The Education of the Psychiatrist of Tomorrow†

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It is said that psychiatry is dead or at least dying, and that its great days are past. William Faulkner told us that the past is never dead, that it is not even past. But what may be past or passing is the more limited professional role which psychiatrists played earlier in this century. We are more numerous, more diverse in function, and society calls upon us to serve many needs, for some of which we are ill-prepared.[1]

Obviously, few matters could be of more importance to the future of our profession than how its young are prepared. We have learned that a profession, unlike a craft, cannot be satisfied with customary procedures. We must constantly search for means to organize and use intelligence in new ways. Such a search may help us to learn that which is essential and basic to our task, that which may be found appropriate and useful to our purpose and to the changing needs of our society.

Earlier I have drawn attention to the evolution of our educational programs. Before World War II, the situation facing the candidate for special training in psychiatry was not very promising. There was no regular curriculum and periods of study and experience, following the internship, were usually one or two years. There was a limited number of fellowship opportunities afforded by the Rockefeller Foundation and the Commonwealth Fund. A few took advantage of the fellowship to obtain psychoanalytic training abroad, fewer attended Queens Square Hospital in London for neurological training. Most of the recipients took resident training in the available psychopathic hospitals, such as I undertook in Colorado in the middle 30's. Others without fellowship assistance obtained training in the large public and private hospitals of that period.[2]

Since the end of World War II, the single most important determinant of change in the academic departments of psychiatry in the United States was the enactment of the National Mental Health Law passed by the 79th Congress in 1946. This law made possible substantial, even generous, funds for education and research. In the three decades which have elapsed since then, there has been a truly remarkable growth in the number, the size, and in the diversification of function of our academic departments of psychiatry. This growth has been influenced by many

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factors. There have been political factors such as the federal subsidy of education and research, later the provision for health insurance for the aged and the poor, and the community mental health movement. Psychosocial factors included the exponential increase in the modes of psychotherapy and together with political influence, led to the notion of the open hospital, the therapeutic community, deinstitutionalization and the championing of the rights of the disenfranchised. Parallel influences included biological and clinical factors. This trend has been called Neo-Kraepelinian with its serious considerations of genetics, greater precision in noting signs and symptoms of disease, charting of the natural course of illness and follow-up study of the effects of intervention on prognosis. In essence, the introduction of Rauwolfia and chlorpromazine in the earlier 50's and their daily use by practicing psychiatrists have returned psychiatrists to their biological heritage and drawn attention to the neurobiological as well as the motivational model as explanations of illness. This has led to a more balanced view of psychopathology explicable not only in the paradigmatic terms of unconscious psychologic conflict, but also in terms of deficit.

As to the major changes since 1946, most briefly there are about 300 approved programs and about 4,800 residents in training. Of the 300 programs, about 10% are in child psychiatry, 60% in general psychiatry, and 30% in combined general and child psychiatry. Our professional journals inform us regularly about these programs; namely, as to the administrative sponsor, geographic location, number of residents who are graduates of foreign medical schools, and the special problems to be met when their numbers will be decreased, and the limited number of residents enrolled in 5th year programs.

Most recently, there appears to be a leveling off in the number of psychiatric residents and a decrease in the number of medical students who choose psychiatry as a career.

For obvious reasons, the programs have changed over the years. Initially, they were quite informal and apprenticelike. With the increased number of residents, programs became more formal and structured, more didactic, less personal and with an expanded set of clinical assignments. From the beginning, the majority of assignments included inpatient, adult and less often child; outpatient, adult and child. Other assignments, at times happenstance or elective, often designed for service need more than for educational purpose, included the emergency service; consultation on the medical, surgical, obstetrical, and pediatric inpatient floors and outpatient clinics; assignments to large state hospitals for chronic illness; to courts, jails, prisons, and institutions for delinquent children and adolescents; rarely to institutions for the retarded and epileptic, and more recently, to community outreach and store-front clinics.

Before World War II there were few scientific investigators available as models with whom the young resident could become engaged in

ongoing research. During my salad days in the 30's, psychiatry had no Rockefeller Institute to groom its young professors as was the case in medicine and physiology. We had to wait almost 15 years before NIMH became a reality. Our model was the clinician, teacher and scholar, and later the psychoanalytic psychotherapist practitioner. We did not have a high regard for the occasional psychiatrist called the medico-legal, or forensic specialist, the alienist. They usually were quite distant and foreign to the center of our educational concerns. While some programs were strictly monistic, most avoided the extremities of the psychophobe and the biophobe. Pluralism, then, as it is now, was concerned with the determinants of behavior from genetic, biologic, psychologic, and interpersonal factors, all of this in a developmental time sense of phases of growth. In general, the curriculum reflected the beliefs, experiences, and prejudices of the senior faculty and was determined too by the physical setting and the patient populations admitted for study.

Regrettably, the distance between neurology and psychiatry increased to the detriment of both, and only in the past decade because of the drugs has there been a more viable relationship with pharmacology. Before we speak of the future, that is, how best to prepare young men and women who are entering the field at this time, let me outline briefly what I believe have been some of the achievements of the past 30 years and then discuss some of the areas in which we have not done as well as we had hoped to do.

I have dealt with these matters in detail on other occasions, but shall at the moment, just mention them briefly.

The goal set in the 40's to increase the number of professionals in the field was surely reached. During my professional lifetime, the increase in the number of psychiatrists changed from less than 2 per 100,000 to almost 12 per 100,000. Furthermore, with this increase in numbers, there was a parallel increase in the diversity of their function. Earlier in the century, with rare exception in forensic work (the alienist) and occasionally in the children's clinic, most psychiatrists were found in the large public and private mental hospitals. Today, most of them are found in the general and the special practices of psychiatry in the community with special interests in child or adult, or both, utilizing a broad range of psychological (individual and group), pharmacological and physical approaches to treatment. Others are associated with legal, penal, educational, industrial, health and welfare agencies; less often with laboratory, clinical, psychosocial and epidemiological research, and still others with full-time administrative responsibilities in clinics and hospitals and in community planning.

Another goal that appeared to be fully achieved was that of the establishment of psychiatric units in general teaching and community hospitals. As stated earlier, due to the generous support from federal funds, with the appointment of full and part-time faculties, and due to the Hill-Burton Program, which provided aid for hospital construction,

a very considerable number of psychiatric units were built in university teaching hospitals and in community hospitals.

With these services in the general hospitals, there came significant changes in the perception of the psychiatric service by the public, as exemplified by the growing use of ambulatory services, including the hospital emergency room, as a primary source of medical care. Psychiatric service in the general hospital made possible the study and care of acutely psychotic patients, patients with organic brain disease, occasional disabled neurotic patients, and limited services for addicts and alcoholics, and chronic patients at points of crisis. In addition, it cared for others not ordinarily seen or treated by psychiatrists. It also made possible the development of interdepartmental programs with our sister clinical discipline, with several of the preclinical departments, and with psychology, biology, statistics, and the social sciences in the medical school and in the university-at-large. Obviously, the psychiatric units in the general hospitals, splendid as they are, fulfilling many urgently needed clinical services, as well as their multiple educational functions and opportunities for research, did not, could not, solve the problems relating to chronic mental illness. In some ways they compounded the problem by the further separation of the chronically ill and their sequestration in the large, long-term hospitals. Those of us with community mental health centers within the university department have begun to share some of this responsibility, but there remains a considerable gulf between caring for the acutely ill and caring for those who are chronically ill.

Later, with the introduction of milieu therapy and the therapeutic community, the psychiatric nurse, the clinical psychologist, the social worker, and increasing numbers of paraprofessional persons assumed new and independent roles, both in diagnosis and treatment.

It is difficult to know how successful we have been and whether we have achieved our goal in the teaching of all medical students. Personally, I believe that this should be one of the major objectives and goals of the academic department of psychiatry, but I also know that there has been considerable variation among the departments in their interest and devotion to the teaching of the medical student.

Regrettably, from our personal experience in the liaison programs with medicine, pediatrics and obstetrics, I do not believe we have achieved the goals that we had in mind many years ago and in fact we find the liaison programs have led to a downgrading and deterioration of the psychiatric consultative services.

Another goal, only partially achieved, was the recruitment of residents into full-time research activities. Since my return to clinical research after many intervening years as Department Chairman, I noted that only a limited number of clinical psychiatrists are engaged in basic or applied clinical research. This has been a disappointment particularly for those of us who initiated the Career Investigator Program of the

Public Health Services more than 20 years ago. I gather that my sample of experience may be valid for the nation as a whole.[3]

Quite independent of the American academic departments, two developments revolutionized our field. As Klerman has pointed out in a recent splendid review, both occurred in the early 1950's.[4] One was the introduction of Rauwolfia and the phenothiazines, the other was the introduction of new psychosocial methods of treatment, introduced for the most part by several courageous and innovative superintendents of mental hospitals in Great Britain, who opened the doors of their hospitals and eliminated restraints. The concept of the therapeutic community became the rallying slogan of the hospital reforms of the 50's. The mental health care system changed markedly as a consequence of new technology, shifts in community attitudes, altered professional practices, and changing public policy. The sum total of these trends has been a shift from inpatient to ambulatory care, from institutional to community settings, and from the public to the private sector. From almost total reliance on a system of involuntary incarceration and treatment in public institutions, there was a shift to a voluntaristic and pluralistic system.

But, as we should have known from past experience, reform movements often create more problems than they solve. For example, we have become aware of the adverse neurologic complications of potent drugs and realize that the psychiatrist of tomorrow surely must be better grounded not only in pharmacology but in achieving greater precision in clinical diagnosis.

Our own community mental health programs also emerged from this movement. Regrettably, its critical phases were launched without adequate systematic experiment and trial and as a result, many chronic psychotic patients, who had long been institutionalized with absent or long-lost social skills, were catapulted into the community without adequate means for their care. Chronic illness is not a myth and cannot be removed by sweeping it under the rug of ill-prepared community facilities.

With the movement out of the mental hospital and into the community, we not only became more aware of the adverse neurologic complications of potent drugs, but even more aware of the limits of our psychosocial technology, particularly with the results of group therapy with schizophrenic patients.

A third problem is the demand for social control. What are the limits of even an enlightened society to tolerate, to integrate, deviant behavior? The limited capacity for many chronic patients to lead independent social lives generates complex issues for public welfare, urban zoning, health-care agencies, and legal institutions. In these matters, civil libertarians and other critics are becoming more and more concerned about the ethical aspects of institutionalization and deinstitutionalization.

As for the future, let me repeat what I said on an earlier occasion. The

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

How best to prepare for the future? At the risk of being obvious, let me mention briefly what I would consider to be basic and essential in the education of the psychiatrist of tomorrow.

I would hope that he or she would have had a liberal education in the preparatory collegiate period. One that not only did justice to physics, chemistry, biology, and mathematics, but also to psychology, the social sciences and the humanities.

Second, I would hope that the medical education was equally liberal in terms of adequate exposure to and experience with all the major aspects of modern medicine. Third, I would hope that one day we may be able to return to the free-standing internship as a preparation for clinical psychiatry. The current compromise arrangement is far from satisfactory and many psychiatrists start their career training inadequately prepared as physicians.

During the residency period, I would hope that the period would be conducted in a broad conceptual and therapeutic frame of reference involving biologic, intrapsychic, and interpersonal systems — and interactions with one another, plus a developmental approach to such. This would require adequate sampling of patients, rich and poor, young and old, black and white, those subtly ill and those with florid symptoms. It also would require an ambiance of pluralism and an insistence on critical perceptiveness of data and openness to new information and experience.

At the moment, you are probably aware that a major thrust of our government is the support of what is called primary health care. The Public Law includes internal medicine, pediatrics, family medicine, and perhaps OBS/GYN to be essential in the preparation of those who will be engaged in primary health care and in family medicine. For one reason or another psychiatry was omitted both as a necessary discipline in the preparation of such persons and also omitted in the role of guide and counselor in the practice of primary health care. I believe the undergraduate education of the medical students in the field of psychiatry serves as a necessary foundation for those who engage in primary health care. I also believe that there are going to be increasing

demands on these primary health care providers to meet the mental health needs of their patients and their families.

While it is unlikely that the psychiatrist will become a full fledged primary health care provider, certainly he can come closer to those who do provide such services in order that he may contribute his skills and knowledge beyond the walls of his hospital or his office. But it seems apparent that there is no system that is exclusively primary health care. There is need for more psychiatrists to serve as guides, exemplars and consultants to those who serve the sick in clinics, neighborhood health centers, social and health agencies and the courts. When you examine the practices of the internist, pediatrician, gynecologist, it is obvious that their practices are limited either to acute illness, to the age of patient, or to gender.

What is the setting in which the medical student makes his eventual career choice? There are those who believe, and my limited personal observations across the country seem to substantiate the belief, that the medical school, as a whole, is in a state of dysphoria academia. At least it appears to suffer some degree of pleasure deficit. Few good things seem to happen.

There are feelings of indignation and resentment, even of abandonment, on the part of many members of the faculty when faced with marked reduction of the accustomed federal largess for education and research.

Because of the exponential growth in the number of faculty and the narrowed interests of many special groups; with the reduction, if not the elimination, of earlier-day generalists there is less intimacy between departments, and few department chairmen are capable of citizenship in the medical school-at-large beyond the special interests of their department.

Because of current financial stringencies, many, if not most, full-time clinical teachers must now sing for their supper; that is, earn their keep by seeing sufficient numbers of private patients in order to insure their salaries. As a consequence, teaching, even more than their research activities, is sacrificed, particularly the teaching of the medical student.

The omnipresent anxiety and competition for promotion to tenure are heightened oftentimes with the application of criteria appropriate for preclinical appointments, inappropriately applied to clinical appointments, with many negative consequences.

Deans are worried, harrassed,and now separated from their faculties by increasing numbers of internuncial associate deans, assistant deans, and administrative officers assigned to graduate studies, extramural affairs, student affairs, physical plant, alumni, public relations, and community relations. We have become more complex and at times seem to founder in a sea of memos. Deans' responsibilities for university hospitals also carry the great burden of prodigious financial deficits, which, in turn, oppresses the university-at-large. These matters

have not only made deanship less than attractive, but also may account for the limited tenure of many chairmen in the past ten to fifteen years.

In this general ambiance of disquiet, most of my colleagues with whom I meet, talk, and take lunch, believe that the future will almost surely bring some degree of administered medical economy, even though they are not sure when or how, and it makes them anxious. I sense, also, some degree of petulance and sulking, of reluctance to face the realities of the day, to become more accountable, and to consider how best we can use our intelligence and experience to meet these cost containment challenges to our responsibilities to education, clincal service, and research.

Departments of psychiatry share in these feelings. They are concerned about money, the added cost of the internship, the cutback in the number of residents, which, in turn, affects patient care provisions and at times leads to reduced hospital census, which, in turn, makes for more trouble with reduced income.

Our medical students and residents look about them in the urban areas, with which they are familiar, and believe that they appear to be saturated with practicing psychiatrists. There is the overall question which I dealt with earlier, of the fundamental concern of the psychiatrist with the definition of his professional role, namely, who am I and what am I to do differently from the others. I can assure you this concern is clearly perceived by students and residents. And with this there are the understandable disappointments when earlier expectations are not fulfilled. Perhaps we have awakened to too many false dawns: the somatic therapies of the 30's, the psychotherapeutic exuberance after World War II, the sociopolitical venture of the community mental health programs, with the mixed blessings of deinstitutionalization, and the neuroleptic drugs.

Particularly in reference to the theme of this conference, we should examine carefully our relations to the law, the court,and the criminal. We may have promised more than we are able to give, but there is little question that we have added considerably to the humanizing of criminal justice in our search for the psychological antecedents of deviant behavior. Because of the ambiance of mistrust, we must do what we can to create a better understanding between law and medicine. We appear to live in different universes and, at times, to speak to each other only in tongues. I would hope sincerely that our teaching programs of the future provide adequate means for each resident to learn at first-hand some of the basic problems of diagnosis and treatment of patients whom they will see in the courts, jails, and prisons of our day.

I have learned a great deal from my associates, Drs. David Barry and Richard Ciccone. Dr. Barry has pointed out the important functions of the court clinic as a portal of entry into the mental health care system for a group of patients, predominantly young, non-white male of lower socioeconomic status. Many of these persons who otherwise would not

receive psychiatric care can be identified and treated when the clinical services are located in close collaborative proximity with those who direct the criminal justice system. Not only does the psychiatrist have to learn how to respond to the needs of these patients, but it is equally important how the judge and the lawyer and others in the legal set look upon behavior called deviant. I commend statements made earlier by Jonas Rappeport and Alan Stone that we declare the rationality of our treatment programs and our right to treat patients with the best possible facilities and in the best manner, according to our professional judgment, without costly and legal trappings.[5,6] If you have not done so, may I recommend that you read the *Apologia pro vita sua,* literally entitled "Defensive Psychiatry, or How to Treat the Mentally Ill Without Being a Lawyer" by an eminent clinician and old friend, Zigmond Lebensohn.[7] Among other matters, he quoted from the commencement address given to the graduates of our medical school in May, 1974 by W. Allen Wallis, the Chancellor of the University of Rochester:

> Probably few of you realize, that before your careers have run their courses those lawyers (who are now graduating from law schools all over the country in even larger numbers) may have more influence than you have over what you do, how you do it, and how you are rewarded.
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> You may find lawyers defining the range of treatments that you are allowed to use in specified circumstances. Lawyers may prescribe the criteria by which you are to choose among the allowable treatments. Lawyers may specify the priorities you must assign to different patients. Lawyers may require you to keep detailed records to establish at all times that you are in full compliance. Lawyers may punish you unless you can refute beyond a reasonable doubt their presumption that your failures result from not following all of their rules, regulations, and requirements. And lawyers may decide what incomes you deserve.
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> Should you have the temerity to differ with the lawyers, you will be backed by the authority of your knowledge, your science, your skill, your art, your experience, your judgment, your dedication, and your conscience. Which is to say that in the eyes of the law you will have precious little backing; for knowledge, science, skill, art, experience, judgment, dedication, and conscience — whatever else their merits — do not constitute due process of law.

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