Reports for the five years 1st April 1953 to 31st March 1958 / The Cassel Hospital for Functional Nervous Disorders.

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Publication/Creation

Ham, Surrey : Cassel Hospital, [1958?]

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SOUTH-WEST METROPOLITAN REGION

THE CASSEL HOSPITAL

FOR FUNCTIONAL NERVOUS DISORDERS

Group No. 51

Founder: The Right Honourable Sir Ernest Cassel, G.C.B., G.C.M.G., G.C.V.O.

Patron: Her Majesty Queen Elizabeth the Queen Mother.

REPORTS

FOR THE FIVE YEARS

1st APRIL 1953 TO 31st MARCH 1958

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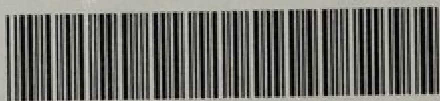
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Founder:
The Right Honourable Sir ERNEST CASSEL, G.C.B., G.C.M.G., G.C.V.O.

Patron:
HER MAJESTY QUEEN ELIZABETH THE QUEEN MOTHER

Management Committee:

Sir Francis Cassel, Bt. (Chairman)
I. Caplan, Esq.
Miss M. Cook
The Countess Mountbatten of Burma, C.I., G.B.E., D.C.V.O., LL.D.
R. Morley, Esq., C.B.E.
The Countess of Radnor
Dr. J. R. Rees, C.B.E., M.D., F.R.C.P., D.P.H.
R. Sargood, Esq., J.P.
Neville Vincent, Esq.
V. E. Vincent, Esq.

Secretary:
Miss Dorothy Mallion

Finance Officer:
Mr. W. J. C. Piper

Medical Director:
T. F. Main, M.D., D.P.M.

Medical Staff:

Consultants:	J. L. Rowley, B.M., B.Ch., B.A.O. (Part-time)
	L. H. Rubinstein, M.D., D.P.M. (Part-time)
S.H.M.Os.	Berta Andratschke, M.D.
	A. Brook, M.B., B.Chir., D.P.M.
	Enid Caldwell, B.A., M.B., D.P.M.
	I. Gluck, M.D., D.P.M.
	M. Pines, M.R.C.P., B.A., D.P.M.
	Phillipe M. Ployé, M.D. (Part-time)
Registrars:	J. Bolland, M.B., Ch.B.
	J. McKellar Davie, M.B., Ch.B., D.P.M.
J.H.M.O.	P. E. S. Lomas, M.B., Ch.B.

Psychologists:
Mrs. Margaret Wrenn, M.A.
E. H. Rayner, B.Sc., Ph.D.

Senior Medical Secretary:
Miss Mary. A Macrae

Matron:
Miss Doreen Weddell, S.R.N., S.C.M.

Deputy Matron:
Miss B. Thomas, S.R.N., R.F.N.

Executive Sisters:
Miss H. Bogie, S.R.N.
Miss G. Elles, S.R.N., S.C.M.
Miss E. J. Gazdar, S.R.N., S.C.M.
Miss I. Gleeson, S.R.N.
Miss G. West, S.R.N.
(All above as at 31.3.58)

Catering Officer:
Miss I. Gleeson

Staff with service of 20 years or over:

Chauffeur: Mr. A. Hazeldine

Foreword from the Chairman of the Management Committee

With the circulation of this 1953-1958 Report I would like to pay a very grateful tribute to all those whose work during this period has made possible the treatment, training and developments at the Cassel Hospital, which are of world-wide interest; and in particular to our brilliant Medical Director, Dr. T. F. Main, who is such a mainspring of inspiration. I would also thank our Doctors, the Secretary, Matron, and all members of the Nursing, Administrative, Domestic and Maintenance Staffs.

In addition, I would like to add my own special thanks to all the members of the Hospital Management Committee, who give up so much of their valuable time to the hospital; and who have been so wise and helpful at all the stages of our development.

True progress does not stand still and I feel confident we can look forward to equally important progress in the years to come.

FRANCIS CASSEL,
Chairman of the Management Committee.

6th March, 1959.

REPORT OF THE SECRETARY TO

THE CASSEL HOSPITAL MANAGEMENT COMMITTEE

Introductory

The Report now presented is the fourth to be published since the inauguration of the National Health Service and is also the thirty-third Report of the Cassel Hospital.

Patron

In February 1954 Her Majesty Queen Elizabeth, the Queen Mother honoured the Cassel Hospital when she graciously consented to become its Patron.

King George V and Queen Mary became Patrons of the Hospital when it opened in 1921 and Queen Mary continued as Patron after the death of King George V and until her own death in March 1953.

Hospital Management Committee

During the five years under review the Management Committee has met monthly with the exception of August (the holiday month).

Chairman: The Regional Board in April 1953 appointed Sir Francis Cassel, Bt., as Chairman of the Hospital Management Committee. Sir Francis Cassel had already been a member of the Committee for many years.

Vice-Chairman: With much regret we had to record the death, on November 1st 1954, of our Vice-Chairman, Lord Courtauld-Thomson, in his 90th year. He was one of the four original Trustees of The Cassel Hospital for Functional Nervous Disorders and had been Vice-Chairman since its inception in 1919.

In November 1954 the Hospital Management Committee appointed Mr. V. E. Vincent as Vice-Chairman; Mr. Vincent has been a member of the Committee since March 1945.

Committee Members: Apart from the Chairman and Vice-Chairman, the Committee's membership has changed as follows during the period under review.

June 1953: The Committee was pleased to welcome Lady Brain who was appointed by the Regional Board to fill the vacancy on the Committee caused by the death of Sir Felix Cassel. Lady Brain was also a member of the Regional Board.

June 1954: Dr. W. Clifford Scott, who had been associated with the Cassel Hospital since 1936 when he was a member of the medical staff and who later became a member of the Management Committee, resigned from the Hospital Management Committee to become Associate Professor of Psychiatry at the McGill University, Montreal.

March 1955: The Committee suffered a great loss by the sudden death of Mr. W. Morrell who had been a member of the Committee since June 1948.

April 1955: The Committee was pleased to welcome Miss M. Cook and Mr. R. Sargood who were appointed to fill the vacancies caused by the death of Lord Courtauld-Thomson and the resignation of Dr. W. Clifford Scott.

May 1955: Mr. Neville Vincent was appointed to fill the vacancy caused by the death of Mr. W. Morrell.

August 1955: The Committee was sorry that Mrs. M. A. Crockatt found it necessary on the grounds of ill-health to resign from membership of the Management Committee. The Committee wish to place on record their appreciation of her services to the Hospital. Mrs. Crockatt had been a member of the Committee since January 1949.

December 1955: Owing to the fact that he had many other commitments, Major Walters found it necessary to resign from the Management Committee. Major Walters had been a member of the Committee since 1948. The Committee greatly appreciated the services Major Walters had given to the hospital over the years.

June 1957: The Committee was sorry that Lady Brain had felt it necessary to resign from the Management Committee in view of her appointment as Vice-Chairman of the Mental Health Committee of the Regional Board. The Committee wish to place on record their appreciation and thanks for all her past help and services to the Hospital and Committee.

May 1957: Dr. L. Minski, M.D., F.R.C.P., D.P.M., and Mr. Robert Morley, C.B.E. were appointed to fill two vacancies on the Hospital Management Committee. Owing to the difficulty he experienced in attending Hospital Management Committee meetings, Dr. Minski resigned in November 1957, and his resignation was accepted with regret.

National Association of Hospital Management Committees

The Hospital Management Committee again wishes

to place on record its thanks to Mrs. M. A. Crockatt (late representative) and Lady Radnor (present representative) for their interest in this Association on ~~their~~ its behalf.

Medical Advisory Committee

The Medical Advisory Committee continued to act as an Advisory Body to the Hospital Management Committee in matters of medical policy, with the exception of a period from November 1954 to October 1955, when the Management Committee decided to work for an experimental period without a Medical Advisory Committee, but with individual members of the medical staff having direct access to the Hospital Management Committee through the usual hospital channels.

Whitley Council Joint Consultative Committee

This Committee continues to function on the basis laid down by the Ministry and several matters have been dealt with which have proved helpful to the smooth running of the Hospital.

Private Analysis of Patients

In April 1954 the Ministry of Health ruled that no further patients should be admitted to the Cassel Hospital who were obtaining psycho-analytic treatment elsewhere under private arrangements.

Treatment of Child Out-Patients

In January 1954 the Committee agreed to have child Out-patients at the Cassel Hospital. This was an innovation and in order that the fundamental character of the hospital was not altered by this experiment the Hospital Management Committee decided that not more than eight child Out-patients should be treated at any one time.

Mother/Baby Patients and Re-Designation of Beds

Since 1954 for varying reasons a number of young children have been admitted together with their mothers. This is a unique development in hospital technique.

In view of this present practice of admitting Mother/Child patients the Committee, in March 1956, re-designated the 104 hospital beds as to 94 adult and 10 children's beds.

Economy

The Standing Economy sub-Committee has continued to keep a close watch on expenditure, and on the recommendations of its Executives the Hospital Management Committee has been able to make further adjustments and re-organisations resulting in approximate savings of £2,350, £2,500, £2,399, £3,497, and £2,806 on the approved estimates for 1953/54, 1954/55, 1955/56, 1956/57 and 1957/58 respectively. The Committee asked that its appreciation of the joint efforts that had gone to make these economies be conveyed to all Staff concerned.

STAFF

Psychologists

In 1955 the Committee granted thirteen guineas from "Free Monies" to enable Mr. Rayner, the Assistant Psychologist, to attend a course at the Tavistock Clinic on Rorschach technique.

Psychiatric Social Worker

In August 1955 Mrs. Leaf resigned. The position has been left unfilled, the duties involved being allocated to the nursing staff.

Matron—Part/Time Employment

In June 1955 the Matron, Miss Weddell, who had been with the hospital for nine years, tendered her resignation. Miss Weddell was to commence training as a child Psycho-Analyst and this would necessitate more work than she could undertake in her spare time.

The Hospital Management Committee was unanimous in its praise of the value of Miss Weddell's work to the nursing service and arranged for her to transfer to a part-time basis from October 1955, this arrangement to be for a trial period on both sides and subject to an acceptable decision of the Whitley Council as to salary and conditions of service.

Miss Weddell transferred to part-time work in April 1956 with the agreement of the Ministry and the Whitley Council that she should continue on her present salary (*pro rata* to the number of hours worked) and full emoluments and with the proviso that the part-time appointment should be subject to review by the Ministry in March 1957.

The part-time arrangement has continued and the Minister has asked the Hospital Management Committee to report on the position in April 1959 when the arrangement will be subject to a further review.

Nursing

Retirement. Nurse Blanche (with twenty-nine years service) and Nurse Bigg (with twenty-one years service) retired from the Cassel Hospital in September 1954.

The Chairman, on behalf of the Committee, presented a Wireless set and a letter of appreciation to each.

Educational. The Fourth School for State Registered Nurses was opened by the Countess Mountbatten of Burma on 13th April 1955. Miss Ruth Thomas and the Medical Director lectured in the

School and Dame Elizabeth Cockayne gave the closing address. Sixty-two students attended.

Car Driving. It being considered that car driving should become one of the ordinary skills required of the nursing staff in the course of their duties, the use of one of the hospital cars for official work by the nursing staff was arranged in 1957. Those sisters who cannot drive are given the option of being taught by the hospital chauffeur.

Administrative and Clerical

The Ministry's Administrative and Clerical Review Team visited the hospital in November 1953. No posts were found to be redundant and the present establishment was approved and fixed, subject to a suggestion for two adjustments as and when the opportunity occurred. There have been few changes in personnel.

Maintenance

In April 1956 the hospital lost the valuable services of the Head Gardener, Mr. A. J. Harris, who died at the age of seventy after a long illness. Mr. Harris had been in the employ of the hospital for nine years.

Domestic

In September 1956 Miss N. J. Willard, Catering Officer, retired from the hospital service. Miss Willard had been on the Staff since 1947.

Capital Expenditure

The Committee is greatly indebted to the King Edward's Hospital Fund for a generous gift of £450 made in 1953 towards the re-surfacing of two hard tennis courts used by both patients and staff.

During the five years under review the Committee has put forward the following capital development schemes:

1. Central Heating of whole building.
2. Sound-proofing of some consulting rooms.
3. Conversion of Ross Ward into a more permanent structure.

The Regional Board approved the first two schemes. The installation of an oil fired boiler and an improved central heating scheme weie included in the Board's Capital Programme for 1955/59 at an approximate cost of £16,000, but the Committee decided in 1957, with the agreement of the Board, to postpone these works in view of other plans under discussion concerning the future policy and function of the hospital.

Maintenance Expenditure

The Committee was pleased that towards the end of 1953 it was possible for the first time to transfer to the sub-head Building, Plant and Grounds up to 50% of any anticipated savings on the approved maintenance estimates. The underspending for the year was approximately £2,350; of this the Committee allocated £1,350 to extra maintenance works and handed back to the Regional Board £1,000 for use by more needy hospitals.

A further saving of £2,500 for 1954/1955 was made from which the Regional Board allocated part towards the salary of a Junior Hospital Medical Officer for the same period and a further amount towards a new boiler.

Wording of Advertisements for Medical Staff

The Committee is concerned by the Regional Board's ruling that the wording of advertisements for Senior Registrar and Registrar staff should state that a personal analysis was " desirable " but that it should not be made a requirement, as it is the firm opinion of the senior medical staff of the hospital that a personal analysis for all our medical staff is essential for the type of treatment practised at this hospital. The Board's ruling also precludes medical staff who are undergoing a personal analysis from claiming income tax relief for expenses incurred on the personal analysis.

Project with Tavistock Clinic

In 1950 the Committee made a loan from Amenity Funds to aid the making of a research film by the Children's Unit of the Tavistock Clinic. The film " A Two-Year Old Goes to Hospital " was completed, illustrated brochures on it were published and the film widely shown to medical and nursing circles.

Training of Psychologists

The Committee is co-operating and participating in the Regional Board's scheme for the in-service training of clinical psychologists in order to provide trained psychologists for hospitals in the Region. To date five trainees have spent periods varying from 2-3 months at the hospital under the supervision of the Senior Psychologist.

Accommodation

Following several changes in the tenancies of houses for medical staff the Hospital Management Committee (in accordance with the Ministry's ruling and with the approval of the Regional Board) revised all rents for hospital houses for medical staff.

In November 1956 the Hospital Management Committee loaned to the Kingston Hospital Group a furnished nursing staff house not required by the Cassel Hospital for the time being. The house will be used by Kingston until it is required again by the Cassel Hospital.

In October 1957 the Hospital handed back to the Ministry a medical staff house which was no longer required by the hospital.

Garden

The long term plan for the improvement of the garden has further progressed during the five years and, in spite of strict economy, the charm and attractiveness of the garden is often the subject of comment by visitors.

Freud Centenary

A Conversazione was held in June 1956 to commemorate the centenary of Freud's birth. To this were invited all psycho-analysts who are in the Health Service, trainee psycho-analysts, senior psychiatrists interested in the use of psycho-analytic concepts in their work, representatives of the British Psycho-Analytic Society, the Royal-Medico Psychological Association, the Medical Section of the British Psychological Society, the Editors of the International Journal of Psycho-Analysis, the Regional Psychiatrists of the four Metropolitan Regional Hospital Boards, certain General Practitioners who refer cases to the hospital, present and past medical and nursing staff and Editors of the Nursing Press. The Conversazione was much enjoyed. The Medical Director gave an interesting address of welcome to the assembly and many letters of appreciation were afterwards received. An extract from his address follows:—

> "Today, with the passage of a full century since Freud's birth, the pioneering days seem to be over. And it seems true that psycho-analysis has acquired a certain respectability and that violent prejudice has become attenuated. The rearing of children, the regard for workpeople by employers, the treatment of criminals by penologists, the mentally sick by psychiatrists seem to have changed. But by how much? And how much of the change is owed to psycho-analysis? It is difficult to say. We are too near to Freud, too much in his great shadow, too awestruck by the magnitude of his life's work to be in a good position to assess well the historical impact of psycho-analysis upon the world. It may well be that future surveys of the inevitable resistance to psycho-analysis will record that after the early skirmishes something like a period of polite but cold warfare began, and that the penetration of this science by 1956 into psychiatry, education, social science and literature was of a pale, watered kind, and that its status as a fundamental science was largely unrecognised by universities or indeed anywhere except in psycho-analytic societies.
>
> It may be later recorded that in 1956 one of the human, unscientific responses to psycho-analysis (that perhaps will in the long run much delay the acceptance of it as a rigorous science) was the excited welcome it has had by those seeking for magic, and who were content to worship out of emotional need, anything that seems like psycho-analysis. Those who worship it because they believe it to be what they wish it to be have created a response—mostly, but not only in America—among those who believe themselves to be psycho-analysts because they wish to be. The resultant confusion of magical beliefs and practices is one way in which a section of the world defends its sleep against the pain of deepened awareness. Because its findings concern the very emotions of mankind, psycho-analysis must be for a long time, unlike any other science, beleagured not only by enemies but by friends!
>
> When it is considered that it has met and always will meet difficulties of acceptance based on both super-ego resistances and id-resistances as well as acceptance as science by those with informed ego-based judgment, the record of the last half century falls into perspective. Psycho-analysis has not stood still and Freud has been followed by many faithful scientists. Its future as a science none can predict, but it is interesting to compare the varying degrees of tolerance shown it today by various continents and nations.
>
> In Russia it has been suppressed for over a quarter of a century; in Asia there is little or none. It is pursued little in Africa, more in Australia. It grows steadily in South America and vigorously—even luxuriantly—in North America. In Europe, its birthplace, it is recovering in all countries from the war. Last month in Germany, the Reichspresident made perhaps a deliberate signal that the days of suppression of human knowledge were well over in his country, when he attended the Freud Centenary lectures in Frankfurt together with the Rectors of several universities.
>
> In our own country which Freud always admired and to which in the end he came, and which shelters his remains, we may be many a day from the time when official recognition of this science will bring our Prime Minister and the Vice-Chancellors of Universities to functions of the British Psycho-Analytical Society, but psycho-analytic training has been sought since the war on a greater scale than ever. In 1948 the Institute of Psycho-Analysis and the associated Clinic decided to remain outside the Health Service, but the advent of the Health Service was a remarkable occasion for psycho-analysis none-the-less. In assuming responsibility for its people's health, the Government began to employ psycho-analysts. The future of psycho-analysis in this service, its opportunities and the dangers for it, are not easy to foresee, but Freud in 1919 permitted himself an interesting

speculation which is relevant to the present occasion:

> '. . . let us assume that by some kind of organisation we were able to increase our numbers to an extent sufficient for treating large masses of people. Then on the other hand, one may reasonably expect that at some time or other the conscience of the community will awake and admonish it that the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving life; and that the neuroses menace the health of a people no less than tuberculosis, and can be left as little as the latter to the feeble handling of individuals. Then clinics and consultation departments will be built, to which analytically trained physicians will be appointed so that the men who would otherwise give way to drink, the women who have nearly succumbed under their burden of privations, the children for whom there is no choice but running wild or neurosis, may be made by analysis able to resist and able to do something in the world. This treatment will be free. It may be a long time before the State regards this as an urgent duty. Present conditions may delay its arrival even longer; probably these institutions will first be started by private beneficence; some time or other, however, it must come.
>
> The task will then arise for us to adapt our technique to the new conditions. I have no doubt that the validity of our psychological assumptions will impress the uneducated too, but we shall need to find the simplest and most natural expression for our theoretical doctrines. We shall probably discover that the poor are even less ready to part with their neuroses than the rich, because the hard life that awaits them when they recover has no attraction, and illness in them gives them more claim to the help of others. Possibly we may often only be able to achieve something if we combine aid for the mind with some material support, in the manner of Emperor Joseph. It is very probable, too, that the application of our therapy to numbers will compel us to alloy the pure gold of analysis plentifully with the copper of direct suggestion; and even hypnotic influence might find a place in it again, as it has in the treatment of war-neuroses. But whatever form this psychotherapy for the people may take, whatever the elements out of which it is compounded, its most effective and most important ingredients will assuredly remain those borrowed from strict psycho-analysis which serves no ulterior purpose.'

The Cassel Hospital is one of the clinics started by private beneficence and now owned by the State, to which analytically trained physicians have been appointed, and which has associated its staff training programme with the Institute of Psycho-Analysis. This and a few other clinics like it may be the only ones that the Health Service of even a great nation like ours can for the time being staff in this way. But there are indications (not least of which is the growing number of psycho-analysts) that these are only the first to base their work with neurotic patients on psycho-analytic science, and that these will be joined later by other clinics that will increasingly have important effects on the scientific philosophies that underlie medicine and psychiatry. The scientific problem for us—as for those in the future—is to find ways and means of using psycho-analytic science in the interests of the National Health Service without doing violence to its concepts.

It is a sign of the times that a nationally owned institution can tonight commemorate Freud's birthday centenary, and can invite to join them so many others employed by a National Health Service who have a sincere concern for the science he founded, as well as representatives of several learned bodies."

Future of the Hospital

In May 1957 the Minister agreed in principle to the proposals that the amount of in-patient treatment should be reduced in favour of an expansion of out-patient treatment. He could not agree, however, to the acquiring of other premises in London which the Committee had thought would be beneficial for the future work, but suggested that the proposed work should be effected at the hospital in its present situation.

Proposals were then put forward involving an increase in medical staff, a reduction in the number of beds from 104 to 50 and the development of an Out-patient department.

In February 1958 the Regional Board gave approval in principle to the scheme and it went forward to the Ministry.

Social Activities

Social activities inside the hospital continue to be organised by the Cassel Hospital Sports and Social Committee (Patients and Staff). Its small funds are obtained from profits on cigarette sales, gifts from patients, occasional grants from Free Monies of the Hospital Management Committee, and, for a time, from a small " shop " run in the hospital by the patients.

Free Monies

The " Other Funds " Accounts which obtain their income from the Minister, Regional Board (Endowment Fund), and gifts, are used to provide amenities for patients and staff or for any other hospital purpose decided by the Hospital Management Committee. During the five years under review these funds have increased from £192 to £485.

The main sources of income have been:—

	£
1953/58. Ministry of Health and Regional Board allocations ...	75 per annum
National Council of Social Service, through Sir Felix Cassel... ...	100
A Committee Member	45
King Edward's Hospital Fund for London—to renovate hospital tennis courts	450
Dr. D. Rapapport of the Austen Riggs Center, Mass., U.S.A. ...	10
An ex-Patient	20

The main expenditure from these funds has been:—

	£	s.	d.
Contributions towards Christmas festivities (5 years)	245	0	0
Celebrations for Coronation of Queen Elizabeth II	35	0	0
Assistance and loans to Patients ...	20	3	11
Contributions towards Patients' Television Sets	25	0	0
Renovation of Billiards Table used by Patients snd Staff	50	0	0
Fee for Physical Training instruction for Patients	9	0	0
Re-surfacing hospital tennis courts ...	450	0	0
Patients' and Staff outing	20	0	0
Membership Fee to National Association for Mental Health (5 years) ...	5	5	0
Fee for Rorscharch Course taken by Assistant Psychologist	13	13	0
Expenses for Medical Director to attend British Psychological Society's Annual Conference at St. Andrews	19	16	3
Freud Centenary Celebrations	40	0	0
Grant for entertaining Psycho-Therapy and Social Psychiatry Sections of the Royal Medico-Psychological Association	21	0	0
Gratuities to 2 Nursing Staff on retirement	42	15	0

Conclusion

In conclusion I would like to express my thanks to the members of the Hospital Management Committee for their unfailing help and advice, and to the Medical Director and all other colleagues and staff for their co-operation.

The Medical Director's Report

This account concerns the period 1st April 1953 to 31st March 1958. During these five years the hospital continued to offer psychotherapy of some months duration to selected in-patients; it ceased to offer full psycho-analysis to in-patients, but did so to selected out-patients, including a few children. It made a study of some root problems of in-patient psychotherapy, the selection of patients likely to respond, and when, and how, to treatment, the "special patient," the "incurable patient," family neurosis, puerperal disorders, neurosis in mothers; it made applied studies about the effect of hospitalisation on treatment; it increased patient participation in the running of the hospital; it continued to develop procedures for maintaining in-patients as responsible members of families and working organisations outside the hospital; it experimented with the admission of children whose mothers were admitted for treatment; it made experiments in the teaching of psychology to nurses; and it trained junior medical staff in techniques of psychotherapy. In my opinion the hospital increased its sophistication during this period about the scope, limitations and techniques of psychotherapy and psycho-analysis conducted on in-patients.

The general plant and fabric were maintained and in some respects improved. The annual costs, including those of salaries, of the five years were £72,844, £70,028, £66,991, £66,756, £68,954 (diagrams 32 + 33 on pages ~~10 and 11~~). The reductions made in the face of rising prices and wages were a by-product of technical efficiency allowing economies in non-medical overheads, and were not primarily instituted because of financial need.

MEDICAL ADMINISTRATION

Findings from treatment and from ongoing studies of the medico-social field of the hospital were translated during the period into administrative actions concerned with the medical, nursing and domestic care of patients. The following account of medico-administrative developments concerns the findings on which these changes were based, the changes themselves, and some of the results.

I have emphasised in previous reports an abiding difficulty of in-patient psychological treatment—the provision of conditions for an uncontaminated transference* situation and have reported administrative experiments designed to solve this. During the five years now reported further experiments were made, each extending over many months, during which study was made of the effects of the hospital organisation on transference situations in analysis, and in psychotherapy with less ambitious aims.

It may be recalled that prior to 1951 attempts were made to free each analysing doctor from administrative duties so that he could confine himself to the study of the unconscious currents in the therapeutic relationship, with a colleague undertaking the general management of his patients. These attempts gave rise, however, to a complex network of professional relationships whereby several doctors became obliged to each other for caring for each other's analysands, and this led only to more subtle contamination of analytic neutrality. From 1951 to 1953, a second experiment was therefore conducted in which patients undergoing full analysis were placed in a Social Therapy Unit (S.T.U.) managed by one doctor and nursing team. Their analysts undertook to do only analysis and to avoid and to remain free from all administrative obligations and duties in the hospital. The S.T.U. doctor was responsible for all the general care and management of all patients in analysis, their illnesses, drugs and hospital activities, and consultation or communication with the analysts was avoided even about such matters as when the S.T.U. doctor should discharge an in-patient to out-patient status. This arrangement had none of the disadvantages of the earlier one but it carried its own. The analysts were at the hospital but not of it, and as time passed they felt much the need to help shape those decisions, not only by which their patients were managed, but by which the hospital as a social organism was run.

Conferences were held in 1953 to discuss the problems and findings of this two-year effort. The opinions of the analysts about ways in which the handling of patients might be improved showed that their two years' divorce from administrative responsibility had led them to warm views about management at variance with those of the S.T.U. doctor. In turn, they were unaware of some of the administrative problems their patients had created and of the solutions attempted, and, because of their lack of familiarity with the interlocking details of hospital life, they were in a poor position to make workable

* The term "transference" refers to the emotional attitudes which a patient develops towards his doctor during treatment. These attitudes provide important clues about the patient's habitual modes of mental functioning for they often contain feelings "transferred" more or less inappropriately from earlier experiences; but this holds true only if the doctor himself refrains from active behaviour earning these attitudes. Where he plays a real and active role in the patient's life his patients' attitudes towards him become less revealing and more justified by events. They are therefore less fit to be examined only as products of the patient. In the same way as a surgeon needs for his work a field uncontaminated by bacteria, so a psycho-analyst needs a treatment situation uncontaminated by "real relationships" arising between him and the patient outside the treatment setting.

recommendations. It was also clear that the S.T.U. doctor's views on how the analysts could better have done their work were just as ill-informed, and that information about patients known only to the analyst might have helped the S.T.U. doctor in his medical and nursing management. The split in administrative and analytic functions which had seemed to provide an "uncontaminated" treatment setting had led instead to one in which an inevitable growth of attitudes in analysts and administrative doctor had taken place in relative ignorance of each other's work. Moreover, the recognition of the patients' contributions to this growth had been obscured. The sole communicant between the parties had been patients liable to give one-sided information and thus to divide those around them, and the doctors' undiscussed disagreements over what might or should be done in various circumstances had grown without check. Such difficulties appear to be classic with in-patient analysis.*

The discussions showed that in this system of conducting analysis misunderstandings of an order sufficient to disturb analytic neutrality were inevitable in spite of goodwill and effort by all. It was concluded that without some communication between administrative and analysing psychiatrists certain disturbances of feeling and behaviour in patients were unlikely to be analysed effectively in the hospital setting. The experiment was, therefore, abandoned in 1953.

In spite of its failure the experiment was informative. It drew the attention of all to patient-participation in social splits, and conversely to the social participation of medical staff in patients' disturbances. It threw light on parallel situations with out-patient analysis with severely disturbed patients, where it is the relatives who hold administrative functions, and who encounter difficulties which notoriously lead them to interfere with or break off the treatment. It allowed the administrative doctor and his nurse to develop techniques of managing severe panic and behaviour disturbances without resort to sedatives and it is unlikely that he would have discovered these had he also been simultaneously conducting analysis. It drew the attention of all to a key psychiatric symptom to which too little attention had hitherto been paid and yet which once stated is obvious; the fact that in-patients are prepared to give up home, work and friends, and to accept in-patient status, without uneasiness or much time-sense; and in certain cases to cling to it avidly as a desirable way of life. In-patient status came to be recognised as frequently indicating a particular psychopathology meet to be studied in its own right rather than as a "natural" result of distress; but difficult or impossible to analyse until all parties (including doctors and nurses) cease to regard a hospital as an unremarkable place to work and live in and begin to see it as an odd place. This period also showed that no matter the success with which the transference situation is kept "uncontaminated," to place a classical analytical situation in a hospital setting is to modify it in many more ways than had hitherto been supposed.

The general conclusion was reached that when psycho-analysis is allied to an offer of board, lodging, nursing, and sanctioned lack of responsibility, the handicap is severe. This handicap is not merely one of ego-defects in patients who require such conditions; but of collusive relationships in hospital to accept such defects and render them painless; and thus involve the therapy in anaclitic satisfactions. It became agreed that one prime task of in-patient psychotherapy is to convert an in-patient to an out-patient; and that useful results can only be expected in those patients for whom hospitalisation is a mere incident in their treatment, and for whom there is a real possibility of conversion from in-patient to out-patient status within a few months. A generalisation may be permissible at this point; the concentration of treatment resources in hospital which permits advanced technical adventure in the care of severe illness adds inescapably the secondary feature of hospitalisation; and where the technical adventure is psychotherapy ultimately aimed at producing changes within the patient rather than in the environment, the effects of the second feature may be so great as to ultimately bring the work to a standstill.

Following the discussions in 1953 it was decided to experiment with mutual communication between the S.T.U. doctor and the analysing doctor. This experiment lasted a year during which analysts received information about their patients' behaviour in hospital from the S.T.U. doctor, while the latter accepted advice from the analysts about such matters as patients' work, sedatives and nursing. The analysts thus had power to influence the management of their own patients (without becoming personally involved in conducting it) but had no direct responsibility for the consequences of their decisions on other patients and on staff. These others thus became involved in procedures the stresses of which they could not alter and inevitably they involved each analyst in discussions about ways of administering not merely for his patients but for all.

Interest grew to the point where it became clear that along with powers to amend the hospital setting in accordance with their work-needs, the analysts would have to carry matching responsibilities for the total results of the exercise of these powers, and that they should be directly responsible for the staff carrying out their wishes.

Several features of hospital life now came increasingly to be seen by the analysts as an inevitable part of the analytic setting provided, however

* A. H. Stanton & M. S. Schwartz. (1954) "The Mental Hospital," Tavistock Publications Ltd., London.

indirectly, by them, and carrying its own mixed blessings for patients; and such matters as the concern about conversion from in-patient to out-patient status, the use of sedatives and special facilities, came increasingly under the direct scrutiny and control of the analyst. This meant departures from classical analytical neutrality, but many elements of the patients' behaviour in hospital hitherto known only to the S.T.U., now came to be viewed by the analysts as the results of the setting provided rather than as inevitable features of their patients' "illness." Increasingly from 1953, therefore, technical emphasis was placed less upon neurotic elements in extra-hospital relationships and more on the characteristic uses a patient makes of the hospital as well as of the analyst and his treatment; and it came to be recognised by the analysts that the gratification and irresponsibilities of hospital life were inevitable, could not be ignored as secondary "external" events, and could stultify analysis. In 1954 it was decided not to admit for full analysis any patient whose initial stay was likely to be long.

Simultaneously the findings from psycho-analytic work led to interest in their application for other patients—the majority, to whom briefer forms of psychotherapy were being offered. Here, too, it was clear that while it is important to accept the fact that certain patients are so ill as to require their treatment to begin on an in-patient basis, out-patient treatment with its lessened demand for dependency should be instituted as soon as possible. (There is some evidence that up to three months hospitalisation can be felt as a mere interruption of ordinary living, but from then on it is felt increasingly as an alternative, until from eighteen months onward hospitalisation comes to be the patient's ordinary way of life and anything other is extraordinary. These figures seem to be roughly true for adults but may be grossly inaccurate for children.)

It was not easy to bring the hospital administration into line with these findings. Our few out-patient vacancies were reserved for out-patient analysis, and with medical staff sufficient only to staff the beds, it was not possible to provide a proper number of out-patient vacancies for those in-patients who recover to a point when they are fit to leave hospital but who are still in need of treatment. Attempts to get from the Regional Hospital Board extra medical staff to provide out-patient vacancies for recovering in-patients, failed. The hospital was thus having to retain, to complete their treatment, certain in-patients who could have been discharged and treated as out-patients—a medically and financially undesirable situation. Until a proper medical staff could be provided to give balance (of in-patients and out-patients) to the hospital, other methods were therefore sought of limiting the de-socialisation inherent in any hospitalisation and of maintaining patients in adult roles and in contact with their ordinary lives even though they were in hospital.

Experiments and developments had been pushed far in these directions before 1954; but they now progressed farther. First, it was sought to recognise and admit those who needed in-patient status initially and who could benefit by being treated to a finish as in-patients without a protracted stay. A second aim was to offer in-patients more initiative and responsibility in their daily lives while in hospital and more opportunities for encountering there the ordinary social pulls and pushes of community life. A third aim was to allow in-patients to retain social and working contacts with their ordinary lives so that admission to hospital might become an adjunct to, rather than a method of, living.

In 1954 a medical organisation was set up to grow these developments. It was shaped to give the medical staff increased freedom to manage as well as to treat their patients, more responsibility for the practical details of their patients' lives in hospital, and powers commensurate with these responsibilities. Plainly no one doctor could be given control of issues which would effect the patients or staff of his colleagues but it was sought to place each senior doctor in a position of maximal control over that portion of the hospital which concerned his own patients.

Initiative and Responsibility in the Hospital

Four new medical Firms, each with some 25 beds replaced the S.T.U. and the two psychotherapy Firms. The hospital building lent itself to each Firm being allotted its own beds in its own area with clearly defined boundaries. Within each area the senior doctor of the Firm was placed in charge of everything and everybody. He was given medical, nursing and domestic staff, who, once allotted, were responsible in their daily work only to him and not at all to any central hospital agency such as the Medical Director, the Matron or the Domestic Supervisor. These latter could train, allot and re-allot staff and hold central budgetary powers and could proffer advice to the Head of the Firm but had no rights to direct the Firm staff on any matter concerning their daily work. The head of each Firm was made responsible for the selection, admission, discharge, the medical, nursing, and domestic care, and all activities of the patients within his area. The community life of the Firm, its patient-staff problems, the arrangement of its accommodation, the maintenance, cleaning and redecorating of the Firm area, the care and running repairs of furniture and fittings, became his responsibility. Each Firm was given an annual budget to enable it to buy directly or from central services replacements of fittings or minor furniture and material or equipment for maintaining its area. The head of each Firm was free to delegate responsibilities

to members of his own Firm (patients or staff) in his own way.

The heads of Firms have met with me weekly to discuss hospital policy on the basis of problems arising within their firms; and the Matron was available for this conference. I have conducted my work as Director only with my own central executive staff and the heads of Firms, and have sought not to make decisions for other staff of the Firms, so that each head of the Firm should be free to deal with all of its problems. Each Firm has had direct access to my own executives, the Principal Administrative Officer, the Matron and the Finance Officer, whom I made responsible for providing various services for the heads of Firms.

I should state at this point that although Medical Director I also took charge of one Firm. I am aware that the occupation of two roles in an organisation is a classic error of administration, and I am grateful to my senior colleagues for their forbearance and for helping me and each other to avoid confusion between my two roles.

A joint meeting between the senior medical and nursing staffs of the four Firms has also been held weekly to exchange information only. A visitors' gallery is open to all other staff at these meetings. Practical issues, technical experiments or theoretical conclusions have been reported, papers read and issues of current medical or nursing interest discussed. Thus each Firm staff has been aware of developments in other Firms.

The medical staff interest within each Firm has lain essentially in the treatment of individual patients but their supervisory powers over the whole have inescapably led them to interest in social forces, role-relations and the daily Firm activities, matters for which they alone were responsible. Weekly meetings quickly became the rule within each Firm, of medical staff for case conferences and technical supervision, and of the medical and nursing staff for the study of group dynamics and practical issues, medical or domestic, within their Firm. Weekly meetings of patients also arose within each Firm and were attended by nursing staff and sometimes by doctors to discuss patients' problems and plans as a group. Patients in each Firm began to use their own group resources to solve problems created by each other without referring to the staff. The nursing staff on the other hand could present their own problems to the patients who created them, as a group, and to seek or offer advice or information. Disturbed feelings and attitudes of individuals or groups have become delineated as a routine, and obstacles to activities have been brought into the open for examination. These meetings have been and often are heated and unsatisfying—but now the patients as adults can study and act on domestic issues about which in the past they have been passive recipients. The patients have offered help with staff problems and have involved each other in the running of each Firm area in the same way as various members of a family are involved in the running of a home. Slowly a system of work grew up in each Firm and in which patients participated. They had always cared for and cleaned their own bedrooms but now they took over other tasks hitherto undertaken by staff and which had manifest purposes for their own daily comfort. When discomforts arose with the Firm possible action about them became a matter to be discussed by patients' conference and not merely passed to the staff for solution.

By 1955 it had become usual for patients to plan how they would carry out new or routine domestic tasks in each Firm. In each they had elected a Patients' Chairman to meet regularly with the Firm's senior sister or doctor, and a Works Manager, to allot and supervise the patients' daily work. Certain dull routines (such as corridor cleaning) required a rota from the Works Manager, but others (such as planning colour schemes for the redecoration of a bedroom, choosing and buying paints and brushes and material for making curtains or re-covering bed-covers and then carrying out the work) were sought after as unsupervised minor group projects. The patients had taken over; somehow it had become " their " hospital. The patient groups became active and responsible but in spite of all there was not enough work in any Firm for truly adult development. I and my executives therefore turned to the central services of the hospital in a search for further opportunities for patient-participation.

The domestic staff of the kitchen, the dining room, the still-room, the common rooms and recreation and work rooms were now placed in various Firms and made responsible to the heads thereof; so each Firm in addition to looking after its own affairs, became responsible for providing one central service to the whole hospital. One became responsible for the kitchen, a second for the dining room, servery and crockery, and the other two took over the maintenance of different common rooms and recreation rooms. In each Firm the patients did not at first regard these areas as their own but they would assist the staff who worked there. The staff in turn felt free to call the Works Manager of their own Firm to provide help, and the nursing staff could ask patients to help them solve labour problems in the extended Firm. The patients showed their capacities to be greater than either they or staff had assumed and so when domestic staff left or retired these were not invariably replaced. Their work was rather left to patients, until they carried, as groups, entire responsibility for providing each other with certain services.

The nursing staff has not directed nor inspected the work nor insisted that it be done. They have

been content to leave all decisions to the patients, who now complained about or sanctioned neglect. The important fact was not the work—although this could lead to greater comfort for patients—but that the patients were enfranchised as responsible adults whose supervisory discipline could come from themselves. Individual patients have refused help on very few occasions, and this has been handled differently by each Firm at different times. One Firm staff obliged its patients in the absence of medical exemption to be at the disposal of the Works Manager up to three hours a day. In another the patients' group dealt entirely with refusals. Another left it to the direct control of the patients' treating doctor. In a fourth the head of the Firm considered individual cases reported by the Works Manager.

In 1956 the patients were given freedom to plan the hospital menu within a fixed budget, each Firm planning for a week at a time. The Finance Officer and a patient familiar with catering accounting priced out the cost of various commodities per head, so that the patients' group planning their menus could arrange individual dishes realistically and within the budget given. Market fluctuations were reported weekly by the catering officer. Oddly enough, until they learned the ropes, the patients tended to underspend. Beginning in the same year the analysis of all hospital costs was made available to patients and their various Chairmen have occasionally taken up with me points of view about better distribution of the hospital budget. The practical significance of these matters is real enough, but, more important, they provide occasions for patients to participate in workaday awareness of some financial verities of their daily lives. This has some importance in a passive situation where most patients have no immediate financial stake in treatment, some have none in recovery, and a few have one in remaining ill.

Male patients by now were accustomed to seek work outside hospital, but extending the Firm boundaries and work helped to give dignity and purpose to the domestic skills of the women. I have set my face against occupational therapy and other forms of non-functional, manufactured, or pupillary work, but there was still not enough real work to make the hospital a transitional half-real community. The hospital was examined further for more opportunities for allowing patients to think and to do. We found some by modifying the style of nursing.

Changes in nursing techniques had begun after we had learned* that devoted nursing and unsparing efforts to soothe neurotic distress, however natural to nurses, not only failed in the long run to quiet the tensions in our patients, but changed these into dangerous regressive forms which then required even more nursing. We knew that professional kindness fails because of its ultimate insincerity, and that honesty about what can and cannot be given with goodwill by the nurse is a *sine qua non* in the management of severe cases. The nursing staff by 1954 was well aware that a maximal amount of nursing is by no means the optimal, and experiments to seek the optimal amount of night nursing had surprisingly but conclusively shown that one nursing orderly (with one night sister sleeping, but on call, in the hospital) created a better situation than could several night sisters whose eagerness to nurse would always stimulate complementary regression. There was now much less insomnia, nightly panics were rare and regressed suicidal behaviour exceptional. The whole hospital, patients and staff, slept soundly, It was time to pay attention to the optimal amount of day nursing.

As earlier, it was decided that while no staff should be dismissed, whenever a member of the non-medical staff (including nurses) left for another post consideration should be given to the possibility of having the work shared out among patients and remaining staff. Prior to 1953 many staff reductions had been made, but over the period under review the following additional reductions took place as by-products of the medico-administrative aims now discussed:—

*	*1st April,* 1953	*31st March* 1958
Still Room and Servery Staff	$5\frac{1}{4}$	$1\frac{1}{2}$
Cleaners	$10\frac{1}{2}$	$3\frac{3}{4}$
Linen Room	$1\frac{3}{4}$	$\frac{3}{4}$
Telephonists	$2\frac{1}{4}$	$1\frac{3}{4}$
Kitchen Staff	7	6
Catering Staff	1	$\frac{1}{2}$
Nursing Staff (including assistant nurses)	$14\frac{5}{6}$	$11\frac{3}{4}$
	$42\frac{7}{12}$	26

These staff changes both arose from and resulted in a sharing out and reshuffling of work which left each sister with fewer staff but with the same responsibilities. She could discharge these only by enlisting the collaboration of patients and each became interested in developing techniques of doing so. Her work altered, but brought its own rewards. She became much more a social change-agent, a consultant to patients in their activities, ambitions and neurotic feelings, and less a colluder in primitive ways of living. Not all experiments were successful; indeed, some had to be quickly abandoned, but the patients steadily increased their range of responsibilities and activities in ways which could be inherited by each new generation of patients. Each successful experiment in delegating to patients was a crisis of initial resistance,

* T. F. Main—"The Ailment." *Brit. J. Med. Psych.* vol. xxx, 1957. Pp. 129-145.

* The above figures refer not to the number of people employed but to their equivalent in whole-time work.

doubt and effort by all, and then—usually in two weeks—settled into successful collaborative activity of some pride and purpose.

In certain jobs (such as clerical work in the Finance Office and assistance in the Linen Room and those involving the comfort and recreational facilities of patients) staff/patient working relations were reliably successful, but if the work concerned food, it was otherwise. Here, although staff and patients might work together with superficial goodwill, strains arose regularly on both sides, communication became insincere and the service suffered. Discussions made it clear that over food, patients felt themselves sooner or later as menial assistants to the staff, whereas staff felt themselves to be menial assistants to the patients. The mutual dissatisfactions were resolved by arranging that no mixed staff/patients' team should work together on food. The patients of one Firm were given responsibility for the patients' still-room and servery meals and drinks, the dining room, and the setting and washing of patients' crockery and cutlery, while the patients of a second Firm took on the cooking of certain evening meals for the patients. The domestic staff undertook similar duties for the staff.

The tensions quickly decreased to ordinary work-a-day proportions. Thereafter at times of staff shortage and at Bank Holiday week-ends the patients took over entire responsibility for all cooking and serving of meals.

Thus the patients in Firms plan, budget and carry out much work which had hitherto been done by staff. They own and collectively manage their own laundry, bedrooms, corridors, common rooms, dining room, servery, still-room, and certain meals. They are part owners of the hospital television sets, arrange and run their own recreation, their own crafts, extra-milk and newspaper services, shop and library. They decide on the rooming arrangements in each Firm, welcome new patients, help each other in crises and in minor bodily illnesses. They hold their own councils and have their own executives, decide the codes of behaviour and confer on the problems each creates for his fellow.

The aim to offer more initiative and responsibility to in-patients was thus achieved in part by providing them as opportunity offered, with powers, responsibilities and facilities to organise something of their daily lives and to participate in the running of the hospital. It is noteworthy that they have shown a fine recognition of each other's capacities and limitations in their work teams, and that they have developed a smooth machinery to exempt from responsibility those who are unable to contribute much. Their judgment about those too ill to be active has been at least as sensitive and tactful as expert staff. While they proved capable of creating a culture which can tolerate individual neurotic disturbance and yet control anti-social expressions of it, they have usually needed discussion with the staff before they could deal decisively with problems of stealing or sexual misdemeanour among themselves.

The developments described are not final and are certainly imperfect, but they have gone further than anyone—staff or patients—expected. They have depended on the capacity of the staff to delegate to patients, to tolerate disorder pending the patients' recognition of their powers and responsibilities to sanction or amend it, and to await spontaneous action by patients rather than seek obedient action by them in a crisis. None of the details arose out of a planned programme; rather they grew out of occasions used with imagination by a staff who were prepared to stand tension without seeking premature authoritative solutions. It can be said that for most patients alternatives to the role of invalid are on offer to patients from patients and that surrender of all adulthood is not automatic on admission.

Contacts with Ordinary Life

The third aim—to allow patients to retain contacts with their working and social lives—is now reported. The policy was continued of allowing in-patients to seek work outside the hospital, either part-time or full-time, paid or unpaid, from the first day of admission. This had needed the support of special arrangements for early breakfasts, late evening meals and the arrangement of therapeutic sessions to suit these workers. Prior to admission patients have been advised by letter that it may not be necessary to give up their work while in hospital and a few have managed to continue full-time work during the whole of their stay. Some others living far afield have sought new jobs locally from the hospital. A sample day of patients' extra-hospital work, chosen at random in 1956, showed that 47 were engaged on the following jobs: 1 market gardener; 10 clerical work; 1 buyer in store; 1 chemist in paint factory; 3 accountants; 1 civil servant; 2 milk bar assistants; 1 physiotherapist; 3 garage hands; 1 swimming instructor; 1 town clerk; 1 medical research worker; 1 worker in plastic factory; 1 librarian; 1 domestic; 1 counter assistant; 1 musician; 1 jewellery salesman; 1 research worker in a national laboratory; 1 pathologist; 2 shop assistants; 1 university lecturer; 1 handyman; 1 student; 4 nurses; 2 hospital orderlies; 1 barman; 1 bank clerk.

The fact that by Ministry of Health regulations patients must pay a proportion of their current earnings to the hospital (as agent of the Ministry) has not reduced the readiness of patients to seek work outside the hospital. I imagined it would but I was wrong. Indeed, although the Ministry's charges are not popular, there is much evidence that some patients welcome the dignity of giving something to the hospital in return for what they get.

In-patients were given full permission to leave the hospital any day at their own design for as long as they want, to visit outside, to work in their homes and to stay away overnight as they wished. Only the catering office had to be informed—as in any home. Some have been too ill to accept any such offer, but it became common and ordinary for patients to visit the cinema and seek entertainments outside hospital, to go home for one or more nights a week, or at week-ends, to work at home, visit friends, care for children, go on outings with spouses, etc.

Week-end leave has been taken even by patients living up to 150 miles away from the hospital but it is in commoner use with patients whose homes are local. Discharge from hospital for home has indeed become not an event but a process. The difficulties of abandoning the shelter of hospital can now be early recognised by all in this small community and can come early into treatment; sometimes from the first week of admission.

The result of early treatment of the anxieties concerning departure from hospital has not been that the patient is shortly discharged, but rather that the treatment of other problems can proceed less impeded by resistances arising from inability to abandon hospital. The effect on the communal life of patients has been an increased regard for home life as a part of the ordinary culture of the hospital. To some extent the hospital has ceased to be an alternative to home; it has become, rather, a supplement to the home's limited resources for handling neurotic disturbance.

It seems increasingly clear that the hospital should take over only such functions as the family cannot provide, and only for such days in the week as the patient and family require; in short, admission to hospital should often be a partial not an absolute matter.

Towards the end of the period reported, it therefore developed that every night some patients would be at home, and at week-ends—when the doctors were off-duty—fair numbers, varying from a quarter to over half of the patients, would be out of hospital, either visiting or staying at their homes. At Christmas 1956 only a minority of patients opted to stay in hospital, the others spending this festival at home with their families. The group effect on individuals was a spur to participation in this procedure. In 1957 every patient went home for Christmas although up to Christmas Eve a few were uncertain, and the hospital may remain open at any future Christmas because of a minority too disturbed to go home.

In addition to aiding patients to remain in active touch with their world outside hospital, the world has also been invited in.

When a patient has been admitted, accompanying relatives have been interviewed by the Firm Sister and shown round the hospital, have been given freedom to visit at any hour of the day up to 10.30 p.m. without prior permission or notice, to mix with the patients' community, to buy and eat meals with them in hospital, to join in hospital activities and entertainments and to take the patient on outings as often as they wish. Participation of visiting relatives in patients' affairs, particularly during evenings and week-ends, has helped the experience of breakdown to be shared by the family without disruption of relations within it. More than once a visiting husband has been drawn into the patients' social system and has found himself on a patients' work roster to wash up the dishes after his evening meal or performing minor cleaning in a Firm area!

A specific example of bringing important relatives into hospital is now considered because of its particular interest.

Mothers and Children in Hospital

From 1948 onwards women patients, unable to accept the offer of admission because no one would be able to look after their young children, had occasionally been admitted together with the children. By 1954 we had sufficient experience of such cases to consider further the implications of admitting a mother to hospital without her child. Some mothers of young children, though disturbed in themselves, were anxious about their children's care at home, while others were clearly only too glad to hide in the social vacuum of a hospital from tasks of mothering which, if faced, led them to panics or depressions. In the former instances there was the possibility that we might be damaging the mothering capacity of the patients by alienating them from their children. In the latter we seemed to be buying short term relief for ourselves and them by colluding with their hidden wishes to neglect or be separated from the children. We were aware in any event that to disrupt for weeks or months a mother/child relationship would certainly create problems for the future of this relationship and perhaps for the emotional development of the children involved. As an investment in mental hygiene the avoidable admission of mothers alone would seem to lose more on the roundabouts than it gained on the swings.

The hospital therefore began in 1954 to accord permission to all mothers to bring their pre-school children into hospital and to care for them there, and where this offer was not accepted encouragement was given to the mother to visit her children frequently. Important anxieties of mothering hitherto neglected because unseen in the peace of isolation in hospital now became impressively urgent and real. They could no longer be hidden or denied by either patients or staff, and so came into treatment. From 1955 onwards it was therefore made a condition of admission that mothers should bring their pre-school

children with them. Some exceptions have had to be made for particularly distressed patients, but these have been few, and with the improvement of these mothers their children have been admitted later. In one case only, staff concern about a mother's neglect of the baby led to it being sent home, to be re-admitted some weeks later when the mother had become able to care for it herself.

From now on the hospital got requests for the admission of mothers suffering from puerperal states, with disturbances of the mother/infant relationship presenting as depressions, panics, fears of infanticidal wishes, etc. We made preparations for staff care of the babies concerned in view of the mothers' symptoms, and doubted our nursing strength. We found, however, that once in hospital even the puerperal cases benefited from the general patients' ethic that patients could help each other, and the staff ethic that a nurse should not look after a mother's baby but instead help the mother to look after it; and we found to our surprise that many mothers quite unable to look after their babies at home and requiring there much nursing themselves (often having given their babies away to the care of their neighbours, relatives or local authorities), became able *within a matter of days* to look after themselves and their infants and to accept the help of other mothers in so doing. These rapid changes are under study and cannot be attributed only to the psychotherapy given.

Since 1955, mothers with toddlers have formed the majority of patients in one Firm, while puerperal problems have been admitted to another.

Each of these Firms has created arrangements which allow mothers to remain in charge of their children, to wash and feed and take them out in perambulators and perform general mothering functions with the support of those around them. Each mother and child share a room which is usually in the homely disorder inseparable from the care of children, with toys, bottles, diapers drying on clothes horses, etc., and each mother brings her own child's cot, high chair, pram, toys and linen. We have not sought centralised efficiency in laundering, sterilising, or white-tiled hygiene, but to create conditions which each mother could recognise as similar to those in her own home and which she could use with a sense of domestic familiarity. Some pairs share a bedroom with others. The patients' organisation has studied and adapted to the problems created by children in hospital and has actively made many special arrangements; a special lunch time for mothers and children, laundry facilities in each Firm area, a common room with apparatus for children's play, a sand pit and swings in the hospital grounds, a television hour sacred to children, etc. For toddlers whose mothers were having group treatment at a particular time, the hospital psychologists have arranged a children's play session and have begun studies in child development. This record of end-events does scant justice to the anxieties, irritations and satisfactions created by the assimilation of children into the hospital, to the daily problems arising, and to the contributions made by the children themselves towards a " real " atmosphere.

The medical staff have not been confident of their ability to treat children's upsets and infections, but Dr. C. A. Baggeley, our nearest general practitioner, agreed to the children registering on his panel and their mothers visiting his surgery. We are grateful for this and for his willingness to visit the hospital as required. Thanks are due also to the Maternity and Child Welfare Clinic at Ham, which is attended regularly by mothers and children, and to Dr. Eric Periera, the Medical Officer of Health for Richmond, for his generous help and advice about dealing with outbreaks of infectious disease.

But what of the fathers? They have been encouraged to visit the hospital after work and at week-ends, to play with their children or help with their care, to visit their wives, to share baby-watching duties. In certain cases where the husband/wife relation has merited special care, the husband has been offered lodgment at the hospital for the week-end and/or personal therapy. The trend however is to encourage the husbands to take their wives and children to stay nights, and especially week-ends, at home, as often as possible. The mothers have been helped to visit their school-age children at week-ends and sometimes these have been admitted in school holidays; all are free to visit each other at any time.

In puerperal states an early finding was made about the family disturbance which follows the advent of the new baby. In these cases such is the family disruption that father and mother and baby are often cared for by three different agencies—neighbours, relatives, local authorities, etc. It has become the hospital practice, therefore, for a senior sister to visit such a home as soon as the admission request is received, to gather together mother and infant for a co-ordinated admission, and to help the husband become a participant in the family event of hospitalisation. Because these families often live far afield, the hospital car has been used. Certain nurses could not drive. Driving lessons are now part of the nursing curriculum.

Patients' Organisation

I have mentioned that a stable patients' organisation grew within each Firm during the period, with weekly meetings. A Patients' Committee, headed by a Chairman, has been elected each month from the slowly changing patient population of each Firm, and given executive powers by them in respect of work and recreation. The Firms and patient committees have had their own officers and sub-committees, e.g. works manager, a housing committee to organise

rooming arrangements of patients, a mothers' group to make proposals for their own needs, a catering representative to sit on the hospital catering committee, etc. These patient representatives have had regular liaison with the Firm staff to share problems and plans. Rivalry has regularly developed over such matters as which Firm could produce the best fete, the best party, the best colour scheme or redecoration, raise the most money—and these are in contrast to the rivalries of some years ago which tended to revolve around which patient was in most need of special facilities.

Prior to 1954 a patients' Central Committee was elected by all patients in the hospital. It reported to them at a weekly meeting, and it organised all patients' work and recreation. Since 1954 it has had much less to do, but it has remained in being, to organise central entertainments, to lay down procedures and codes of behaviour and to co-ordinate action between Firms; it has reported to all patients at a fortnightly meeting. They have appreciated the help of Mr. L. Bradbury, who visits three half-days a week, in arranging gramophone concerts and classes in art and musical appreciation. The patients' organisation has seen to it that, while any patient is free to have acoholic drinks in the hospital, this freedom is not abused. I and the senior hospital executives have met the Patients' Central Committee fortnightly to discuss developments or issues for which the ordinary hospital machinery was not sufficient. The Patients' Central Committee has continued to have its own secretary, office and typewriter, has had direct access to senior hospital executives, and has had attached to it the Deputy Matron who acts as the liaison officer between it and all staff organisations.

The patients of any Firm have been able to turn to the patients' central organisation for collaboration in work or recreation. One example may serve. Patients from the Firm running the patients' still-room, servery, and dining room (responsible for providing teas, mid-morning and evening drinks, sandwiches, cleaning crockery and cutlery, and controlling allocations of tea, butter, sugar, jam), ran head-on into difficulties created by other patients, e.g. taking more than their share, keeping cups and saucers in bedrooms and making other shortages in the servery. The sufferers in the hospital no longer needed in dependent ways to complain to staff—they claimed their rights and complained of the shortages to the patients of the Firm running the servery. These, however, could not solve the problem—for it was created by the behaviour of patients in general—so they called on the Patients' Central Committee to help them. At a patients' General Meeting those running the servery complained of doing more than their fair share and of being the target for complaints over problems created by patients from other Firms. The patients as a whole now decided that while the one Firm should organise the patients' duty rosters in the servery, all patients in the hospital should be available for this duty. The whole patient community thus assumed responsibility for assisting the work of one firm. This example of a patients' community disciplining itself and helping its members is in contrast to the sort of dependent discipline a staff would require of patients if staff were responsible for rectifying shortages.

A sample chosen at random of the Minutes of the patients' fortnightly general meeting now follows with their permission. The names of the patients have been altered, to ensure anonymity.

MINUTES OF PATIENTS' MEETING 2nd FEBRUARY, 1956

A meeting was held in the Orleans Room attended by 16 patients, 4 members of the Committee and Sister Erikson. More patients arrived later.

Chairman	*Mrs. Brown*
Vice Chairman	*Miss Jones*
Secretary	—
Treasurer	*Miss Smith*
Fifth Member (Acting Sec.)	*Miss Miller*

The minutes of the previous meeting were read and confirmed.

Matters listed below were discussed at the meeting.

Treasurer's Report

Report read by Chairman. Mrs. Thoms commented that she thought there was a limit to the amount of Entertainment Funds. Mr. Johns said any excess of £3 should be handed over to the sports and social Fund. There were complaints that there was not enough money to run dances. It was agreed that not enough notice of dances was given, and improvements on the present system of arranging dances were left to the new Chairman and Committee.

Mrs. Thoms proposed, Mr. Johns seconded, that the excess over £3 from the Entertainments' Committee be given to the Sports and Social Fund.

16 in favour
1 against
6 abstained

Entertainments Committee Report

Mrs. Bleak, the chairman, said there was nothing to report, and read the Treasurer's Report and commented that notice of dances should be given one week ahead.

Mothers' Report

Mrs. Brown, the Representative, mentioned a children's playroom. They were temporarily using an unused bedroom, but there was a children's treatment room in West which could be used, also temporarily, especially for week-ends. There were complaints that the children might spoil the room.

The meeting felt very strongly that a separate room exclusively for the use of children and their guardians was essential. Mrs. Thoms proposed, Mr. Johns seconded, that the Hospital authorities should be again requested to provide a room for children and the mothers would contribute some equipment to be kept there permanently.

22 in favour
1 abstained

Mr. Johns commented that Dr. Main did not want a staff room used, but a patient's room.

(The meetings of October 6th and 20th discussed this same question with great feeling, the difficulty being solved because there was a spare room available (R.14) which was offered as a play room.)

Mrs. Brown complained that adults wanted to watch other programmes while Children's Television was on. Miss Low said children had priority during Children's Television and this was the feeling of the meeting in general. It was stressed that children, not adults, would have the right to choose which channel should be viewed. A proposal was made by Mr. Gilbert seconded by Mrs. Thoms that children should have priority during Children's Television time but that they should not be in the Orleans Room unless in charge of a responsible adult. This was carried unanimously.

Mr. Head said a child had caused a disturbance during evening Television. On further enquiry it was found that this incident involved a child running into the room and running out again. Mrs. Brown said that the child had obviously escaped momentarily from its mother and the remedy would be to turn the child out of the room. She could say, on behalf of the mothers that this action would be welcomed.

Mr. Gilbert said children caused great disturbance in the Dining Room. Mrs. Brown said the mothers would meet and discuss this and report to the next meeting.

Servery Report

Mr. Hand, the Representative, said that a cloth was provided for cleaning the toaster, patients should please use this instead of the tea-cloth. Tea towels should be washed through on the 3-5 shift, and the Centre Firm should boil them weekly. He suggested that patients who work full-time, should do an occasional late night tea duty. Miss Low suggested that each servery representative make an official list of patients with regard to servery duties and check it with the Firm Sister. The question of patients who did full-time work outside the hospital also doing servery duty was left over till next meeting.

Mr. Peak queried the patients' washing of tea towels. He wondered whether the Staff tea towels were sent to the laundry, but no one knew. Miss Clear said that the Firm tea towels, at least were sent to laundry. Mr. Peak proposed and Miss Mill seconded that in the interest of hygiene, and in consideration of the fact that table cloths were not used—thus saving expense—we should protest against the decision that tea-towels should not be sent to the laundry. This was carried unanimously.

Mr. Hand continued that anyone who wants to change servery duty should alter the list and inform Reception. Mr. Gilbert said that if someone was prepared to sign for the servery keys, they should be given to them even if their names were not on the list, and this should be mentioned to Matron. When it was put to vote, there were 14 in favour of this and 7 abstentions. There were various objections and the Chairman commented that a new arrangement was clearly required.

Patients who want early breakfast should put their names in the book before 4 p.m. The butter machine was to be replaced, and some of the patients requested a simpler kind of machine, but this was felt to be going too far ahead. A report book was to be placed in the servery for complaints about the previous shift. The meeting was unanimously in favour.

Servery Inventory

23 teaspoons down, 20 trays missing, 17 of the best blue cups short, 30 forks up—but still 60 down on the original—14 mustard spoons found.

Mr. Peake commented that there should be 110 best blue cups, and proposed that enough new cups be bought to bring the number up to 100 in view of the original amount. Mr. East seconded, and the motion was carried unanimously.

Mr. Johns complained of shortage of sugar in the last few days, and Mr. Hare said that the tea ran out very quickly. Mr. Hand said that he would put out more sugar, and would servery people please fill the urns right up with water.

Sports/Social Report

Mr. Johns said that no meeting had been held. Mr. Lord had bought a book of snooker rules for the hospital and a vote of thanks was passed. He requested that the St. Lawrence Hall piano be repaired, and Mr. East added that the C.R. piano was also out of order again. These matters should be reported to the Executive Sisters of the representative parts of the building.

Chairman's Comments

Casting Vote: *The Chairman brought up the question of whether the Chairman should have a casting vote as well as an ordinary vote. Mr. Johns proposed—seconded by Mr. Peak—that the Chairman should have a casting vote but no other. This was carried unanimously except for two abstentions.*

Water: *The Chairman also reminded the meeting that patients should put in all wash basin and bath plugs during frosty weather. Mr. East said that the water*

could be turned off by a valve under the basin. Several patients said that this had caused flooding and it was decided that the valve should not be touched, also that any leak should be reported straight away to a Sister.

Wood: *The Chairman reported that some wood, left over from making swings, had been voted to be given free to Mr. Bear who had previously gone to a lot of trouble over the swings.*

Milk Losses: *In order to stop the considerable milk losses, the Chairman suggested that one person from each firm should collect appropriate amount of milk and take it to the firm rooms, which would isolate any losses. Some patients thought this was unnecessary, and it was left to be decided at firm level. Mrs. Stair of Rubinstein Firm reported that her firm had already started to use this method and found it very satisfactory.*

(The meeting still being in progress at 9.16—the late tea in the Servery was retarded by fifteen minutes).

Page Numbering: *The Chairman mentioned that Sister Thomas had asked for volunteers to help with page-numbering of a lecture report. Work could be collected from Miss Finkin's office at any time of the day—and the necessary equipment and information would be given for this simple and straight-forward job.*

Ross: *The Chairman read out a letter signed by Mrs. Thoms, Chairman of Main Firm, in which she said: " In view of the fact that Main Firm is a large firm, and the facilities in Ross Ward are barely adequate for our needs, coupled with the fact that young babies are housed in the ward and therefore disturbance is to be avoided, it has been decided by the members of Main Firm that ALL facilities in the ward, including the quiet room, will in future be for the use of Main Firm patients only. Following the above decision, we hereby return the sum of £1, recently allocated by the Sports and Social Fund for the purchase of various items of kitchen equipment for use in Ross Ward kitchen."*

Mr. Johns said that the previous inhabitants of Ross Ward had been more generous with their facilities than the present ones. The Chairman commented that the Quiet Room in Ross had been the only one in the Hospital, and quiet study should not surely cause disturbance to the young babies as had been feared. It was stated that the typewriter was noisy, and the suggestion that it could be used in the Firm Room, leaving the Quiet Room for study, was not taken up by Main Firm. On the Chairman enquiring to whom the typewriter belonged, Mr. Gilbert replied, " To the Firm Sisters."

Mr. Head suggested the work room typewriter should be locked in a cupboard but it was felt that it would be sufficient if it were merely put away in one, when not in use, out of the children's way. Mr. Gilbert interposed here, that the cupboards be moved to another wall to make more room for billiards, but this was decided to be deferred to another meeting.

B.E.L.R.A.

Miss J. Wood who had instigated and collected for this charity, now had to resign due to going out to work. In the absence of other volunteers, Mrs. Brown undertook to continue the work.

Crockery

The Chairman of Main Firm reiterated that crockery should not be left in the Common Room which they had to keep clean and tidy. In future they would undertake to remove none of it and would let it just pile up there.

Telephones

G.P.O. had complained that the patients telephone had remained unanswered one afternoon, causing delay over the delivery of a telegram. Would patients be more ready to answer the phone, especially if it is very persistent, as it may well be a matter of urgency. One telephone was out of order, which could have caused the delay, but this would be remedied. It was further requested that the condition of the two pianos be looked into.

Watch Committee

The Chairman said that the Patients' Executive normally were required to act as a Watch Committee to check any immoral behaviour on the part of the patients. Miss Lark suggested having a separate committee, but it was decided to hold an Extraordinary Meeting on the following Monday, to discuss the subject exclusively.

Losses

As it was getting late, the question of recent losses was deferred until the next Patient's Meeting.

Catering Representatives

Mr. Sands volunteered to be Catering Representative on the retirement of Mrs. Tetley.

Complaint

Mrs. Pain suggested that patients who do not contribute to the Television Fund should not be allowed to vote when a choice of programmes was made. The Chairman proposed, Miss Miller seconded, that the names of people who pay, should be put on a board in the Television Room, and the patients not on this list could not vote in the choice of programmes.

Voting—5 in favour
3 against
3 abstentions.

The proposal was carried.

It was decided to postpone the elections until the next meeting, as nearly all the patients had gone out to get tea, and it was very cold in the Orleans Room.

The Chairman declared the meeting closed.

NURSING PROBLEMS

The nursing staff have been key agents in the developments so far described. Within each Firm the clinical teaching of nurses and directions about the handling of any one patient has been the responsibility of the head of the Firm and his doctors; but formal teaching in nursing theory and practice has remained the responsibility of the Matron.

The formal teaching has concerned emotional development from infancy to old age, but academic knowledge alone has not been expected to make for successful practice. This must depend on—among other things—personal attitudes, and inner freedom which can make the knowledge alive for daily use. Teaching has therefore been geared to the capacities of the student nurses. The first step has been to use scientific methods of selection aimed at choosing candidates who would not be unduly disturbed by the learning experiences offered during the training, and for whom psychology could be an enriching subject. Next, seminar and case discussions have offered such theory as could increase the nurse's sensitivity to the meaning of her immediate working experiences and problems. Thus it has been sought to help the nurse extend her personal skills in living situations and no attempt has been made to school her in " correct " nursing attitudes to be applied to various conditions. The nurse is helped not to study classical clinical syndromes but to understand in some depth her difficulties with her immediate patients, at the time of their impact on her; and their characteristic difficulties of relationships with fellow patients, relatives and herself. We have sought to help the nurse develop in awareness and to use her own resources confidently without having to match up to standard expectations or to fall back on stock solutions. (One example may illustrate this. A nurse noticed that a particular patient somehow always left her feeling inferior. She recorded this —and found that other nurses felt the same after seeing this patient. The patient's need to do this could now be studied with fair objectivity, with interest and without fear.)

With the growth of the nursing staffs' tolerance for the inevitability of their own feelings, the regular evaluation of nursing procedures, begun in 1951, has continued; and some hallowed nursing stereotypes were found to be methods of sealing off rather than dealing with nurse/patient relations of a disturbing kind. Studies of the use patients make of classic nursing procedures (such as the giving of sedatives), continued to show that these tended to be used by both nurse and patient as substitutes for sincere interchange in difficult situations, or as solutions of despair in lieu of understanding. The nursing staff has continued to recognise that the relationship offered to patients (e.g. of initiative or invalidism) depends much on the nurse's conception of her own role.

Particularly for new nurses it has not been easy to forego the undeniable satisfactions of behaving as maternal authorities, checking, controlling and tending dependent patients, acting and thinking and deciding on their behalf, organising them and offering them peaceful dependent, childlike roles. Such behaviour, essential for the nursing of severe bodily illness, is of little use for neurosis but it is not easy for a trained nurse to change. On the other hand, the organisation of the Firms has helped nurses to develop satisfactions of a different order; to understand group processes, to enjoy the movement of patients towards reciprocal adult rights, to assist them to organise, without subservience, and to care for their patients strengths as well as their weaknesses.

An " atmosphere " has been sought within each Firm of security in which to be ill, but also of freedom to be healthy. This atmosphere is an amalgam of staff and patient norms and expectations of behaviour, difficult to describe but highly important in deciding the way new patients approach treatment, the roles they play and the quality of the relationships they form. For instance it is common to find that new patients have been accustomed before admission to take daily sedatives or tranquillisers. Some have been addicted for years. The patients' usual expectation is that these will be continued or bettered in hospital. However, the hospital does not aim to hide distress with drugs, but to understand it in the hope of resolving it, and drugs which blunt the capacity to experience anxiety or other ego functions thus hinder psychotherapy. The new patient finds himself therefore with a nursing staff prepared to tolerate anxieties, irritations and despairs without wishing to obliterate them or to remove the patient's responsibility for himself, with a doctor interested to understand in depth the hidden problems which give rise to the symptoms; and, perhaps more immediately important than any, with fellow patients who have earlier given up the language of drugs for more sincere verbal communications and who can tell him casually of the usefulness of real treatment. Within a month of admission most new patients stop taking sedatives.

An interesting finding has been that the cessation of sedatives has not increased the amount of general distress in the hospital. Far from it. There has instead been a most dramatic fall in the amount of distress shown and the nursing attention needed. With almost no exception even addicted patients have been not more but very much less disturbed without

drugs. Sedatives can of course shelve a problem and buy temporary peace for both patient and doctor, but the experience of the hospital has been that in the long run patients' distress is made worse by sedatives, and that a management system which offers initiative and participation on an adult basis backed by psychotherapy is impressively more potent. The changes in the annual bills for drugs and appliances of the last 10 years reflect the hospital practice. They are also of some note in view of general alarm about the national drug bill. These are however mere secondary results of the present system of handling neurotic patients.

	Drugs and Dressings			*Med. and Surg. Appliances*			*Total*		
July 5, 1948									
	£	s.	d.	£	s.	d.	£	s.	d.
Mar. 31, 1949 (9 months)	404	13	2	49	12	10	454	6	0
Mar. 31, 1950 (12 months)	532	1	11	20	6	10	552	8	9
Mar. 31, 1951 (12 months)	276	10	3	15	18	0	292	8	3
Mar. 31, 1952 (12 months)	154	6	4		Nil		154	6	4
Mar. 31, 1953 (12 months)	187	17	6		Nil		187	17	6
Mar. 31, 1954 (12 months)	176	11	5		Nil		176	11	5
Mar. 31, 1955 (12 months)	127	18	3	1	16	1	129	14	4
Mar. 31, 1956 (12 months)	126	13	11	8	7	3	135	1	2
Mar. 31, 1957 (12 months)	93	11	7	35	0	3	128	11	10
Mar. 31, 1958 (12 months)	56	1	0	1	11	3	57	12	3

The need to help the nurses to occupy mature rather than maternal roles and which could thus in turn help free patients from childish ones led in 1954 to a study of the nurse's role as a citizen as well as a professional woman. The system of providing a nurse with residential and corporate board, lodging, entertainments, was seen to carry the danger of gripping her every hour in an authority system. In a hierachy and domestically dependant on it, the danger was that she could seek only in the nursing of her patients the personal power and other satisfactions essential to her but inappropriate to her task, which her life otherwise denied her. Steps were therefore taken towards ensuring that nurses could have satisfactory personal lives free from hospital forces when off duty. Non-residence would have been the best situation but discrepancy between the National Health Service charge for residential accommodation and the living out allowances prejudiced this matter. Certain nurses chose to become non-resident at cost to themselves and the others were offered two-roomed flatlets at some distance from the hospital, containing facilities which allowed them to do their own chores, cleaning and cooking, and lead their own private lives without meeting each other and with no supervision by or obligation to the hospital. This scheme actually saves some £600 per annum and has enabled the nursing staff to live more independantly and realistically and to be better fitted to help the patients do the same.

It may be questioned why with the emphasis on group-dynamics and sociology the nursing staff were not recuited from social workers, but only from general trained nurses, some with training in mental nursing. The reasons are two-fold; nurses fill the hospital's need for workers of maturity, accustomed to assume professional responsibilities for others; and they do not confuse bodily illness with neurotic malaise. A third reason is less worthy—they are the lowest paid professional workers in the socio-psychological field.

In each of the years reported a group of nurses finished the Course and a second group undertook training, but the nursing techniques mentioned above led to a reduced nursing staff and thus to fewer vacancies for trainee nurses. It is a severe penalty of our present system of patient participation that our output of trained nurses has fallen.

All trainee nurses paid regular visits to Day Nurseries, Juvenile Courts, the Old Bailey, Rehabilitation Centres and some hospitals.

In 1955, the Matron, Miss D. Weddell, qualified as a lay psycho-analyst and so became the first member of her profession to do so in Britain. Sister G. Elles also did so in 1957, becoming the second.

Three trainee lay psycho-analysts gained experience as unqualified assistant nurses—Mr. A. W. Tyson, M.A. (Oxon.), Fellow of All Souls and collaborating translator of Freud's works (1954), Miss F. A. Kamel, M.A. of Cairo (1956-58) and Mrs. Herbert, B.A.(Cantab.) (1957) to date.

Miss Weddell, wishing to undertake some analytic practice offered her resignation as Matron in 1957. With the unanimous agreement of the medical and nursing staff the Hospital Management Committee invited her to remain as Matron on a part-time basis for a year's trial. At the end of the year's trial the medical and nursing staff were again unanimous and the Management Committee accepted their recommendations that the arrangement should continue. The Ministry of Health, which has watched this arrangement with interest has called for a report in April 1959 on its progress. The benefit is unique in psychiatry and has been much valued by the medical and nursing staff.

Some nursing staff changes were as follows:—

Miss E. Skellern became the Sister in Charge of the Social Rehabilitation Unit, Belmont Hospital in September, 1953, until 1957 when she commenced training as a Tutor at the Royal College of Nursing.

Miss M. S. Trimble took a Personnel Officer's training at Marks & Spencer Ltd., and in 1957 became Sister in Charge of the Social Rehabilitation Unit, Belmont Hospital.

Miss B. Barnes won the " Nursing Times " bursary for journalism, awarded to celebrate the fiftieth anniversary of the founding of the Royal College of Nursing's Official Journal. In 1958 she became Co-ordinator of a survey conducted by the World

Federation for Mental Health on the Psychological Problems in General Hospitals.

Miss E. Collinson left to take a secretarial course and returned as an Office Sister.

Mrs. A. Bowman became Assistant Matron at Netherne Hospital.

Miss J. Cunnold became Sister in Charge of the Neurosis Unit at Warlingham Park Mental Hospital.

Miss J. King became Matron of Danehurst Nursing Home, Sussex.

Miss D. Lloyd became Welfare Officer at the Air Ministry.

Miss C. Legge qualified as a child psychotherapist, and took up work with Miss A. Freud at the Hampstead Child Therapy Clinic.

Miss G. W. Elles, Tutor, left in October 1954 to do research work with Dr. Maxwell Jones on psychopathic families, financed by the Nuffield Foundation. She then returned to the Hospital as an Executive Sister and in 1957 she undertook a study of The Cost of Neurotic Breakdown.

October 1956 saw the retirement of three older staff members who had earned the affection of generations of patients and staff by their devoted work. Miss Mary Blanche commenced duty in 1925 and Miss Ethel Bigg in 1934. Each gave unstinted service to the hospital as assistant nurses first at Swaylands, then during its wartime location at Ash Hall in the Midlands, and since 1948 at the hospital's post-war location at Ham Common. They left with gifts from the Management Committee, staff and patients and good wishes from all. Miss Willard had for 10 years been Catering Officer and Domestic Supplier. It was she who undertook the domestic reorganisation at the new site at Ham Common; she will be remembered for her concern for the comfort of everyone.

MEDICAL STAFF

Psychotherapy has remained the lynch pin of the hospital work. The developments so far reported resulted from medical findings and were made simply to provide conditions in which it could be fruitful. A temporary symptomatic relief which a change of social environment may bring for patients has not been valued nor sought. The hospital's aim has been to produce changes within the patient, and the setting was altered not to provide minimal strains nor relief from maximal strains, but strains optimal for fruitful psychotherapy. All else was subsidiary.

In the four Firms senior medical staff have been in a position to be informed of all that has concerned their patients and to control and guide with little reference to central authority the hospital management of their patients, *in the interest of psychotherapy*. The senior doctor in each Firm and his medical staff have preserved themselves in psychotherapist roles by delegating to other members of the Firm staff wide administrative powers and responsibilities for conducting the Firm. Weekly conferences of the Firm staff have been held and the Firm head and his medical colleagues have guided and directed the staff, but otherwise the system has left the doctors free to undertake individual or group therapy uncontaminated by daily management roles. Each Firm has had between two and four medical staff, who have met together regularly for case conference and case supervision. In 1956 two Firms joined forces for seminars of group case-supervision, the head of each Firm remaining responsible for supervising the cases from his own Unit.

Each medical Firm has developed its own interests in particular types of patients, has taken its week on a 4-weekly rota to deal with all applications for admission, has formed its own waiting list and is in direct correspondence with referring doctors.

The training of the junior medical staff in the techniques of psychotherapy with in-patients and out-patients has been, together with treatment and technical development, a primary task for the head of each Firm. It is no light one. For a doctor of promise to achieve the requisite skills, experience, and personality freedoms needed for skilled psychotherapy usually takes some four years and makes heavy demands on the time and application of his trainers. The training has been linked with that at the Institute of Psycho-Analysis. In hospital the training has consisted of supervision by a senior of cases in psychotherapy, and attendance at case conferences and seminars. During the period progress was made with methods of reporting on patients and with group teaching and supervision, but the Firm Heads have held it to be unfair both to patient and doctor to allow trainees to take on the severest cases. The selection of patients suitable for the capacities of our trainees has been a frequent difficulty, for the majority of patients referred present serious technical problems, and many, as the statistics show, have failed to respond in the past to other forms of psychiatric treatment.

The external training at the Institute of Psycho-Analysis costs several hundred pounds per annum—up to half a junior's salary—and also takes some four years. The hospital reaps the benefits of this additional training and it says much for the junior doctors that they have continued to undertake it and to give a full day's work to the hospital.

I am aware that in spite of the paucity of psychiatrists thoroughly trained in medical psychology, the hospital is at present alone in requiring and giving such training* and I wish to comment on the cost of analytic training as an important determinant of this situation. It is not easy for doctors having trained

* But an out-patient unit, the Tavistock Clinic, notably does so.

in medicine and then in psychiatry to face at a relatively mature age the prospect of further junior posts and a training for psychotherapy which is lengthier and more expensive than any other training in medicine. More could be done to reduce this cost for the trainee. Prior to the National Health Service the personal contracts of the hospital doctors required of them a training in psycho-analysis and the fees were paid by the hospital. With the advent of the Health Service such contracts were no longer permitted by the Minister, but in 1953 the Income Tax authorities ruled that the cost of personal analysis for medical staff (the most expensive element in analytic training) was allowable for tax purposes, because the nature of the hospital's work required it. This decision was reversed during the hospital year 1954/55 on the grounds that personal analysis was not a formal condition of employment required by higher authorities but only by the hospital. The Regional Board then refused to continue to make it a formal requirement in advertisements for posts at this hospital, agreeing only to describe it as " desirable." There is now no Tax-relief and the financial burden on our junior staff in training has since then been full and onerous. I mention this matter in some detail because there is no prospect of psychiatry in this country being married to any but a superficial, wild, or half-tutored psychotherapy unless Income Tax concessions allow extensive training of a sort which can do justice to the infinite subtleties and complexities of human behaviour. It is not unreasonable to expect the physician to seek by personal analysis to know as much about his own mind as he expects his patients to know about theirs.

The medical staff techniques during the period have not changed basically. Psycho-analytically orientated therapy, individual or group, has remained the principal purpose of the hospital. This is the most time-consuming treatment in medicine and yet if it is skimped it is wasted. Moreoever, if it is not offered, the cost of certain illnesses, in invalidism and in decades of consumption of social services or in inefficiency and wasted lives, is difficult to realise. The hospital medical staff has been barely sufficient to offer more than the bare minimum and has worked long hours throughout the period. The application of psycho-analysis to psychotherapy has required early and accurate diagnosis of the psychopathology in depth, accurate prognosis, the early definition and acceptance of limited goals and a strategy of treatment defined in analytic terms. But it cannot be pretended that medical ideals are ever achieved and these are no exception. At most it can be said that the senior staff made progress in these matters and in terms which could be passed on to their juniors.

The staff have been much helped in the diagnostic and final discharge conferences by the contributions of the psychologists; and by the nursing staff reports on patients and their relations with relatives.

Of the present 12 medical staff, eight are qualified psycho-analysts, and three are in analytic training. In addition to psychotherapy with in-patients all analytic staff and trainees undertake some analysis with out-patients. During the period 14 trainees qualified as psycho-analysts, 9 leaving for other posts.

This somewhat high turnover is in contrast to the Consultant Staff which, including myself, is 1 full-time and 2 part-time doctors. In the next grade are 6 S.H.M.Os., upon whom therefore falls most of the responsible work of the hospital. It can be counted on at any one time that at least two of these S.H.M.Os. will be fully trained in advanced work. They can earn much higher salaries as Consultants to other hospitals or in private practice as psycho-analysts, than as S.H.M.Os., and despite their wish to continue at the hospital it is understandable that having no hopes of promotion they prepare to leave. Because of the medical staff structure the hospital has thus never been able to build up a proper core of well-trained staff members, and it remains an unbalanced unit, short of fully trained Senior Staff. The appropriate authorities refused during the period to increase the Consultant Staff or to permit the S.H.M.O. staff to change to maximum part-time work, (a step that would have allowed the fully trained ones to increase their incomes by some private practice and so stay part-time at the Hospital). Those S.H.M.Os. who left during the period were replaced by doctors who were of some seniority in psychiatry, but relative beginners in this special field. Once the effort in training them begins to bear fruit, under present conditions they must leave.

The turnover of junior staff (2 registrars and 1 Junior Hospital Medical Officer) is acceptable but a fluid core staff is another matter. The amount of case-supervision demanded from the Consultants, both for junior staff and Senior Hospital Medical Officers, added to the needs of patients, has meant that no senior staff member has had proper time for reading, writing or research. This serious deficiency is the result of official but false economies in the one basic essential—an adequate Consultant Staff.

Prior to 1954 all patients referred for admission were assessed for their suitability for treatment as in-patients, and after assessment were discharged, those held suitable to the waiting list, and the others to other sources of treatment. However with the growth of waiting lists, the waiting period for re-admission and treatment became unduly long, and in 1954 it was decided to close all waiting lists and to reject patients for consideration unless there was a reasonable prospect of a bed within a month or two. From then on, each Firm conducted its own waiting list. Waiting lists were kept down to a maximum of three months and referring doctors had

to accept the fact that the hospital could accept only some of the patients referred to it.

The selection of patients for psychotherapy, one of the knottiest problems of psychiatry, has remained under study. With some patients the diagnosis and prognosis are easily arrived at but with others careful and prolonged case study is necessary before deciding for or against psychotherapy. It cannot be expected that our referring doctors should have expert knowledge of the scope and limitations of psychotherapy, or be expert in selecting their patients for us. In the event some 15 per cent of letter referrals have been regarded as unsuitable and of those admitted for assessment some 45 per cent have been so regarded after assessment.

Assessment studies in the hospital are made on the basis of several psychiatric interviews, and investigations by the psychologists and the nursing staff. At the end of a fortnight an assessment conference is held. A psychopathological formulation is made, with prognostic predictions, and attention is paid to the effect on the patient's home and working life of his entry into hospital, to the advantage and disadvantage of hospitalisation during treatment, and to the problems likely to be met when the patient is discharged. The therapeutic plan concerns the number of weekly sessions required and the likely total length of treatment. In some cases the plan may seek major alleviation of the patient's difficulties, but in others limited goals far short of a cure may be set. (An example of the latter arises in the " hopeless patient " with a history of addiction to treatment and suicidal behaviour where this has been withheld. It is regarded as a worthwhile contribution to free the patient from the addiction and the suicidal alternative without relieving other problems presented).

MEDICAL STAFF CHANGES

1953 Dr. Sohn joined as Senior Registrar.

1954 Dr. Sohn became Senior Hospital Medical Officer.

Dr. N. Cohen (As Senior Registrar) and Dr. Charles (as Registrar) joined.

Dr. W. A. Saffery left to undertake Psycho-Analytic practice in Cape Town.

Dr. W. Pappenheim left to become Registrar at the Tavistock Clinic.

Dr. G. Levinson left to become consultant to the West Sussex Child Guidance Clinic.

Dr. S. H. Klein left to become consultant at the West Middlesex Hospital.

1955 The following joined the staff:—Dr. Gluck as Senior Registrar, Dr. Zeitlyn as Senior Hospital Medical Officer, Dr. Pines, Senior Hospital Medical Officer, Dr. Butcher, Registrar, and Dr. Lomas, Junior Hospital Medical Officer.

Dr. S. S. Davidson, Dr. H. A. Thorner, Dr. Dewar, Dr. Sohn left to take up private analytic practice, and Dr. McIntyre left to be part-time consultant at the Marylebone Hospital.

1956 Dr. J. L. Rowley joined as part-time consultant.

Dr. A. Brook as Senior Hospital Medical Officer.

Dr. Gluck became Senior Hospital Medical Officer.

Dr. Ployé changed from full-time to Part-time Senior Hospital Medical Officer.

The following left:—

Dr. N. A. Cohen to become Senior Hospital Medical Officer in West Middlesex Hospital.

1957 The following joined the staff:—

Dr. Enid Caldwell as Senior Hospital Medical Officer.

Dr. J. Bolland and Dr. J. McKellar Davie as Registrars.

Dr. J. J. Butcher left to undertake Psycho-Analytic practice in Toronto.

Dr. A. Charles left to become Senior Registrar at Friern Hospital.

Dr. L. H. Rubinstein was Chairman of the Consultants of the Portman Clinic of the Institute for the Scientific Treatment of Delinquency for the period January 1956 to January 1958. He became Scientific Secretary of the British Psycho-Analytic Society in 1958.

In 1957 I had the honour to be elected Chairman of the Medical Section of the British Psychological Society, and also Chairman of the Psychotherapy and Social Psychiatry Section of the Royal Medico-Psychological Association. I was appointed Editor of the British Journal of Medical Psychology in 1956, and have been on the Editorial Committee of the Journal of Mental Science since 1957. I was granted leave of absence in 1957 to become visiting Consultant to the Surgeon General U.S. Navy and to the National Institutes of Mental Health, Washington, U.S.A., and to the Institute of Living, Hartford, Connecticut.

OTHER TEACHING ACTIVITIES

Various members of the staff were involved with external organisations in teaching activities.

Nursing

At the invitation of the Surrey County Council, the Matron, Sister G. Elles, and the Medical Director in 1953 and 1954 undertook an experiment in teaching psychology to Health Visitors by group discussion methods.

A major experiment took place in the spring of 1955 when the hospital ran a school of two weeks for senior nurses—8 Ward Sisters, 16 Children's Ward Sisters, 3 principal Tutors, 13 Tutors—all from London Hospitals; and 16 Health Visitors. The school was financed through the generosity of the Cassel Bursary Fund and a report has been issued under separate cover. Experience with earlier Summer Schools led us to use only two lecturers, Miss Ruth Thomas, a Children's Psycho-Analyst, and myself. The relationship of the lecturer to the School was placed under steady scrutiny, and following each lecture, group discussions were convened by members of the hospital nursing staff trained in discussion methods. These convenors then reported the content of the group discussions to the lecturers whose task now was to interpret the meaning of this content in terms of unconscious resistances and anxieties arising from the last lecture and to formulate at once the next lecture in the light of the problems revealed. By this method some success was achieved in choosing lecture topics which at the moment of delivery held something more important to learning than intellectual interest—warm relevance to prevailing emotional interests.

From 1957 onwards the Matron has conducted a running seminar for Tutors from Mental Hospitals and Sister Bogie has conducted a second for Health Visitors. Members of the nursing staff have addressed various organisations and groups at other hospitals on aspects of their work.

Papers of particular interest have been: 1955—"Human Relations in Administration," at Departmental Sisters' Conference Royal College of Nursing by Miss D. Weddell. 1956—"Nursing Neurotic Patients"—5 papers read at the Annual Meeting of the Royal Medico-Psychological Society (Psychotherapy and Social Psychiatry Section), by Miss Bogie, Miss Gazder, Miss Gleeson, Miss Thomas and Miss Weddell. 1957—"Some Dreams in Child Analysis" at the British Psycho-Analytical Society on the occasion of Mrs. Melanie Klein's 75th birth day—Miss D. Weddell. 1957—"Post Hospital care of the Family" read to the Psychotherapy and Social Psychiatry section of the Royal Medico-Psychological Association—Miss G. Elles.

Medical

The medical staff have also addressed various organisations and groups at other hospitals. Some of these have been:—

1953 "A Day Hospital"—Psychotherapy and Social Psychiatry Section of Royal Medico-Psychological Assoc.—Dr. T. F. Main.

1954 "In-Patient Psycho-Analysis"—The British Psycho Analytical Society—Dr. T. F. Main.
"Psychopathology of Schizophrenia"—Royal Medico-Psychological Association, Quarterly Meeting—Dr. T. F. Main.
"In-patient Psychotherapy of Neurosis"—Maudsley Bequest Lectures—Dr. T. F. Main.
"The Psychotherapy of Schizophrenia"—Maudsley Bequest Lectures—Dr. W. M. McIntyre.

1955 "One Body and Two Body Psychology"—University College—Dr. T. F. Main.
"The Dynamics of the First Interview"—Runwell Hospital—Dr. T. F. Main.
"Maternal Deprivation"—Medical Officers of Health and Public Health Students, Salford—Dr. T. F. Main.
"A Recidivist Thief"—International Congress of Criminology, London—Dr. L. H. Rubinstein.

1956 All day meeting of the Psychotherapy and Social Psychiatry Section of the Royal Medico-Psychological Association at The Cassel Hospital:—
"Problems of Hospitalisation of Neurosis"—Dr. T. F. Main.
"The Significance of the Hospital Setting in Group Psychotherapy"—Dr. N. Cohen.
"Migraine and Depression"—Dr. L. H. Rubinstein.
"The Social Structure of Psychiatric Hospitals"—Psychotherapy and Social Psychiatry Section of the Royal Medico-Psychological Association.—Dr. T. F. Main.
"Here and Now in Diagnosis of Psychotherapy"—Cambridge Psychiatric Society—Dr. T. F. Main.

1957 "The Mental Hospital as a Therapeutic Community"—National Association for Mental Health—Chaplains Conference—Dr. T. F. Main.
"The Experimenter and Two Body Relationships"—University College Psychological Society—Dr. T. F. Main.

1958 Psychotherapy and Social Psychiatry Section of Royal Medico-Psychological Association — Cassel Hospital Symposium on "Mothers and Babies in a Psychiatric Hospital"—Dr. T. F. Main.
"In-patient Group treatment of Mothers with Babies"—Dr. Gluck.
"A Note on the Psychopathology of Puerperal Illness"—Dr. Lomas.

PUBLICATIONS

Medical

DR. T. F. MAIN.
- "The Ailment." *British Journal of Medical Psychology* 1957.
- "Perception and Ego Function." *British Journal of Medical Psychology* 1957.

DR. L. H. RUBINSTEIN.
- "The Psychopathology of Homosexuality." *British Journal of Medical Psychology* 1957.

Nursing—Published in "*The Nursing Times*"

MISS D. WEDDELL.
- 12 Articles on the General Nursing Council Syllabus on Psychology. *May* 1954.
- "The Education of the Nurse. A Plea for a Particular Experiment." *Sept.* 1955.
- "Human Relations in Nursing Administration." *Dec.* 1955.
- "Sigmund Freud Centenary." *May* 1956.
- "Nursing Emotionally Disturbed Patients." *May* 1957.
- Comment on The Royal Commission on The Law Relating to Mental Illness and Mental Deficiency. 1954-1957. *October* 1957.

STATISTICAL TABLES

These are set out for the five-year period, 1st April 1953 to 31st March 1958. Some require little comment.

Tables I

As in former years some two-thirds of the patients treated have been women. It has been so throughout the history of the hospital. No explanation is offered, and it would be unwise to regard the hospital sample as indicating any general trend in the comparative incidence of neurosis between the sexes. It will be noted that the figures for the year 1955/56 are the lowest. This is because during that year the experiment was made by two Firms of admitting for trial treatment those who after initial assessment had a doubtful but not unequivocally bad prognosis. Where trial treatment succeeded, they were classified as admissions and are included in this Table; where it failed, they were regarded as an extended assessment and are included in Table 9.

Tables II

There is little significant variation throughout the years except in the last when there was a higher proportion of patients referred from General Practitioners. This is in line with medical policy of developing more contacts with General Practitioners.

Tables III

There is little difference throughout the years in the diagnostic categories. Such classifications do not indicate the degrees of illness present, nor the severity of the psychopathology.

Tables IV and V

It will be seen that about half of the patients had had previous psychiatric treatment; and some had had two or three previous treatments, psychological, physical or both. Sedation is recorded here when it was given by a psychiatrist and not incidentally by a General Practitioner; and the term includes tranquillisers.

Tables VIII

The categories used here are ambiguous and their use probably varied between one doctor and another. The yardsticks of improvement in psychiatry are notoriously difficult, for objective scales usually can refer only to trivia, while penetrative measurements often suffer from subjectivity. Symptomatic changes are unsatisfactory as yardsticks; for a small gain in symptoms may reflect a major freeing of the personality, while complete relief from symptoms may be obtained without any change in the basic illness upon which they rest.

Follow-up, unless it makes full and costly objective study of the patient, his relationships and actions at home, work and in society can be equally misleading. A thorough follow-up was undertaken in 1957 by a hospital sister, trained in social work and psychoanalysis, on 25 patients who had been discharged at least 12 months. The investigation involved skilled contacts with the patient, his relatives and general practitioner, estimates of the patient's performance at home, at work and in social life, and the amassing of detailed objective behavioural and financial facts and the responses of those around the patient. Findings from this sample showed that the medical staff's estimate of the degree of improvement following treatment was often more modest than that expressed by the patient and his relatives at follow-up; lower in 13 cases, the same in 11, and higher in 1.

A letter follow-up of patients discharged between April 1953 and March 1956 was undertaken in November 1956. This type of follow-up is easy on staff time, money and effort, but is notoriously unreliable. The following figures from it are presented with several reservations:—

Letters sent	572
Letters returned (marked "gone away")	96
Failure to reply	220
Replies received	256
Analysis of replies received:—	
Much improved	109
Improved	56
I.S.Q.	33
Worse	22
Dead	4
Emigrated	1
Percentage of repliers Improved ...	75
Percentage of repliers Unimproved...	25

It would be unwise to conclude that after treatment improvements are held and bettered. It may be so but these figures should not be regarded as proving it.

An attempt was made to follow up by letter the fate of those patients "Not Improved," by writing

in 1957 to all patients discharged between April 1955 and March 1956. Fifty-three replied; of these thirty-seven described themselves as improved (69 per cent) and 10 had sought further treatment as follows:—

Insulin	1
E.C.T.	2
Sedation	2
L.S.D.	1
Psychotherapy	1
Psycho-Analysis	1

Again, these figures do not permit of any conclusions.

Tables IX

The effect of a change in admission policy from 1954 is reflected in these figures. Waiting lists were shortened and the offer of assessment of patients for whom there could be no hope of treatment without a long wait ceased. The effect is apparent from 1955 onwards. It will be noted that from 1956 the experiment in two Firms of offering trial treatment to all comers was discontinued. It will also be noted that in 1957/58 some out-patient assessment for in-patient treatment occurred.

DISCHARGES FROM TREATMENT

Period 1st April 1953 to 31st March 1954

TABLE 1. No. of Patients discharged after treatment:—

Female	*Male*	*Total*
85	48	133

TABLE 2. Sources:—

General Practitioners	*Consultants*
21%	79%

Areas:—

1.	Newcastle	1
2.	Leeds	2
3.	Sheffield	13
4.	East Anglia	4
5.	North-West Metropolitan	29
6.	North-East Metropolitan	16
7.	South-East Metropolitan	15
8.	South-West Metropolitan	40
9.	Oxford	1
10.	South-Western	1
11.	Welsh	2
12.	Birmingham	1
13.	Manchester	3
14.	Liverpool	1
	Scotland	1
	U.S.A.	1
	France	1
	Haifa	1
	Total	133

TABLE 3. Diagnostic Categories:—

Addiction	3
Anxiety Hysteria	14
Anxiety State	13
Character Disorder	14
Depressive State	24
Hypochondria	1
Hysteria	20
Manic Depressive Psychosis	1
Obsessional Neurosis	20
Paranoia	2
Psychosomatic Disorder	7
Schizophrenia	10
Total	133

TABLE 4. Previous Psychiatric Contracts:—

1.	Mental Hospital	19
2.	Neurosis Centre	11
3.	General Hospital	20
4.	Private Psychiatrist	27
5.	O.P. Psychiatric Clinic	35
6.	Cassel Hospital	1
7.	Prison	1
8.	Naval Hospital	1
9.	Private Nursing Home	1
	Total	116

Total No. of Psychiatric contracts = 116.
No. of patients involved = 74, many had 2 or 3 previous contracts.
Average length of previous psychiatric treatment = 19·9 months.
i.e. 55% had had an average of almost 20 months previous psychiatric treatment.

TABLE 5. Previous Psychiatric Treatment:—

Narco-Analysis	10
Continuous Narcosis	9
E.C.T.	14
Modified Insulin	8
Insulin Shock	1
Sedation	19
Leucotomy	1
Psycho-Analysis	11
Interpretative Psychotherapy	12
General Psychotherapy	56
Group Therapy	1
Special Techniques	2
Social Case Work	1
Total Treatments	145

TABLE 6. Disposal:—

General Practitioner	110
Mental Hospital	4
Psycho-Analysis	8
O.P. Clinic	5
Back to Consultant	2
Private Mental Hospital	1
Rehabilitation Centre	1
Patient Discharged Self	2
Total	133

TABLE 7. Average length of treatment in Cassel = 7·3 months.

TABLE 8. Condition on discharge:—

Much Improved	22
Improved	65
I.S.Q.	44
Worse	2
Total	133

Percentage Improved = 65

TABLE 9. Triage:—

Total number seen for assessment	253
No. regarded as suitable for treatment	153
No. regarded as not suitable for treatment	100

Diagnostic Categories of Triage Patients not suitable for Treatment:—

Addictions	7
Anxiety Hysteria	10
Anxiety State	1
Anorexia Nervosa	1
Character Disorder	22
Depression	13
Hypochondria	2
Hysteria	10
Left before examination	1
Manic Depressive Reaction	1
Neurosis Unclassified	4
No obvious Psychological Disorder	1
Obsessional Neurosis	10
Paranoid State	1
Psychosomatic Disorder	1
Schizophrenia	6
Sexual Perversion	7
Sub Normal Intelligence	2
Total	100

DISCHARGES FROM TREATMENT

Period 1st April 1954 to 31st March 1955

TABLE 1. No. of patients discharged after treatment:—

Female	*Male*	*Total*
102	45	147

TABLE 2. Sources:—

General Practitioners	*Consultants*
27%	73%

Areas:—

1.	Newcastle	1
2.	Leeds	3
3.	Sheffield	4
4.	East Anglia	2
5.	North-West Metropolitan	31
6.	North-East Metropolitan	13
7.	South-East Metropolitan	32
8.	South-West Metropolitan	48
9.	Oxford	3
10.	South-Western	—
11.	Welsh	2
12.	Birmingham	3
13.	Manchester	2
14.	Liverpool	2
	Scotland	1
	Total	147

TABLE 3. Diagnostic Categories:—

Addiction	3
Anorexia Nervosa	1
Anxiety Hysteria	17
Anxiety State	13
Character Disorder	20
Depressive State	40
Hysteria	19
Manic Depressive State	1
Mixed Psychoneurosis	1
Obsessional Neurosis	13
Organic Cerebral Condition	1
Paranoia	1
Psychosomatic Disorder	3
Schizophrenia	12
Sexual Perversions	2
Total	147

TABLE 4. Previous Psychiatric Contracts:—

1.	Mental Hospital	25
2.	Neurosis Centre	12
3.	Private Psychiatrist	22
4.	Cassel Hospital	6
5.	O.P. Psychiatric Clinic	38
6.	General Hospital	20
7.	Other	5
	Total	128

Total No. of psychiatric contracts = 128
No. of patients involved = 78 (53%)

TABLE 5. Previous Psychiatric Treatment:—

General Psychotherapy	41
Interpretative Psychotherapy	8
Group Therapy	4
Psycho-Analysis	3
Other Techniques	3
Sedation	21
E C T	16
Narco-Analysis	4
Insulin Shock	4
Modified Insulin	3
Continuous Narcosis	1
Total Treatments	108

TABLE 6. Disposal:—

General Practitioner	110
Psycho-Analysis	18
Mental Hospital	6
O.P. Clinic	4
Patient Discharged Self	4
Referred back to consultant	2
Referred back to Hospital	2
Absconded from Hospital	1
Total	147

TABLE 7. Average length of treatment in Cassel = 8·9 months

TABLE 8. Condition on discharge:—

Much Improved	27
Improved	80
I.S.Q.	40
Total	147

Percentage Improved = 72

TABLE 9. Triage:—

Total number seen for assessment	192
Total number regarded as suitable for treatment	121
Total number regarded as not suitable for treatment	71

Diagnostic Categories of Triage Patients not suitable for treatment:—

Addictions	4
Anxiety Hysteria	3
Anxiety State	10
Cerebral Organic State	3
Character Disorder	10
Depressive States	8
Hypochondriasis	1
Hysteria	13
Inadequate Personality	2
Manic depressive Psychosis	2
Obsessional Neurosis	1
Psychosomatic Disorder	1
Paranoia	2
Schizophrenia	7
Sexual Perversion	4
Total	71

DISCHARGES FROM TREATMENT

Period 1st April 1955 to 31st March 1956

TABLE 1. No. of patients discharged after treatment:—

Female	*Male*	*Total*
62	36	98

TABLE 2. Sources:—

General Practitioners	*Consultants*
19%	81%

Areas:—

1	Newcastle	1
2	Leeds	3
3	Sheffield	3
4	East-Anglian	1
5	North-West Metropolitan	13
6	North-East Metropolitan	10
7	South-East Metropolitan	15
8	South-West Metropolitan	34
9	Oxford	2
10	South-Western	—
11	Welsh	4
12	Birmingham	3
13	Manchester	4
14	Liverpool	—
	Scotland	3
	USA	2
	Total	98

TABLE 3. Diagnostic Categories:—

Addiction	1
Anxiety Hysteria	20
Anxiety State	5
Character Disorder	10
Depressive State	10
Epilepsy	1
Hypochondriasis	1
Hysteria	16
Manic Depressive Psychosis	3
Obsessional Neurosis	11
Psychomatic Disorder	4
Schizophrenia	6
Mental Deficiency	1
Sexual Perversion	2
Paranoia	4
Unclassified	3
Total	98

TABLE 4. Previous Psychiatric Contracts:—

1	Mental Hospital	24
2	Neurosis Centre	5
3	Private Psychiatrist	23
4	Cassel Hospital	3
5.	O.P. Psychiatric Clinic	14
6.	General Hospital Psychiatric Dept.	6
7.	Other	3
	Total	78

Total No. of psychiatric contracts = 78
No. of Patients involved = 49 (50%)

TABLE 5. Previous Psychiatric Treatment:—

Psycho-analysis	1
Interpretative psychotherapy	9
General Psychotherapy	28
Group Therapy	—
Narco-Analysis	2
Continuous Narcosis	1
E.C.T.	18
Modified Insulin	2
Insulin Shock	9
Sedation	12
Leucotomy	1
Total Treatments	83

TABLE 6. Disposal:—

General Practitioner	96
Mental Hospital	1
Observation Ward	1
Total	98

TABLE 7. Average length of treatment in Cassel = 9·6 months

TABLE 8. Condition on Discharge:—

1.	Much Improved	17
2.	Improved	44
3.	I.S.Q.	35
4.	Worse	2
	Total	98

Percentage improved = 62

TABLE 9. After Triage:—

	Female	*Male*	*Total*
After Triage	19	11	30
After—failed trial treatment	20	10	30

DISCHARGES FROM TREATMENT

Period 1st April 1956 to 31st March 1957

TABLE 1. No. of patients discharged after treatment:—

Female	*Male*	*Total*
66	37	103

TABLE 2. Sources:—

General Practitioners	*Consultants*
12%	88%

Areas:—

1.	Newcastle	3
2.	Leeds	1
3.	Sheffield	6
4.	East Anglian	2
5.	North-West Metropolitan	22
6.	North-East Metropolitan	6
7.	South-East Metropolitan	25
8.	South-West Metropolitan	54
9.	Oxford	—
10.	South-Western	2
11.	Wales	2
12.	Birmingham	5
13.	Manchester	9
14.	Liverpool	1
15.	Scotland	1
	Channel Islands	1
	No information	3
	Total	143

TABLE 3. Diagnostic Categories:—

Addiction	2
Anorexia Nervosa	1
Anxiety Hysteria	13
Anxiety State	13
Cerebral Organic State	2
Character Disorder	22
Depressive State	17
Hypochondirasis	2
Hysteria	28
Obsessional Neurosis	12
Paranoia	1
Polyneuritis	1
Psychomatic Disorder	3
Schizophrenia	19
Sexual Perversion	3
Unclassified	4
Total	143

TABLE 4. Previous Psychiatric Contracts:—

1.	Mental Hospital	28
2.	Neurosis Centre	18
3.	Private Psychiatrist	25
4.	Cassel Hospital	1
5.	O.P. Psychiatric Clinic	22
6.	General Hospital Psychiatric Dept.	21
7.	Other	6
	Total	121

Total No. of Psychiatric contracts = 121
No. of patients involved = 83 (58%)

TABLE 5. Previous Psychiatric Treatment:—

General Psychotherapy	25
Interpretative Psychotherapy	6
Group Therapy	2
Psycho-Analysis	1
Special Techniques	9
Narco-analysis	6
Continuous Narcosis	2
E.C.T.	19
Modified Insulin	4
Insulin Shock	4
Sedation	13
Leucotomy	—
Total	91

TABLE 6. Disposal:—

General Practitioner	129
O.P. Clinic	4
National Hospital Queen Square	2
Mental Hospital	1
Dead	1
Discharged Self	4
Probation Officer	1
On remand—admitted to prison	1
Total	143

TABLE 7. Average length of treatment in Cassel

= 8·4 months.

TABLE 8. Condition on discharge:—

Much Improved	18
Improved	52
I.S.Q.	31
Worse	1
Dead	1
Total	103

Percentage improved = 68

TABLE 9. Discharged after Triage:—

	Female	*Male*	*Total*
Discharged after Triage	25	15	40

DISCHARGES FROM TREATMENT

Period 1st April 1957 to 31st March 1958

Table 1. No. of patients discharged:—

Female	*Male*	*Total*
85	36	121

TABLE 2. Sources:—

General Practitioners	*Consultants*
37%	63%

Areas:—

1.	Newcastle	3
2.	Leeds	2
3.	Sheffield	8
4.	East Anglian	—
5.	North-West Metropolitan	19
6.	North-East Metropolitan	9
7.	South-East Metropolitan	12
8.	South-West Metropolitan	51
9.	Oxford	3
10.	South-Western	4
11.	Wales	6
12.	Birmingham	2
13.	Manchester	—
14.	Liverpool	2
15.	Scotland	1
	Total	121

TABLE 3. Diagnostic Categories:—

Addiction	1
Anorexia Nervosa	2
Anxiety Hysteria	22
Anxiety State	10
Character Disorder	25
Depressive State	18
Hysteria	22
Manic Depressive	1
Obsessional Neurosis	8
Paranoia	1
Schizophrenia	8
Sexual Perversion	3
Total	121

TABLE 4. Previous Psychiatric Contracts:—

1.	Mental Hospital	10
2.	Neurosis Centre	12
3.	General Hospital, Psychiatric Dept.	8
4.	Psychiatric Out-patient Clinic	6
5.	Private Psychiatrist	15
6.	Cassel Hospital	3
7.	Other	7
	Total	61

Total No. of Psychiatric contracts = 61
No. of patients involved = 57 (47%)

TABLE 5. Previous Psychiatric Treatments:—

Psychoanalysis	3
Interpretative Psychotherapy	11
General Psychotherapy	29
Group Therapy	3
Special Techniques	1
Narco-Analysis	3
Continuous Narcosis	—
E.C.T.	11
Modified Insulin	1
Insulin Shock	1
Sedation	11
Leucotomy	1
Total Treatments	75

TABLE 6. Disposal:—

General Practitioner	117
O.P. Clinic	1
Mental Hospital	2
Discharged Self	1
Total	121

TABLE 7. Average length of treatment in Cassel

= 9·0 months

TABLE 8. Condition on discharge:—

Much Improved	16
Improved	68
I.S.Q.	36
Worse	1
Dead	—
Total	121

Percentage improved = 69

TABLE 9. Triage:—

Total No. of patients seen for assessment	77
Out-patients regarded as suitable for treatment	40
No. of in-patients regarded as not suitable for treatment	37

TABLE 10. Follow up Results:—

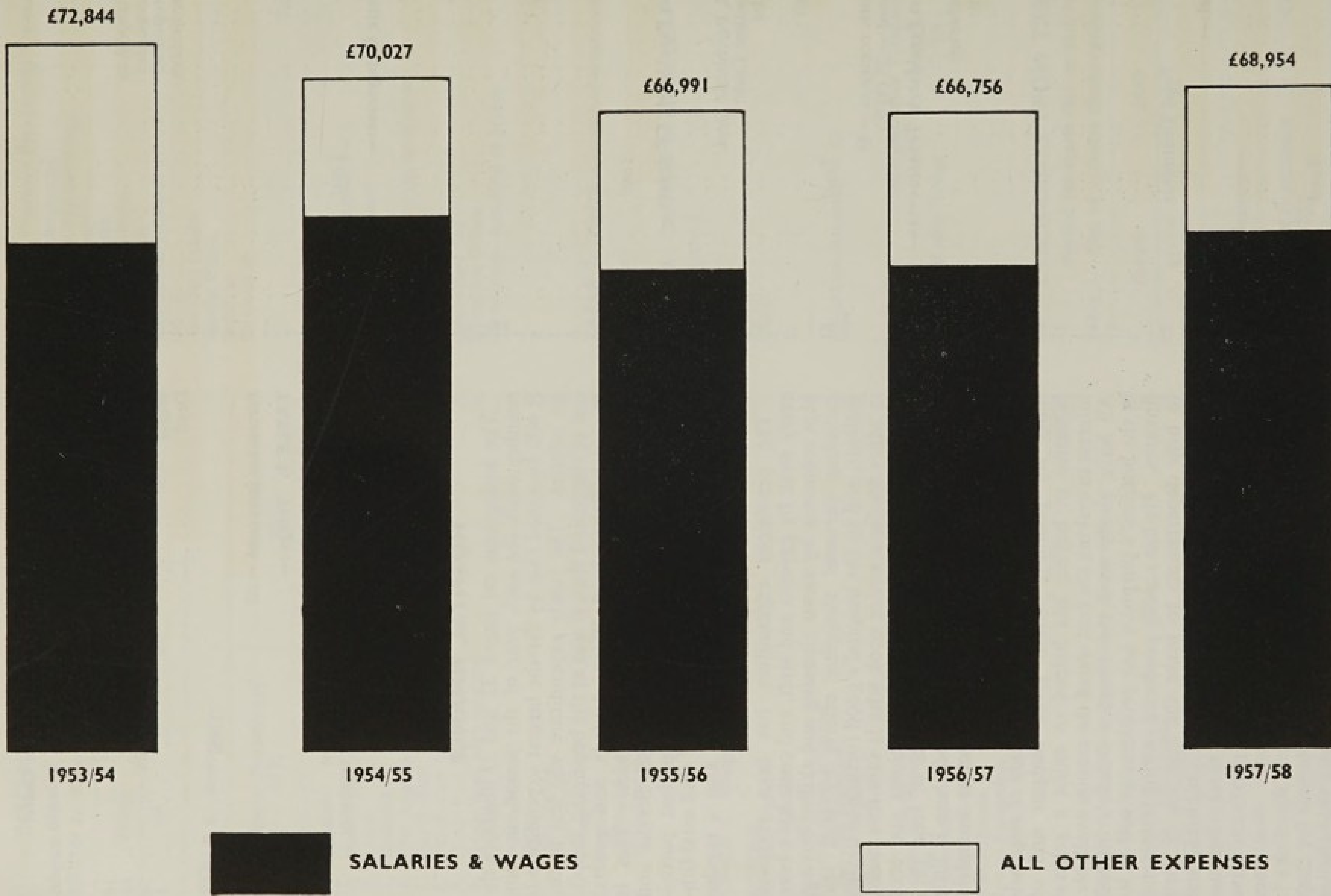
Not yet available.

HOSPITAL FINANCE

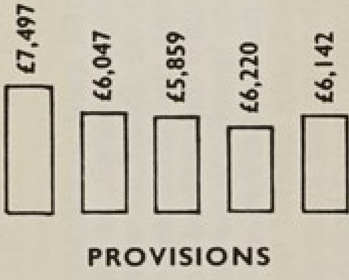
The histograms on pages 32 and 33 illustrate the running costs for each year of the period, *in toto*. It will be noted that by far the largest expenditure is on salaries. The yearly expenditure was less at the end of the period than it was at the beginning, despite National Salary and Wage Awards and general increases in the costs of commodities. This is probably unique in the National Health Service and was achieved mainly by increasing patient participation in the hospital; but reviews of staff establishments and general expenditure were also a regular feature at various staff levels.

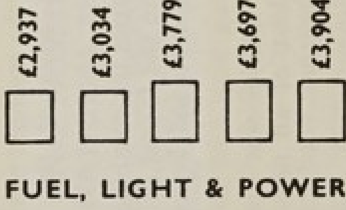
The provisions expenditure has been reviewed every week by patients and staff, and costs have been kept economic by menu planning and skilled buying, including personal shopping efforts by staff and patients, and by the hospital's good fortune in having in Mary Steifer a senior cook who is sure that eating good food is man's chief end. Patients and staff help themselves to the exact amounts of food they want in first and second helpings, and there is little wastage, so that the pig swill collectors complain of their scant reward.

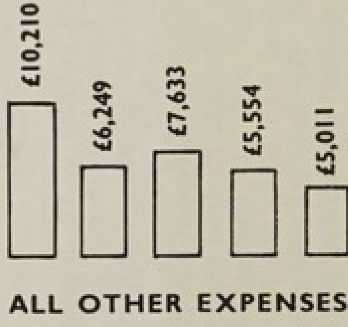
The devolution upon staff departments of responsibility for planning within given budgets and of initiative in buying has helped to enlist a general interest in making the best use of the monies available. All have gladly used the Finance Officer's interest in the hospital's purposes and problems as well as its finances. He has readily produced costing statements to help departments to make the best use of their money, has advised on departmental problems, and has interpreted regulations controlling these. Because of de-centralised control the staff departments have used their planning freedom to make economies knowing that the money saved in some directions is theirs to spend on others to produce benefit for their work ambitions. It seems to me a pity that similar

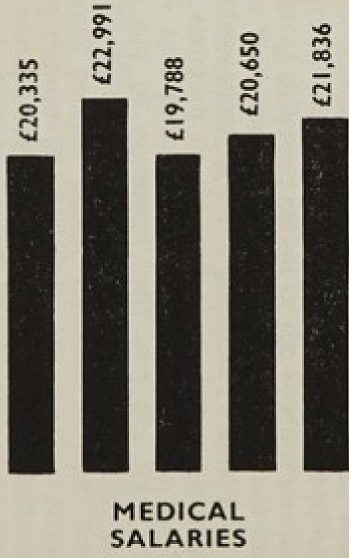

TOTAL EXPENDITURE
1953-1958
£72,844
£70,027
£66,991
£66,756
£68,954
1953/54
1954/55
1955/56
1956/57
1957/58
SALARIES & WAGES
ALL OTHER EXPENSES

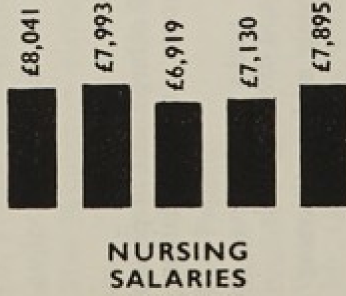
TOTAL EXPENDITURE 1953-1958











freedom to design expenditure within global sums has not been made by the Minister of Health to his sub units; perhaps he, too, would benefit in work morale and financial economies. I am quite convinced that this hospital could offer a better treatment service if it were given freedom to expend the total exchequer monies in its own way than by the present methods laid down for it.

The total expenditure in 1957 was the lowest on record since the Health Service began. In 1958 a rise in expenditure was due to the cost of salaries and wages, but all other expenditure was in fact the lowest of any year. I do not anticipate any further change in the hospital design, and the stage has probably been reached when increased salaries and wages of the future will not be offset by economies in other directions.

It is always a matter for question whether financial economies are true or only apparent, so I must give it as my opinion that the conditions of treatment actually improved during the period and that this improvement created rather than suffered from many of the economies made. It seems to me however to make nonsense of all the hospital's efforts that our doctor-time, the one and only essential for psychotherapy is grossly inadequate and uneconomic and fixed by bodies which however august have no proper knowledge of the hospital's working methods, purposes or needs.

A review made in 1954 of the essential medical and the " non-essential " hotel costs at the hospital showed the following:—

(*a*) Omitting medical salaries the combined standing and running charges were the lowest of neurosis centres in the Region and the second lowest in the country.

(*b*) The cost of medical salaries was the highest in the Region and the highest of all non-teaching neurosis hospitals in the country.

(*c*) Following from the above, the hospital spent a higher proportion of its budget on medical attention and a lower proportion on non-medical overheads than any other neurosis hospital.

These findings are unlikely to be different today from 1954 but the hospital overheads are still not justified by a high enough accompaniment of the one and only essential—medical treatment. The sole purpose of patients being in this type of hospital is that they should receive adequate medical treatment. If they do not, all other costs are uneconomic. The expenditure on medical staff being too low for the nature of the work the hospital economy is unbalanced. A high medical expenditure would better justify the " non-essential " costs.

GENERAL ADMINISTRATION

The system has continued that the senior hospital executive under the Management Committee should be the Medical Director. This method of administration places final responsibility in medical hands, so that all the work of the hospital is subordinated to and co-ordinated with medical requirements, but it requires delegation to administrative executives, who can accept with enthusiasm that their functions are in the long run medically aimed. In this the hospital is fortunate. Miss Mallion, Secretary to the Management Committee has also been my Principal Administrative Officer during the period.

With a maintenance staff of 1 electrician-handyman, 1 chauffeur-handyman, 1 stoker-handyman and 3 gardeners, Miss Mallion has carried out the day-to-day maintenance of the fabric of the hospital and 13 staff houses, has provided the essential services of lighting, heating, power, transport and has maintained 11 acres of garden; major works have been carried out by contract. She and her staff have year by year improved the fabric and maintained a proper standard of external decoration. There has been improvement of paths, fences and a re-conditioning of a greenhouse which had not been in use since the war. A neglected corner of the grounds has been cleared and made into lawn. During tree-lopping we were sorry to lose a 500 years old oak tree which had to be felled; a silver birch and a beech tree have been planted in its stead. The following are among the works carried out during the period:—

Repair to and renewal of floors and ceiling in various rooms.

Repairs to greenhouse.

Internal alterations to and enlargement of patients' washing and ironing room and installation of washing machines.

Resurfacing of hospital paths and drives and repairs to fences, gates and dividing walls.

Installation of steel shelving and partitioning of maintenance workshop.

Installation of extra section to hospital boiler.

Installation of fuel-economy stoves in patients' and staff common rooms.

Treatment of dry rot in a staff house.

New coping to Lawrence Hall roof.

Re-pointing of walls.

Repair of lead flashings and soakers.

Adaptation of bathroom for children's treatment room.

Providing a cross-over from public road to entrance to hospital furniture store.

Front porch of hospital treated for deterioration of fabric.

Three nursing staff houses converted into flatlets for nursing staff.

Installation of new domestic hot water boiler for hospital.

Renewal of glass roof to Ross Ward entrance.

VISITORS

The hospital has been honoured to receive many visitors—and somewhat embarrassed to find time to do justice to their interest. Thursday morning has therefore been set aside as the day on which visitors may come and see something of the work. We have welcomed doctors, nurses, health visitors, members of Management Committees, medical students, general practitioners, social science students, members of Parliament, editors, professional groups from Universities, etc. It is not proposed to mention visitors from the British Isles by name.

Those from abroad who signed the Visitors' Book were as follows; to the others, my apologies for omitting their names.

South Africa
Dr. Moross, Tara Hospital, Johannesburg.

Australia
Dr. Kerridge; Dr. Lindsay Wilson, Perth; Dr. Russell, Sidney; Dr. Benedek, Sidney; Miss P. Lee, Western Australia; Dr. Graham and Dr. Geroe, Melbourne.

Denmark
Dr. Prahm; Dr. Magnussen, Copenhagen.

Finland
Miss Nikulainen, Helsinki.

France
Dr. Duchene, French Ministry of Health.

Ghana
Mr. Pappoe.

Holland
Professor Baan, Utrecht University; Dr. W. A. Vandrager and Miss de Braconier, Utrecht; Mr. G. L. Lie, Leyden; Dr. P. J. de Smet, Hailoo; Dr. Arendson Hein, Arnhem; Dr. Polavsky, Utrecht; Dr. Kulper.

Israel
Dr. Neuner, Dr. Kulscar, Acre; Miss R. Shamah, Jerusalem.

New Zealand
Dr. Pritchard.

Norway
Dr. Thomstead, Oslo; Dr. Dahl, Ulleval Hospital, Nr. Oslo; Dr. Askevold.

Portugal
Dr. Mendes, Lisbon

Sweden
Dr. Greyez, Vadstena.

Switzerland
Dr. Schneider, Lausanne; Miss Minlethaler, Minsinger.

Syria
Dr. Hayek, Lebanon.

Tasmania
Miss Leonie-Martin.

United States of America
Dr. D. Rappaport, Mass.; Dr. R. Knight, Stockbridge, Mass.; Miss Coholaen, California; Dr. R. Cohen, Washington; Mr. Rosenthal, University of Chicago; Dr. Tureen, Washington University; Dr. Taylor, University of Philadelphia; Mrs. Tudor Will (World Health Organisation) of U.S.A.; Miss Maughton, New York; Miss Auffhausen, Yale; Commander H. Wilmer, U.S. Naval Hospital, California; Dr. M. Schwartz, Rockville; Dr. A. Stanton, Boston; Dr. Lillesker, New York; Lt. Denis Briggs, Navy Department; Miss Stone, U.S. Navy, California; Mrs. Marcella Davis; Dr. Solomon, Illinois University; Miss Farmer, Boston; Miss Rains; Dr. G. N. Raines, U.S. Navy; Dr. Seymour Perlin, National Institutes, Washington; Dr. Savage and Dr. Wynne, National Institutes, Washington.

Miss Dryer, World Health Organisation European Nursing Consultant.

50 Members of the 18th International Psycho-Analytical Congress.

THE HOSPITAL AND THE NATIONAL HEALTH SERVICE

The end of the period saw the tenth anniversary of the advent of the National Health Service. When the hospital opted to enter the Health Service in 1948 those who were guiding its destinies were concerned as to whether a State organisation could guard and promote the interests of a hospital such as this, with specialised and little understood function, and consequent administrative requirements liable to be little understood by lay or even medical committees familiar with the needs of more usual types of hospitals. The danger was not that the hospital would be changed by massive decree—general goodwill could be assumed—but rather by numbers of minor regulations quite appropriate for most psychiatric hospitals and by administrative shibboleths of standardisation and years of making precedents. By a multitude of minor changes, each acceptable by itself, there was a danger that the hospital might be changed by procrustean methods of making it fit the Health Service.

To some extent that danger loomed large in the first five years when the Health Service authorities were having to cope with urgent massive problems in

hundreds of hospitals by unpaid lay committees who had little time to study the problems of individual hospitals or to make administrative rulings that would encourage differentiation of function. During the period just reviewed, however, this danger receded. It is true that many criticisms of the Health Service can be made and certainly the National Health Service authorities offer a convenient target for abuse. But it is likely that without the Health Service different, perhaps more numerous frustrations, arising from the falling value of money, would have occurred, without the benefit of knowing who to blame for all the hospital's troubles! The fact is that The Authorities have increasingly endeavoured to understand this hospital's needs, to allow for its special functions and to tolerate with courtesy our protests on occasions when the hospital's requirements have not fitted in with rulings which most other hospitals would find acceptable.

The major disadvantage of the National Health Service for this hospital is this: that while the National Health Service offers a Specialist career in Psychiatry, it offers none in Medical Psychology. The effect of this is that the medical staff numbers, appointments, gradings and salaries in medical psychology tend to be geared to the staff numbers, qualifications and training for psychiatry, and designed by psychiatrists, and not by medical psychologists. One effect of this is that doctors who are well trained in the speciality of medical psychology find their skills officially undervalued. The anomaly arises that if they incidentally have degrees and diplomas of high value in general medicine or psychiatry but of little relevance to medical psychology their appointment to senior posts in medical psychology is not difficult—*but not because of their knowledge of medical psychology*. It is only fair to add that the appointment committees have never appointed to the staff any doctor who was not *interested* in medical psychology, but within the hospital it is by no means unknown to find a doctor, expert and well qualified in medical psychology, working as a junior under a senior who is well qualified in medicine and psychiatry but a mere beginner in medical psychology, ready to listen to his junior and learn from him. This absurd and unfair situation affects only the small specialty of medical psychology and it cannot be expected that any pressure of opinion will arise to change the situation. It may be more than another 10 years in the Health Service before this handicap to medical psychology in the National Health Service is modified.

CONCLUSION

The National Health Service has provided a Management Committee which under its Chairman, Sir Francis Cassel, has been at pains to study, follow and reinforce the work of the staff. It is a delight to me to work with them, and their staunch interest in, and concern for, the hospital are a great support to all the staff.

Although this report is written in the first person singular what it describes is the result of the thought and effort of many people over five years of their lives. The report itself has relied much on the work of the Medical Secretaries, the Senior Psychologist (who prepared the patients' statistics), the Finance Officer, the Matron and the Principal Administrative Officer, all of whom prepared the appropriate sections of it. To them and their staffs and to my medical colleagues I owe a five years' debt of gratitude.

Report of the Medical Advisory Committee

During the period under review there have been changes in the activities of the Medical Advisory Committee. Between 1953 and 1955 it was the forum at which important issues of medical policy were debated and recommendations made to the Management Committee. In 1955, parallel with a reorganisation of the social structure of the hospital, the existing Medical Advisory Committee was disbanded and a new one was formed. The new Medical Advisory Committee extended its scope in the direction of being a Hospital Medical Committee and thus a forum at which all matters of interest to the medical staff could be discussed and, where necessary, recommendations made to the Management Committee, but without the particular emphasis of its being a body for the working out of hospital medical policy. The introduction of regular heads of Firms' meetings enabled issues of policy to be formulated there. More recent activities of the Medical Advisory Committee have included discussions and, where necessary, appropriate action, on such topics as liaison with other clinics and with local medical facilities, assessment of the effectiveness of channels of communication within the hospital, a review of the status of some of the medical posts and the initiation of certain social activities.

ALEXIS BROOK

Hon. Secretary.

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