, now in this room, met in this university hospital and worked together as fellow students. While we may have been drawn here for different reasons, I believe an important one was the opportunity for graduate study in the field of clinical psychiatry in a major university department in a modern medical school with the then rare support of fellowship stipends, modest as they may seem to us in our affluent present.

Over the succeeding three decades, as friends and as colleagues, we have touched each other's lives through our students, our scientific work and membership on various national, scientific and professional groups. We have been seriously engaged in the common venture of the growth and development of clinical psychiatry. More particularly, we have participated in the truly amazing growth of the university department in its educational, clinical service and research functions.

As young men, we dreamed young men's dreams. I doubt, however, if any of us dreamed, much less could have predicted, the changes which have taken place, and more particularly, the rate at which the changes have occurred. There is sufficient evidence, I believe, that we have been participant observers, not spectators, of the human comedy in this middle third of the century. It would indeed be gratifying to believe that our efforts contributed significantly to these changes in our field. We must not delude ourselves by forgetting or minimizing the major political, social and economic forces which played an important part in the over-all development of mental health services in our nation. We must also note that some, but not all, of our problems appear to be the problems of success.

I find that we may have been successful in some matters. However, there are other matters with which we have been

less engaged: for example, in the study and care of the chronic psychotic patient. Regretfully, so far as I know, our efforts as yet have not appreciably modified the incidence or prevalence of madness in our nation or elsewhere.

My major thesis has been to point out changes in department form and function as seen by one department chairman. If what I have seen and experienced is representative, then it may be wise and useful for us to pause and consider our future. It occurs to me that many of the matters to which I have drawn attention could quite properly and profitably be discussed by regional groups of department chairmen. Perhaps even more appropriate would be for some of these matters to be discussed and studied by the National Association of Chairmen of Departments of Psychiatry. Perhaps we could invite to our meetings representatives of the National Institute of Mental Health, of residency review boards, of the American Board of Psychiatry and Neurology, so that together we could plan intelligently and constructively for the future.

Can we expect continuing growth at the same rate it has occurred in the past 20 years, or are we to expect a leveling off of the S curve of growth towards a more stable form, as predicted by John Platt for further changes in science and technology(9)? Whatever the rate may continue to be, it must be clear that what we do and what we may become will, in great part, be dependent upon the nature and demands of the social organization in which we exist now and tomorrow. As David Shakow has said, "In the end, the functions of professions and the functions of disciplines are social, and the values must be social values. Society decides what should be the role and function of a particular profession or group. The final test, of course, is dependent upon what the persons representing the profession have to contribute"(18).

In the ideal world, social organization, like all viable living things, must be dynamic, informed, germinal, adaptive and, moreover, useful to the central purpose which it serves. Should we not be concerned with the design of the organization of our university departments?

Eric Trist and other social system theorists inform us that:

> A main problem in the study of organizational change is that the environmental contexts in which organizations exist are themselves changing—at an increasing rate, under the impact of technological change. This means that they demand consideration for their own sake. . . . This requires an extension of systems theory. The first steps in systems theory were taken in connection with the analysis of internal processes in organisms, or organizations, which involved relating parts to the whole. Most of these problems could be dealt with through closed system models. The next steps were taken when wholes had to be related to their environments. This led to open system models, such as that introduced by Bertalanffy, involving a general transport equation. Though this enables exchange processes between the organism, or organization, and elements in its environment to be dealt with, it does not deal with those processes in the environment itself, which are the determining conditions of the exchanges. To analyze these, an additional concept—the causal texture of the environment—is needed(1).

I believe we could apply these notions properly and usefully to a number of our concerns, including that of psychotherapy. To apply these notions to our organizational problems, we would first have to examine the internal system of the department, its component part and its interdependencies. It appears to me that psychiatry covers a much wider array of substantive matters—physicochemical, biological, medical, psychosocial—than do its fellow clinical disciplines, at least in their more traditional views. We are, perhaps, not only more heterogeneous, but as yet we have not resolved satisfactorily the considerable dissonance among us in our basic belief and value systems. There remain among us both biophobes and psychophobes. We should listen to the caution of Herbert, the 17th century poet, who said, "Woe be to him who reads but one book."

Our internal system as a department is in constant exchange with its environments. Our most immediate environment is our parental home, the medical school, its teaching hospitals and the university at

large. Space and financial needs, competition for faculty and curricular time, the explosion of knowledge and of techniques, the uncanny development of mechanized intelligence—these are some of the matters about which we are in constant exchange with our colleagues in the medical school, hospital and university. It appears that we are able to reach reasonable concordance in that which we share most commonly, namely, in the teaching of undergraduate medical students and in the study and care of the sick.

With other matters, in our research and in certain aspects of our teaching program, there is apt to be greater deviation among us. Earlier, I spoke of the very considerable ferment and change which is taking place throughout the medical school and hospital. With the changes, actual and imminent, can we and our colleagues chart a course safely between the exclusive extremes of a community clinical service station and of a restricted research institute and yet draw properly on each in order to preserve our primary obligation to education?

Has the subject matter entrusted to us, or that thrust upon us, become too broad to be encompassed within a clinical department? Should our preclinical teaching be woven into a department of behavioral sciences in order to share it more fully with psychology, social science, pediatrics, preventive medicine, biology, to mention a few? Should we encourage the establishment of independent departments of psychology and social science in the medical school? Should child psychiatry be woven into the fabric of pediatrics and child health? Should there be established a new department of preventive health services encompassing much of what is done now in preventive medicine, epidemiology, social psychiatry, pediatric family practice and well baby clinics, birth control and well woman clinics?

Has the traditional departmental organization outlived its usefulness? Or should we more boldly consider the establishment of a school of psychological medicine as proposed by Kubie(3) and others in the past? Should the department of psychiatry be established as a university department transcending the medical school and hospital and relating directly to the parent university, in this way facilitating working relations with many departments in the university at large? Should universities establish schools or divisions for applied social studies in order to eliminate the unnecessary duplication of personnel engaged in survey research or in ad hoc responses to emergency inquiries and studies based upon community needs?

But we must remember we have environments other than the medical school, hospital and university. These, too, are environments on which we are dependent and with which we are in constant exchange. I speak now of the environment of the community in both local and national terms where changes are taking place at accelerated rates. The social movement alluded to earlier will be characterized by more, not less, demand on the university medical center. Health is no longer considered a privilege. It is now demanded as a right.

Recent laws relating to hospitalization procedures and Medicare are paralleled by new and additional insurance coverage for professional and psychiatric services in offices and in clinics, as well as for inpatient care in psychiatric hospitals. The establishment of regional medical complexes will certainly affect the medical school, its teaching hospitals and its constituent departments. The burden of this last point is the need for us to realize that the changes which are occurring in our environments are rapid and significant. In great part, they will determine who we are and what we may become.

With Barnaby Keeney, I am aware of the hazards incurred when universities turn themselves into instruments of social action(2). In a recent address Keeney issued a warning against both extremes—activism and detachment. There is little question that, as participant observers of the human comedy and as clinical activists, we are and must continue to be engaged in service to our communities. However, in some manner or other, we must protect and continue to nourish the very basic obligation of the university to contemporary society, to examine objectively the issues before us and

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Whitehead reminds us that a profession, unlike a craft, cannot be satisfied with customary procedures. We must constantly search for means to organize and use intelligence in new ways(25). Hopefully, such a search may help us to take part in the design of our university department organization, appropriate and useful to our purpose and to the changing needs of our society.

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REQUIEM OR REVEILLE:
PSYCHIATRY'S CHOICE

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The Salmon Committee on Psychiatry and Mental Hygiene
The New York Academy of Medicine
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INTRODUCTION

What follows is selective history, the hazard of which was made clear some years ago in reading this note from the Times of London:

> "Then there was a schoolmaster setting essays on Alfred the Great. He urged upon his pupils no mention of the cake-burning episode as being irrelevant to the main thread of our rough island story. The resultant offerings included one which ran: Alfred fought a big battle against the Danes. He lost. He then ran into a wood, where he found a woman living in a hut. He went inside. What went on afterwards, I'm not to mention."

It is said that we are dead, or at least dying, and that our days are past. Faulkner told us that the past is never dead, that it isn't even past. But what may be past or passing is the more limited professional role which we served earlier in the century. We are more numerous, more diverse in function, and are called upon by our society to serve many needs, for some of which we are not prepared. It is said that we deal with myths, that mental disorders are myths imposed and nourished by a harsh society. Obviously, one of the most human of our characteristics is that of variability, and even within reasonably homogeneous groups, there may be a wide distribution of behavior patterns. Yet, within each group certain patterns emerge which are interpreted and identified by the members of the group as illnesses. Jane Murphy's recent report, in which she presents systematic data from Eskimo and Yoruba groups and information from several other cultural areas, calls the labeling theory into question. She concludes: "Rather than being simply violations of the social norms of particular groups, as labeling theories suggest, symptoms of mental illness are manifestations of a type of affliction shared by virtually all mankind."[1] But of course there are myths. There have always been and probably always will be myths about health and sickness, and for obvious reasons particularly about mental illness. How many in this, our age of enlightenment, could have predicted the popular interest in "The Exorcist" and its sanction by the clergy?

There is one matter which I do believe is more substance than shadow. It is the concern of the modern psychiatrist about his professional role. This concern is clearly illustrated by the following selection of titles and comments taken from papers recently published in our professional journals:

> Heaven protect the patient from any therapist who has a political position and a single form of treatment.
>
> Psychiatric therapy often reflects the bias of the therapist and not the needs of the patient.
>
> We have lost our boundaries.
>
> We are over-regulated and over-managed.
>
> There is an anti-intellectual movement promoting craftsmanship at the cost of scholarship through truncating the undergraduate medical curriculum, eliminating the internship, and reducing the residency.
>
> Somebody has to put the whole person together again.
>
> Psychiatrists are found deficient in knowledge of psychotropic drugs.
>
> There is a false egalitarianism obscuring and denying the differences in education, knowledge, skill, and responsibility between professionals and paraprofessionals in the interdisciplinary care of psychiatric patients.
>
> Psychiatrists see their specialty returning to the mainstream of medicine.
>
> The law doesn't trust psychiatry.
>
> Patients are dying with their rights on.
>
> Are you a psychiatrist or a real doctor?
>
> Is liaison psychiatry the answer to medical dualism?
>
> The death of psychiatry.
>
> The life of psychiatry.
>
> Muddled models.
>
> Labeling effects in psychiatric hospitalization.
>
> The psychotherapy jungle--a guide for the perplexed.
>
> Breaking through the boarding house blues.
>
> Social policy in mental illness.
>
> Shopping for the right therapy.

Is psychiatry a white middle-class invention?

It's all in your head.

The future of psychoanalysis and its institutes.

The great megavitamin flap.

Much of what has been cited touches on the professional role of the psychiatrist. To obtain a more immediate sampling, I asked sixty of my psychiatric colleagues, together with twelve psychologists, social workers, social scientists, and biologists, to list for me the three most urgent problems they believe confront the psychiatric profession at this time. Here, as in the list of titles read, the central and pervasive concern of the psychiatric group, in contrast to the non-psychiatrists, was the definition of their professional role. These psychiatrists, full-time, part-time, hospital and office practice, town and gown, junior and senior, would ask, "Who am I? What is the knowledge, which are the skills I shall need in my professional work? Who are to be my patients, and with whom do I share the responsibility for the care of the sick?" Many also sought clarification of their professional role, not only within the medical profession, for example, "Am I a real doctor?", but also within the mental health team (psychologist, social worker, nurse, social scientist, mental health counselor, and others), "What is it I do, and what is it the others do?" No one has described our predicament more succinctly than our esteemed colleague, Leon Eisenberg, who said, "Does psychiatry have a future as a medical specialty? ...There are those who argue that mental disorders are simply forms of social deviance and that psychiatry is nothing more than a covert penal system, designed to maintain law and order. Others contend that mental ailments are problems of living and that people from his neighborhood are better able to treat the patient than doctors distant from him in status, education, and social class. Psychologists tell us that psychiatrists study medicine, which they do not practice, and practice psychology, which they have not studied."(2)

Whether our concerns are different in kind or in number from those of our predecessors in other times and in other places, will be determined eventually by tomorrow's historians. Silas Weir Mitchell's critique of the psychiatric profession in 1894 pointed to some of the deficiencies in the study and care of institutionalized patients at that time. While certain matters of which he spoke are still relevant in our day, we live in a different time and have, for the most part, quite different problems. Several of our colleagues have commented that identity confusion has been recognized as a problem to psychiatrists at least since World War II, if not before, and there is similar confusion in the psychiatric professions of other nations. It is said that each generation is apt to over-estimate its contribution to its society, and perhaps for the same reasons over-estimate the seriousness of its problems.

But what has happened to us? Is our concern appropriate? What has contributed to this confusion about our professional role? It seems unlikely that whatever confusion we may have could be due, certainly not to any serious degree, to the inherent ambiguities of our material, human nature in distress. There is, as yet, no satisfactory unitary concept which encompasses human behavior in biologic, psychologic, and social terms. We have yet to acquire the full and proper language that deals with the whole of man in his society. We have withdrawn into secluded apartments in the Tower of Babel and at times speak to each other only in tongues. But this has been so since the beginning, and I would expect it to be so for some time to come. Our colleagues in medicine and surgery are less concerned with this matter as they are not with the seemingly infinite variations of human behavior in manners and morals. Thus, unlike most of our medical colleagues, we carry a heavier burden of doubt, of conceptual uncertainty, of ambiguity.

More likely, I believe that whatever confusion we have has been determined by certain changes in the aims, scope, and operations of our professional work.

These changes are not only of considerable magnitude, but have occurred at an unprecedented rate of change in these past thirty years. As we are intimately intertwined in the society in which we exist and in which we serve, the changes which have occurred in our field and in all of medicine are obviously part of a larger fabric. It is claimed that more basic and far-reaching changes have occurred in the middle third of our century than in the 300 years preceding it. (3) The Great Depression, the Second World War, Korea, Vietnam, the rise of new nations, the struggle for power, the spread of affluence, the technological revolutions in making and building and distributing, the increase in world population, the explosion of knowledge, the serious attempts to insure full measure of civil rights and living opportunities for all of our citizens--these and others have significantly and materially affected our way of life. In addition, in the past decade of discord and discontent, we have witnessed a movement toward unreason and mysticism which appears to be nourished in an ambience of mistrust of authority figures and of the establishment. One is aware of this in attitudes towards government, the law, the church, and education, as well as towards medicine. That the best educated and most sophisticated generation of young Americans in history should be seriously interested in astrology, palmistry, numerology, even witchcraft, is certainly an enigma, a major paradox, of our time. It is as if Shaw's caution, "Every profession is a conspiracy against society," has been taken quite seriously. But there is little question that in the long run it is society which determines the professions it chooses to serve it. I am aware that change is not always for the better, and that in my lifetime several developments, for example, the psychopathic hospital and the general hospital psychiatric unit, as well as the psychoanalytic movement, have not fulfilled our expectations. We have awakened to a number of false dawns, but there is little question that change has certainly influenced our present professional status.

I have chosen to consider those changes relating to the remarkable increase in our number; to the changing character of the psychiatric patient, together with the exponential expansion of psychotherapeutic modes; to our renewed interest in the study, care, and treatment of the psychotic patient; and to the beginning development of scientific research.

INCREASE IN NUMBER OF PSYCHIATRISTS

Again, to point out how intimately we are woven into the fabric of our society, I believe the National Mental Health Law, passed by our 79th Congress in 1946, was perhaps the single most influential factor in producing change. The law made possible generous financial support, both for education and for research. Certainly, the law had immense influence in effecting the greatest change in our profession, namely, the increase in our number. In 1934, when I began my resident training in psychiatry at Yale, the total membership of the American Psychiatric Association was 1604. In 1939, when I assumed my first faculty appointment as an instructor at Harvard, it was 2235. It was 2913 when I went to Cincinnati in 1942 to chair the department, and 4010 in 1946, when I came to Rochester. Bertram Brown recently has updated the figures and states that today there are 27,000 psychiatrists in the United States, which must include those who are not members of the APA. Further, he estimates that by 1980, there will be 30,000. Brown estimated that the United States has between 1/4 and 1/3 of the world's psychiatrists.(4) If this is so, there must have been a comparable increase in psychiatrists in many other nations. Thus, in my professional lifetime there has been, in the United States, an increase of psychiatrists from less than 2 per 100,000 of population, to currently about 12 per 100,000, and Brown predicts 17.8 per 100,000 by 1980. All of this is quite dry stick unless one has lived and worked and been accountable during the entire period. I grew up in Milwaukee and went to medical school at Marquette, finishing in 1933. With the exception of one psychiatrist in the Child Guidance Clinic and two psychiatrists engaged

principally in forensic work, the only other psychiatrists to be found were in two small private psychiatric hospitals and two large county mental hospitals, the total number of psychiatrists being less than eight for the urban population, about 400,000. Today there are 94 who serve the same area with only doubling the population. Similar growths took place in Cincinnati and in Rochester. Neurotic patients, when identified and respected as such, were seen and cared for by general practitioners, internists, and neurologists. I have no idea how often the alienist saw court cases, nor how many children were seen in the guidance clinic. Psychotic patients, when identified, were sent to psychiatric hospitals.

And so, unlike 40 years ago, when the few psychiatrists who did exist served almost exclusively in public and private mental hospitals, today's psychiatrists are found principally in community, private, and group practices, in clinics and general hospital settings, including those for children and adolescents, in schools, courts, and agencies, on the faculties of our medical schools, schools of social work, and at the NIMH. The principal areas of neglect remain those of the continuing care of the chronic psychotic patient, the alcoholic, the drug addict, the criminal, the retarded, the aged--particularly when they are poor and/or black.

The profession has become a house of many mansions, with considerable diversity among us as to whom we see and care for, what methods we use, and what beliefs underlie our practices. Small wonder, then, that increasing numbers of patients are seen, estimated to be about five million, more than 2.5% of the population.

But the story of this extraordinary increase is incomplete without mentioning the parallel increase in the numbers of our professional colleagues in the mental health field as well as a growing cadre of paraprofessional counselors. This, too, is in marked contrast with my experience as a resident

when psychology and social work were represented by a few valiant souls who served principally as handmaidens. Nurses there were, and I learned much from them, and there were attendants in the large public hospitals. But now there are considerable numbers of psychologists, social workers, nurses, nurse-clinicians, nursing assistants, mental health counselors, and still others, who take part with the psychiatrist in the care of his patient, not only on the inpatient services but in outpatient and office practices and in neighborhood outposts. Many assume duties initially fulfilled exclusively by psychiatrists. Obviously, there is confusion about this, and much of it stems from the lack of clear definitions of the roles of the non-medical professional and paraprofessional persons who are engaged in interdisciplinary involvements with psychiatric physicians. In this we are not alone. In October 1975 it is alleged an ecumenical service was held in London by the Royal College of Psychiatrists, the Royal College of General Practitioners, the Association of Directors of Social Services, and the Department of Health and Social Security. The order of service was initiated by a reading from the Old Testament:

> "In the Beginning, God made a psychiatric service and the psychiatrist ruled therein. And Lo! a psychiatric social worker was fashioned even from the psychiatrist's own rib. And they lived and worked happily together. Then there came a serpent and said to the woman: 'Wherefore dost thou slave for this man? Social work should be generic. Behold, I bring thee a report which, if thou readest, will give thee greater wisdom and better conditions of service.' And the woman did read and straightway she ran away to join others of her kind, Welfare workers, and Child workers, and Blind workers, and Old People's workers, each after her own kind. Then the psychiatrist was wroth and rent his raiment, and would not be comforted, except by a College." (5)

And the confusion extends beyond the members of the mental health team. If you listen carefully, you may hear a chorus of voices, often plaintive, sometimes petulant, but quite persistent, "Who is my doctor?"

THE PATIENT AND PSYCHOTHERAPY

Who is our patient? What do we understand to be the nature of his distress? Is his trouble to be considered disease or discontent? What can we do to help him? These are not trivial questions.

The Parsonian model of the sick role, designed for those who are acutely physically ill, is not useful when applied to the psychiatric patient, or, for that matter, to patients with chronic illness.[6] Most studies indicate that the extent of societal agreement about admission to the sick role decreases as the social and psychological aspects of the condition increase. Obvious differences include the notions of individual responsibility for incapacity; the hazard, as well as the reward, for seeking technical professional help; the dependent-passive-submissive vs. independent-active-self-directed interactions with the professional person.[7]

In our lifetime the physically sick model has been applied to two great public mental health scourges, now happily reduced, if not eliminated, namely the psychoses associated with neurosyphilis and with pellagra. The traditional sick model is also applied without much difficulty to the organic psychoses, as these may be determined by genetic factors, infection, trauma, neoplasm, metabolic disorder, aging, etc., and more recently, because of the vigorous interest in genetics and neurochemistry and the successful use of the psychotropic drugs and other biochemical agents, greater emphasis is given to biological factors in explaining the onset, course, and treatment of the schizophrenic patient, the manic-depressive, and to many other forms of affective disorder. There has also been a more critical view of the exclusively psychological explanation of certain of the neuroses, including the historical paradigm of hysteria.[8] In our modern day the principal thrust of the theory of psychological motivation emerged from Freud's study of neurotic patients, which draws attention to the conflict of competing needs and drives for expression or compromise solution of these needs. The counter theory, more traditional

with medicine, is the neurobiological concept which attempts to explain behavior in terms of deficit, impaired capacities, release or loss of controlled behavior, and the lowering of the organizational level. Each has had its past in the mists of antiquity. We can find allegations that disease or sickness may be related to fear, to shame, to guilt, or to feelings of having done wrong; on the other hand, we can trace our neurobiological concept of brain pathology back at least to Hippocrates. On other occasions I have drawn attention to the uniquely significant impact of psychoanalysis on American (as contrasted with European) psychiatry, which, in turn, led to a wider polarization of belief systems among us, as compared with our European colleagues.(9) We have championed the psychosocial model at times to the detriment of the genetic biological model of behavior, and it has led us quite predictably to respond to a considerably broader repertory of persons in distress. Many engaged in private psychotherapeutic practices were concerned principally with neurotic middle-class patients; however, the nature of the neurotic distress treated changed from that of symptom distress--that is, symptom neurosis--to that of character neurosis. And this, in turn again quite naturally expanded to responding to the needs of those who are unhappy, troubled, alienated, lonely, and afflicted with the malaise and anomie of our time.

Small wonder, then, that we have wandered far from our original aim, the art of treating mental disorders. Now we are concerned not only with the relief of distress, but with the achievement of positive mental health, and so the range of problems has expanded. Psychotherapy, as it was influenced by psychoanalytic psychology, was most concerned with the internal unconscious conflicts of the individual, but now it attempts to change or modify interpersonal, family, and other social systems in which the patient is a member. Our students at times appear to be puzzled about the psychiatrist having been Mr. Inside and now as being Mr. Outside. In my professional life, believing that man's problems have always been inside and outside, I am somewhat dismayed

at the exclusive commitment of some of our colleagues to one pole or to the other. I say, a plague on both their houses. There is little question in my mind that dynamic psychotherapy, as influenced by psychoanalytic psychology, has had a tremendous humanizing influence on all of Medicine. It has helped inestimably in understanding each other and our patients and has made possible a beginning systematic approach to the study of the interaction between patient and physician. Our increasing concern with the human family, as well as the human community, has also added immeasurably to our understanding of the human condition.

Psychotherapy, formerly the province of psychiatrists and psychoanalysts, now includes the clinical psychologist, social worker, nurse, clergyman, and a large group of paraprofessionals. There are also former patients whose credentials as psychotherapists are that they have experienced the distress similar to that experienced by those for whom they care, particularly drug abusers, alcoholics, delinquents, and criminals. We are told that at the moment there are 130 different psychotherapeutic modes. Parloff, in a splendid popular presentation, has classified the four major schools: (1) analytically-oriented therapy; (2) behavior therapy; (3) humanistic therapy; and (4) transpersonal therapy. Others may be classified as pantheoretical, like many group and community-oriented therapies, and still others, defy classification, such as primal therapy.(10) The first two of the major schools, namely, analytically-oriented therapy and behavior therapy, hardly need explanation. The humanistic therapy is represented by a broad spectrum of self-actualizing techniques.

The transpersonalists are not content with the aims of self-actualization. Their goal is to transcend the limits of ordinary waking consciousness and to become at one with the universe. I did not realize how extensively certain of

these methods were used until I read a report in the New York Times on 18 November, 1976, which reported in brief the results of a recent Gallup Poll. A sampling of 1553 adults, 18 or older, in the period from August 27-30, 1976, were given a card with the listing of various disciplines, were asked, "Which, if any, of these are you involved in, or do you practice?" The list included mysticism, Oriental religions, Yoga, Transcendental Meditation, and the Charismatic renewal, a Christian movement that emphasizes the "gifts" of the spirit, such as healing, and "speaking in tongues." Transcendental Meditation registered the greatest following, 4% of those sampled, or an estimated six million of the general population. Next was Yoga, which gained 3% response or a projected total of five million. Both the Charismatic renewal and mysticism gained 2% of the responses, an estimated three million apiece. One per cent of the sample, or a projected total of two million, indicated an association with Eastern religions. The report indicated that those who practiced Transcendental Meditation and Yoga tended to be young adults, 18-24, those in college, or who are generally non-religious in the traditional sense. These findings are attributed to two social trends, "...one is the apparent desire by many Americans to find ways of calming the tensions of modern life, the other is that the new wave represents a revolt against the scientific rationalistic view that has created a profoundly secular climate."(11) Obviously, today's psychiatrist is not the only professional, paraprofessional, or lay person engaged in these matters. But there is little question that there have been considerable changes in the aims, the scope, the population served, of patients today as compared with 30-40 years ago. Most of us would accept the evidence that almost all forms of psychotherapy are effective, with about two-thirds of their non-psychotic patients, that is, regardless of method, and that those patients who are treated do show more improvement in mood, thought, and behavior than do comparable samples of untreated patients.

It is said that behavior modification appears to be particularly useful in some specific types of phobias; there is, as yet, no convincing evidence of the relief from biofeedback, and I know of no critical studies of the effectiveness of the many humanistic and transpersonal therapeutic modes. With the increase in our numbers and the parallel increase in nonmedical and paraprofessional groups, and with the increasing breadth of human problems brought to our attention, it is not surprising that there is confusion about the designation of those who seek help. Traditionally, in the medical sense, it is the patient, he who suffers. But, increasingly, those who come for help, regardless of to whom they go, are also called client, a term which initially meant a dependent, and customarily used by those who are served by a social agency or one who consults a legal advisor. And when one considers some of the objectives of the transpersonalists and the humanists, one wonders whether those who seek such help should be called penitents.

There is so much more for us, as psychiatrists, to learn about this incredibly important and influential phenomenon--that which takes place between the patient (he who suffers)and the physician (he who wishes to heal). It has been the thread of continuity, the means of survival, of the physician through the centuries, regardless of how informed or uninformed, how helpful or harmful he has been to those who have sought his aid.

Perhaps Jerome Frank is right in proposing that the following 6 features (12) are common to all psychotherapies:

1. "An intense emotionally-charged confiding relationship with a helping person, often with the participation of a group.

2. A rationale or myth, which includes an explanation of the cause of the patient's distress and a method for relieving it.

3. Provision of new information concerning the nature and sources of the patient's problems, and possible alternative ways of dealing with them.

4. Strengthening the patient's expectations of help through the personal qualities of the therapist, enhanced by his status in society and the setting in which he works.

5. Provision of success experiences which further heighten the patient's hopes and also enhance his sense of mastery, interpersonal competence, or capability.

6. The sixth shared feature of all psychotherapies in facilitation of emotional arousal, which seems to be a prerequisite to attitudinal and behavioral changes."

Obviously, one of the major areas of unfinished business is the search for that which is basic and essential to the psychotherapeutic encounter. Psychiatrists, with their colleagues in psychology, biology, and the social sciences, must pursue with increasing vigor those studies which one day may enable us to act less blindly and to prescribe the appropriate method to help our patients.

PSYCHOTIC PATIENT

Certainly one of the more dramatic changes in the past 30 years has been the renewed interest in the care and treatment of the psychotic patient. Our professional journal reports attest to the reduction of the resident state and county mental hospital populations, the decline in average length of stay per patient, and the shift towards care in the psychiatric units of the general hospital and beyond, to the OPD and to the office. Undoubtedly there were several determinants, but most of us would agree that the changes stemmed principally from the introduction of the psychotropic drugs and the re-emergence from the past of the moral treatment of our mad. While we are aware of the limitations of each of these factors, it is a remarkable change from my salad days, when we were involved in the psychiatric hospitals of our day with long-stay patients. We used to the full the therapeutic enthusiasms of our day, with dauerschlaf and insulin, with pentavelent arsenicals and the Kettering hypertherm. We used chloral and bromides and the barbiturates as wisely as we knew how, and we practiced the various types of insight and supportive psychotherapies known to us at that time. Sulpha had just arrived, penicillin was yet to come, and we would wait twenty years before chlorpromazine was available.

Later in our stay, metrazol was used and ECT was on the horizon. We seemed to have had an endless number of acutely disturbed patients, and we would respond to their emergency needs, together with our nurses and attendants, with the gusto of seasoned firehorses. We did initiate certain limited community services; for example, we helped to establish outpost clinics in western Colorado for purposes of triage, diagnostic study, first aid treatment, and referral.

Although the psychotropic drugs have altered materially the course and recurrence of psychotic episodes, they are, in themselves, no full solution to madness and often cause toxic reactions even when prescribed appropriately. As for the community mental health movement, I look upon it in principle as a vanguard movement of what will be taking place in all of Medicine. It reflects our increasing concern with the delivery of health services, with the awareness of our current deficiencies in the continuity of care of our patients, and with the pervasive problems of the much-neglected chronically ill patient.

Regrettably, the initial phases of this movement were launched without adequate systematic experiment and trial. As a result, many chronic psychotic patients, long institutionalized, with either absent or long-lost social skills, were catapulted into the community without adequate means for their care. Chronic illness is another non-myth. It cannot be removed by sweeping it under the rug of ill-prepared community facilities.

While these two movements, in concert, have brought about the dramatic change in the care of the psychotic patient, they have, in themselves, also led to quite divergent goals.

The introduction of the drugs and their daily use by the practicing psychiatrist has returned the psychiatrist to his biological heritage and has drawn attention to the neurobiological model as well as the motivational model, as a determinant of illness. It has led to a more balanced view of psychopathology, explicable not only in terms of the paradigm of psychologic conflict,

but also that of deficit. The daily use of medication has required physical as well as psychological screening of patients, and the psychiatrist has had to become familiar with certain laboratory methods to help him gauge drug dosage and to avoid complications. This trend has been called neo-Kraepelinian, with its serious consideration of genetic factors, greater precision in noting signs and symptoms of disease, by the charting of the natural course of illness, and by follow-up studies of the effects of intervention on prognosis. In short, the psychiatrist is returning to being a doctor. But, alas, in all of this our own colleagues on the American Board of Psychiatry and Neurology decided in 1970 to eliminate the one-year internship requirement for certification in psychiatry and neurology. For those of us who have devoted the major portion of our professional lives to strengthening the relations between psychiatry and medicine, this decision was considered regressive.(13) I am heartened to learn that there are movements to correct this error in judgment, at least in part.

But, the community health movement has pointed in another direction. It has led some to insist that our major objectives must be those of primary prevention, that is, for the psychiatrist to become informed and socially and politically active in reducing poverty, population, racial discrimination, and in improving education, employment, and housing. This is a major departure from our traditional engagement with the individual patient. It points towards a collective public health-social engineering role for the psychiatrist and I believe makes demands of him which he cannot fulfill because of his lack of expertness in social and political science. Regrettably, this is clearly illustrated in several instances of our bumbling political intervention in community mental health ventures.

From an educational point of view, I believe it is this dilemma which causes the most confusion in our young residents. We have, as yet, no clear-cut definitions of the public health, social, and political roles to guide us in the preparation of those who may assume these new responsibilities.

And it is in this regard that we have erred in promising not one, but many rose gardens in responding to society's insistent demands that we do something to reduce crime, delinquency, drug abuse, and alcoholism.

RESEARCH

And now, a word about the growth of research in our field. With Lewis Thomas, I believe the most urgent problem of the day is to insure the continued and vigorous support of research in all the fields relevant to our professional work.(14) With him, I also believe that one must support particularly those inquiries that may lead to basic or fundamental knowledge, and not only to those which may have immediate applicability for personal and social change. We must insure fellowship support and adequate facilities for the pursuit of new knowledge, including that which may seem useless at the moment. We must remember that we have just begun. Sigerist reminded us that the physician was a priest in Babylonia, a craftsman in Ancient Greece, a cleric in the early and a scholar in the later Middle Ages. He became a scientist with the rise of the natural sciences barely a century ago. We are just at the beginning.

During my intern, resident, and fellowship assignments in New Haven, Denver, and Boston there was no formal investigative work taking place, although several of us did become involved in clinical case histories and follow-up studies. In fact, there were few models of scientific investigators available to us. At that time psychiatry had no Rockefeller Institute to help groom its young professors, as was the case in medicine and psysiology. We had to wait almost fifteen years before NIMH became a reality. Our models were the clinician-teacher-scholar and later the psychoanalytic psychotherapist-practitioner. It was not until the early 50's that the Career Investigator Fellowship Program was established, with the hope of several of us that a new model of psychiatrist-scientific investigator would be created and fostered.

Robert Morison, more than a decade ago, in his critique of our field, reminded us of the contributions of the Rockefeller Foundation in the period before the establishment of the National Institute of Mental Health. He points out how small the amount of money was:

> "...a little over $16,000,000 in twenty years for Psychiatry and related disciplines. The related disciplines (Neurology, Neurophysiology, Neuroanatomy, Neurochemistry, and Psychology) absorbed nearly two-thirds of the funds. Virtually all of the research supported during this period was in the related disciplines and not in Psychiatry per se. Help to Psychiatry, itself, went largely for the development of full-time teaching departments in medical schools, with smaller portions to training fellowships and some experiments in the application of Psychiatry as in mental health and child guidance clinics. Emphasis in the teaching departments was on bringing this specialty more fully into the mainstream of Medicine." (15)

More recently, Brown summarized a two-year report of the Research Task Force that involved three hundred people and one million dollars to review one billion dollars worth of research in the United States, supported by NIMH and others. The number of research projects supported annually by NIMH has grown from 38, in 1948, when the first appropriations were made under the National Mental Health Act of 1946 (at which time I was privileged to serve as chairman of the First Research Study Section), to nearly 1,500 in 1975.

The report indicates that over the last twenty years the ratio of the amount of NIMH-supported biomedical research to psychosocial research was reversed. Twenty years ago the ratio of biomedical research to psychosocial research was 2-1; in 1972 it was 1-2. This change reflects the broadening of NIMH's commitments in the late 1960's into social problem areas, such as crime and delinquency. (4)

In my recent return to clinical research, after many intervening years of department chairmanship, I noted certain overall impressions of clinical investigation in our field at this time. (16) One impression is of the limited number of clinical psychiatrists engaged in basic or applied clinical research. In a quick review of the twenty ongoing research programs in the

United States engaged in the search for the antecedents of schizophrenia, I found only 7 had psychiatrists as principal investigators, the rest being psychologists. In no way disparaging the considerable contributions made by our psychologist colleagues, I found it somewhat of a personal disappointment that not more psychiatrists are engaged full-time in research, particularly after the aspirations of those who initiated the USPHS Career Investigator Program more than twenty years ago. I gather, from what Brown has written, that my sample may be valid for the nation as a whole. He said:

> "Psychiatry has been a major service-providing instrument of that vital and nourishing enterprise we call mental health research. The psychiatrist has played a significant but smaller role in the actual conduct of research. Only a few psychiatrists--numbering in the hundreds--are full-time researchers." (4)

I have begun to understand better the separate domains of the clinician and the investigator, and at times how difficult it may be for one to understand the other. The investigator defines in clear, operational terms, the variables he wishes to test. It is apt to be a circumscribed or atomic view, as contrasted with the molar, full sweep of the clinician. The investigator points towards behavior of members of a class, the nomothetic position, while the clinician has been traditionally idiographic. The investigator, perforce, because of the circumscribed sample, is ahistoric, while the hallmark of the clinician has been his allegiance to the historic method. And finally, there is the therapeutic intent of the clinician, which demarcates him from his investigator colleague's basic curiosity. Many years ago, I drew attention to other factors which may have contributed to the lag in psychiatric research, as compared with the pursuit of new knowledge in other medical fields. (17)

Other impressions are that few senior professional persons have direct contact with the research subject or patient; the limits of usefulness, of record research, and the lamentable habit of recording data in terms of inferred psychodynamics rather than at the phenotypic levels of behavior; the temptation to use methods familiar, available, and reliable, but inappropriate

to test what it is we wish to learn; confusion between the investigative purposes of hypothesis generation and hypothesis testing; an awesome regard of the all-inclusive and seemingly infinite capacities of the computer.

Of the utmost importance to our university departments of psychiatry should be the existence and support of adequate role models who are significantly and seriously engaged in research, and opportunities should be made for college students, medical students, psychology and social science students, biology students, and particularly for our psychiatric residents to be exposed to the lives and interests and work of the research scientists. And every attempt should be made to identify the special talents of the young and to nourish them with fellowship assistance.

CONCLUSION

It is quite fashionable today to be concerned with death and dying. Even after applying our new and more precise tests, I see no need to call for a special mass to be chanted for the repose of our soul. On the contrary, I see much reason to sound reveille, as it is time to rise to meet and fulfill more effectively our professional responsibilities.

We have become diverse, not quite as much as our older brothers, the internists and surgeons, but more so than the pediatricians and obstetricians, whom we now outnumber. In essence, our diversity is a function of our numbers but is further qualified by increasing fragmentation of functions formerly performed by those of us who have been generalists. There has been an exponential increase of full-time psychiatric faculty in our medical schools, exceeded only by those in Internal Medicine, although the actual number of psychiatrists engaged full-time in research is small in comparison. There has been a continuing demand for our consultative services from health, welfare, and legal agencies, both public and private. The explosive multiplication of psychotherapeutic modes has further fragmented us, although many, if not most, of the newer techniques have been initiated by non-psychiatrists

who assume the greater share of behavior, humanistic, and transpersonal therapeutic approaches, particularly in group sessions.

But, I am heartened by our renewed interest in the psychotic patient and his family, an interest nourished by the use of the psychotropic drugs and their serendipitous impact on neurochemical research, and by the moral treatment of our day, with its compassionate concern for the forgotten and neglected chronic psychotic patient. We have learned that psychopathology survives and prospers under many flags and that behavior can be explicable in the paradigm of deficit as well as that of conflict. One of our greatest achievements has been the education of our medical students, that is, all physicians, whether or not their major concern in later life is in patient care. Consider how significant this is and may become should there be continued development of Family Medicine and Primary Care Physician Programs. Earlier, I mentioned the imperative need for the pursuit of new knowledge in order that one day we may understand better the essence of psychopathology and of psychotherapy.

At times, I am reminded of those immortal words of Pogo, "We have met the enemy and he is us." Obviously, we erred in our uncritical, naive, and passive obeisance to political pressure without adequate and systematic trial before we embarked on our community mental health ventures. And peremptory was our decision to eliminate the free-standing internship for professional training, thus putting at hazard our biological heritage. We must clarify our role and the roles of others, both professional and paraprofessional, who share with us the study, care, and treatment of the sick and their families. The present deceptive egalitarianism has led to confusion worse confounded and in practice to the lowest common denominator of skill.

We must stop acting blindly as self-appointed social engineer saviors and learn from experiment and trial if and how our skills and knowledge are

applicable to social issues. We should examine carefully our relations to the law, to the courts, and to the criminal. We may have promised more than we were able to give, but there is little question that we have added considerably to the humanizing of criminal justice in our search for the psychological antecedents of deviant behavior.

In the present ambience of mistrust, we must do all we can to earn the confidence of our patients and their families to insure privacy, and above all, to do no harm. But, we should not be intimidated by the strident abstractions of those who would prevent us and our patients from knowing more, a right as fundamental as the right to live.

We are overdirected, overmanaged, overburdened, almost overcome by a militant corps of congressmen, lawyers, judges, philosophers, clergymen, ethicists, as well as paraprofessional do-gooders who are unrestrained in their zeal to tell us whom we are to see, what medication we are to prescribe, before or after meals, whom we should admit to hospitals, how long should they stay, which questions we should ask--unprecedented intrusion. But in an historical sense quite interesting. For decades our patients and we have been unsung, unloved, and unheard of, usually swept under the rug of our collective shame and guilt, and now we stagger unsteadily through a forest of committees intent on insuring that we are dependable and responsible and accountable. Personally, I continue to prefer as my guides the moral dicta of an earlier day, taught us by Hippocrates and Maimonides.

I would commend to you the clarity and vigor of the statement made recently by Jonas R. Rappeport: (18)

> "...declare a type of independence from the law, that we declare our individuality, that we declare the rationality of our treatment programs, the rationality of our need to commit some patients to hospitals, that we declare that commitment laws fit the needs of patients, not abstract concepts--and our right to treat patients at the best possible facilities and in the best manner, according to our professional judgment, without costly and wasteful legal trappings."

On another anniversary occasion, three years ago, when several of us took part in the Bicentennary Celebration of the First Public Mental Hospital in the Colonies, at Williamsburg, Virginia, I said:

> "The major function of the psychiatrist, and one unique to him, is that he serves as a crucial bridge between genetics, biology, clinical medicine, on one hand, and the behavioral sciences on the other. The psychologist, the social worker, and the social scientist lack knowledge of the body, the biologist that of the mind, and up to the present, the nurse has had insufficient scholarship in either field to serve the purpose of a bridge. Further, I believe that if we are to serve this function properly, we must become expert in both biologic and psychosocial systems. Only then will we be able to interrelate effectively the knowledge from these basic sources in our unique role and contribution as clinician and scientist. To neglect scholarship at either pole would be to diminish our usefulness for tomorrow." (9)

While we may derive information and knowledge from these two poles, we must also contribute to them, and I believe we can do so best in our historic and, I believe, our essential role as psychiatric clinician. Let us hope that those who conduct the educational programs for those who succeed us will keep this point foremost, and that also they will constantly be dissatisfied with customary procedures of craftsmanship in their search for means to organize and use intelligence in new ways. Such a search may help us to learn that which is basic and essential to our task, that which may be found appropriate and useful to our purpose and to the changing needs of our society.

There is so much to learn, so very much yet to be discovered.

Lacking a bugle to sound reveille, I have drawn upon the following, taken from the verses of Sir Rabindrath Tagore, the late Indian author and poet:

"Listen to the rumbling of the clouds, O heart of mine,

Be brave, break through, and leave for the unknown."

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THE CENTRAL CORE OF MADNESS

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It happened over 40 years ago. The patient, a young man, recently admitted, was frightened, perplexed, and hallucinated. As he wouldn't eat, he had to be tube-fed daily. On each occasion he had to be tube-fed twice, not once, because after the first trial he would vomit what he had been fed. After the second feeding it would stay down. In answer to my question, "Why do you vomit?" the patient said, "Because I have no stomach," to which I replied, "Well, the second time I fed you the food stayed down. Where did it go if you have no stomach?" Almost immediately the patient answered, "It goes to the upper peninsula." This took place when I was a house officer with Eugen Kahn at Yale. I tried as best I could to trace this idea to its source, to look for related ideas through detailed review with the patient and his family of his past and present life history, through the use of projective tests, through his infrequent spontaneous remarks, and even through pondering over fragments of occasional dreams he recounted to me; but to no avail. It remained enigmatic, strange, nonunderstandable.

I learned later of the emphasis placed by Jaspers (1) on the significance of understandability as a criterion of schizophrenic symptomatology. Whether a given symptom can be understood or not Jaspers believed is determined by feeling oneself into the situation of the patient and assessing whether the symptom can be understood logically or emotionally as arising from the patient's affective state, his previous personality, or the current situation. But, as many have noted, this approach is somewhat vague and subjective. I have learned that it depends in great part on how much time you spend with a patient, how informed you are of his past and present life, and on the nature of the trust established between you and the patient. Whatever its significance, the nonunderstandability, together with the characteristic hallucinations, the thought disorders, the passivity experiences and their delusional interpretations--all occurring in a state of wakeful consciousness--these have constituted a

mosaic, a cluster, of signs and symptoms which have demarcated this type of madness from others.(2) Through the mists of antiquity the notion of paranoia emerged, and long before it acquired its modern denotative persecutory or projective meanings, it meant more simply, beyond understanding, and was used to describe the essence of madness.

Perceptive, seasoned clinicians, beginning with Thomas Willis in the 17th century, and others through the 18th and 19th centuries, differentiated what today we call schizophrenia from melancholia, from mania due to fever and that due to wine, from the enfeeblement of the aged, and from those who suffered brain damage in war. Although schizophrenia had many names--stupidity, foolishness, vesania, idiocy, monomania, paranoia, and others--these earlier clinicians described the characteristics of family origin, endogenous cause, early onset, remitting or regressive course, bizarre ideas, dissociation of thought and emotion, and social withdrawal. These were written long before the more precise contributions of Morel, Hecker, Kahlbaum, Kraepelin, and Bleuler and the designations of dementia praecox and schizophrenia.(3) Then, as now, other types of madness, like melancholia, mania with elation and that due to fever, the enfeeblement of the aged, these seemed more capable of empathic understanding--more consonant with human psychological experience. Then, as now, this special type of madness which today we call schizophrenia appeared to be the central core of madness or unreason.

On the occasion of the First Rochester International Conference on Schizophrenia nine years ago, we drew attention to the magnitude of the prevalence of schizophrenia, the lack of agreement about its diagnosis and course, and the multiple conjectures about its origins--all attesting to the fact that it constitutes modern psychiatry's greatest challenge.(4) It appeared then, nine years ago, as it does now, that the need for continuing studies would contribute not only to the understanding of schizophrenia, but also to

our knowledge of perception, thought, memory, and emotion, to human growth and development, and to the continued events of human interaction within the family and in other social groups. One of the objectives of the First Conference was to stimulate us, and we hoped others, to examine more critically what it is we know, or believe we know, and more particularly to seek new knowledge in all the areas relevant to our task.

We are encouraged to learn that in the past decade there appears to be an increased world-wide interest in and support of the investigation of the schizophrenic patient and his family. This is attested to by the number of published scientific papers and monographs, the establishment of special journals, the international studies of diagnosis and course, the development of new methods of biologic research, and the frequent convening of interested groups in assemblies and conferences such as the one in which we are now engaged.

Following our First Conference, and stimulated in great part by Norman Garmezy's seminar on vulnerability to psychopathology (1969), we initiated a pilot study, supported generously by the Scottish Rite Foundation and the Margo Cleveland Research Fund, in which Haroutun Babigian, Arthur Orgel, and Irving Weiner took major responsibilities and were joined later by Alfred and Clara Baldwin, then at Cornell, and now, happily for us, at Rochester. With the appointment of Lyman Wynne as department chairman (1971), we were able, under his leadership, to design and launch the University of Rochester Child and Family Study, whose objectives are: (1) to identify children who genetically are at high vs. low risk for schizophrenia; (2) to examine these groups through three classes of predictor variables: (a) diagnostic assessments of the biological parents, with the implication of differing genetic loadings for the "high risk" children of a schizophrenic parent vs. the "low risk" children of parents who have had other kinds of psychiatric

disorders, (b) the diverse patterns of psychosocial competence, adaptation and biological functioning of the children, themselves, and (c) a constellation of factors in the family and school environments which may differentiate the high from the low risk children; and then (3) to follow these families prospectively and determine whether or not the initial differences were maintained in developmental trends.

It has been my privilege in the past five years to return, after many intervening years, to active participation in clinical research as a part of the University of Rochester Child and Family Study. Together with my associate, Robert Geertsma, and our research technician, Sandra Squires Trieshmann, our assignment in the overall program has been to conduct investigations which aim at the identification of those characteristics of parents which are associated with vulnerability or invulnerability of children at high risk for schizophrenia. Identification here refers to:

1. the documentation of parental characteristics and the nature of the caretaking patterns of behavior from videotaped interviews,
2. the characterization of parental object relations through adjective checklist studies, and
3. the analysis of clinical diagnosis, past and present, through current videotaped interviews of patient and spouse and through careful review of past hospital records.

Our particular project in the overall program has been supported by the Scottish Rite Foundation and the Margo Cleveland Research Fund. Most briefly, I should like to present one diagnostic datum from our studies in progress and share with you several personal impressions of clinical research in this field.

Since the start of the study, we have seen 105 families. Of the first 97 families studied, 50 were diagnosed as schizophrenic during their inpatient

hospital period of study. Following our review of the hospital records, together with our current clinical diagnostic interviews with the former patient and spouse, we disagreed in 50% of the instances with the initial hospital diagnosis of schizophrenia (26 of 50 patients); 47 patients had the hospital diagnosis of non-schizophrenia, and here our agreement was 95%. Our clinical diagnoses, both retrospective and current, are then compared with those reached by John Strauss and his associates, who review past records and use standardized questionnaire interviews currently. In 80% of the families studied thus far, there was agreement between John Strauss's and our group in the diagnosis of the patient during his inpatient hospital stay.

Obviously, diagnosis remains an urgent and central problem of concern. Equally obvious is that most of us in the United States have tended to diagnose schizophrenia less rigorously than most of our European colleagues. And rarely did I find patients described as hebephrenic or as catatonic. I believe, too, that the adjective, paranoid, is used too loosely, and chronic undifferentiated schizophrenia now seems to occupy the center of the stage. I am heartened by evidence of a national movement in clinical practice for greater precision in diagnosis. From a practical point of view, it has now become necessary to discriminate carefully among schizophrenia, mania, the several types of depression, and other psychotic behavior in order to prescribe the appropriate medication. The international studies, both the United States-United Kingdom and the World Health Organization Studies, attest to this greater interest and concern.(5)

One impression which we shall have to check later is that we are dealing with a particular type of schizophrenic patient, selected by us by design. Rarely has illness been initiated in childhood or adolescence. Most frequently, particularly in women patients, it seems associated with the problems of young adulthood, including courtship, marriage, pregnancy and

labor, parenthood, house-moving, employment, economic stress, relation to parents, and with mental illness in the families of origin. Most of our patients' illnesses have been short-term, a number with remitting course, with improvement assisted principally by medication, hospital care, and family rally.

While over one-half of the patients still receive some type of medication, either the major or minor tranquilizers, we found three-quarters of our patients to be currently asymptomatic. By design, the schizophrenic population under study is exclusively white, predominantly middle-class, continuously married, with intact family, and having male children ages 4, 7, and 10 before, during, or after the psychotic illness. While our population may be representative of the population of patients admitted to the psychiatric unit of a university teaching general hospital, it certainly is not representative of populations frequently studied; namely, those of long-term, lower social class patients continuously hospitalized since early life, with little acquisition of social competence, unmarried or divorced, and with limited or no parenting behavior. The need for those of us engaged in clinical surveys to define clearly and fully the populations under study is evident. The possibility of biased conclusions from uneven selection of patients is obvious and a constant hazard.

Another impression is the recognition of the limits of usefulness, not to speak of validity or reliability, of record research. Even in reasonably well-conducted clinical households, one often finds that the data one wishes are not available and that records, when legible, vary considerably in recording primary data of patient behavior. The fullest, most useful records are those prepared by our third-year medical students during their clinical assignment to our floors. Most observers prefer to record data in terms of inferred psychodynamics rather than at the phenotypic level of behavior.

Terms such as "regression in the service of the ego," "introjection of hostile wishes," "homosexual panic," and even more simply, "cognitive slippage," "patient is depressed, or hallucinated, or paranoid," are commonly used without giving any specific evidence of the behavior which led to the inference. I have also become disenchanted with traditional psychological and Rorschach reports, as they, too, may allow you to hear the grass grow but provide no primary data, and consist essentially of inferential statements arrived at artistically. Incidentally, the more recent the record, the more complete the charting of family genetic trees. And rare, indeed, does one find a report of the physical description of the person--dress, mannerisms, posture, gait, expression, height, weight, movement, etc. On another occasion I have noted, "In psychiatry we have been so fascinated by what we hear that we have neglected to look. We can well respond to the wisdom of that Dean of Malapropisms, Yogi Berra, when he said, 'You can observe a lot just by watching.'"(6)

Another impression is of the limited number of clinical psychiatrists engaged in these high risk studies. In a quick review of the 20 ongoing research programs in the United States engaged in the search for the antecedents of schizophrenia, I found only 7 had psychiatrists as principal investigators, the rest being psychologists.(7) Whether this ratio is representative of American psychiatrists engaged in clinical investigative work is not known, and in no way disparaging the considerable contributions made by our psychologist colleagues, I find it is somewhat of a personal disappointment that not more psychiatrists are engaged full-time in researches of this type, particularly after the aspirations of those of us who initiated the USPHS Career Investigator Program many years ago. Furthermore, on my return to clinical investigative work, I am surprised to find that in many of these programs, including our own, few senior professional persons have direct contact with the research subject or patient, such contact being made principally by technicians and in some instances by pre- and postdoctoral psychology students, who obtain the primary data.

The basic problem with this is again the crucial necessity to obtain an informed, sensitive and precise appraisal of the subjects who will provide the primary data. Without such subject identification, the generalization of results and their comparison with results of other studies, becomes indeterminate.

I have learned something about the hazards of research programs dealing with an almost infinite number of variables. There is, quite understandably, the compelling temptation to use methods familiar, available, and reliable, to test what it is we wish to learn. How appropriate they may be to our task is another matter. John Dollard cautioned us years ago, "The first loyalty of a scientist is to his material; he must seek it where it can be found and grasp it as it permits. If he doesn't do this, he is likely to find himself an aimless imitator of others, of better methods not applicable to his field."(8)

I have also learned that we are apt to confuse two investigative purposes: that of hypothesis generation and that of hypothesis testing. One is concerned with discovery, the other with proof. I would predict that in large studies like ours, that more will emerge as discovery, less, as proof.

Because the computer can now handle thousands of variables, this has removed from the investigator's shoulders the necessity for him to select those variables which he wishes to test. This, in turn, tends to produce more variables rather than proving relationships. One is reminded of Edith Wharton's remark of getting into the thick of thin things.

What has been most impressive to me is the old-fashioned altruism of the families who have participated in our studies, however one chooses to define altruism.

In our study, even though a full explanation of the project was given at the time the subjects filled out appropriate consent forms, more than 2/3 appeared to retain little of what they had heard or read when I asked them about this in our interview, which usually takes place at the end of the study.

Almost invariably, while they are not clear as to the purpose of the study, they appear to have enjoyed participating in it, have been impressed with the interest and kindness of those with whom they have met, even though at times they were somewhat puzzled as to why an endless number of silly questions was asked. Most often we hear: "We're really not sure what this is all about, but we and the children have enjoyed doing it. We wanted to take part in it to express our appreciation for having been helped in the past, and perhaps one day, while the information you are getting may not be useful to us, it may be to someone else." I wish sincerely that some of our militant philosophers, theologians, and ethicists, whose instant omniscience in matters of privacy and informed consent appears to be matched only by their overweening arrogance, could hear some of these remarks, and learn from them of the need of the patient to give something of himself and to recognize that among one's fundamental rights is the right to know, and one hopes to know more, about the disturbance which affects his life.

May I now add my word of welcome to those spoken by Chancellor Wallis and Dean Orbison. It is a great personal pleasure to see old friends and colleagues, to greet our distinguished visitors from abroad, and to welcome many new acquaintances. We look forward eagerly to the work of the next several days, expecting to learn more about how we may better understand and help the schizophrenic patient and his family.

While we may not be able to reach the shores of the upper peninsula, perhaps we can be pointed in the right direction.

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Foreword

John Romano

For some time before his death, Bert E. Boothe had planned to write a report describing the design and progress of the Research Development Program of the National Institute of Mental Health. Edward L. Walker and Anne H. Rosenfeld have completed his project; *Toward a Science of Psychiatry* describes the success of the Research Development Program in effecting a significant change in the number and quality of psychiatrists and others interested and engaged in sustained investigative work in psychiatry. Certain chapters of this book have special historical value—such as Chapter 4 on psychoanalysis, which, although born in Europe, flourished as a particularly American experience. Other chapters give a clear account of the development of ideas and hypotheses from the several belief systems that contribute today to the understanding of the mentally sick person, his family, and his community. The final chapter and the appendices will be useful to present and future historians in recording the growth and development of psychiatric research in the past 25 years.

During the mid-1940s, those of us associated with the Research Study Section of NIMH soon became aware of the scarcity of young men and women engaged significantly in psychiatric research. It became clear that the field needed a new type of psychiatrist—namely, the research scientist, as contrasted with the teacher-clinician, the practicing psychiatrist, the psychotherapist, or the administrative officer. Unlike our colleagues in medicine and physiology, we in psychiatry did not have a Rockefeller Institute to help prepare young men and women for pro-

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fessorial posts and research careers. Before 1946, when few persons were engaged in investigative work, appropriate models for the young to emulate were rarely found. Earlier in the century, whatever research had been conducted was done under private auspices or in a few large state mental hospitals. Support subsequently came from state funds through the development of the Psychopathic Hospital movement in Ann Arbor, Iowa City, Denver, and Boston. Contributions were made by the Rockefeller Foundation, the Scottish Rite, and the Commonwealth Fund.

Given this background, one can understand the excitement and promise of the Congressional action that established the National Mental Health Law in 1946. By the late 1940s, we were fortunate that two recently created programs for supporting research scientists—The Markle Scholarship in Medicine, founded in 1948, and the American Heart Association's Lifetime Career Award—met needs similar to ours. We used these two as models to guide us in drafting proposals for the Career Investigator Grant Awards in psychiatry.

For about 10 years before he came to NIMH in 1957, Bert and I had corresponded, principally exchanging information about candidates for the Menninger School of Psychiatry; a number of these candidates had been my students at Harvard, Cincinnati, and Rochester. Bert and I subsequently had an opportunity to work together when he succeeded Philip Sapir as the Executive Secretary of the Mental Health Career Investigator Selection Committee at NIMH. In his devotion and commitment to this position, he was extraordinarily useful in helping the Committee make important judgments about the selection of promising young scientists in our field. He joined us at Arden House at the first meeting of the young investigators and was the principal planner and engineer of subsequent annual meetings. (Incidentally, we are again indebted to the Markle Scholarship Plan for the idea of convening our investigators. The Markle group had done this successfully for a number of years before our first meeting.)

Over the years, Bert became a truly charismatic figure to those young men and women who had been recipients of Career Investigator and Research Career Development awards. They found him to be an able, intelligent, thoughtful, and always helpful person. They recognized that his interest in them was genuine and sustained, and he was both fatherly and motherly in doing much to help them in their later careers. He was modest, even shy at times, gentle, and most generous of himself and in his work with others.

I am sure that the success of this report stems from the thoughtful candor of the many respondents quoted throughout it. The quality and extent of this response is a function of the awardees' respect, admiration, and affection for Bert Boothe.