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Norman Sartorius: A personal history of psychiatry

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Abstract

As part of the intention to document the recent and current history of psychiatry, I was asked to present memories of my involvement in psychiatry over the past 50 years. Reviewers suggested that I should start this personal history of psychiatry with a summary of my curriculum vitae because this will make it easier to place the events I describe into their historical context. Here it goes, then.

Keywords

psychiatry, history, development

BIOGRAPHICAL NOTES

I was born in Germany (in 1935) where my mother, a paediatrician worked at the time. At the age of two we came back to Croatia then part of the Kingdom of Yugoslavia, my mother's home country, and at the age of six I started elementary school in a provincial town. In the midst of the Second World War my mother joined the Yugoslavian resistance against the German occupiers and their local helpers, and we spent the subsequent war years in the forests and provinces of Croatia where we experienced war at its worst. At the end of the war, we came to Zagreb, the capital, where I completed secondary school in 1952.

I graduated from medical school in 1958 in Zagreb and from the faculty of Psychology in 1964. Late in 1967, I joined the World Health Organization (WHO) to work on epidemiological and social psychiatry. In 1973, I became the Head of the Mental Health Unit of WHO; the Unit was elevated to the level of an Office of Mental Health in 1975 and in 1977 became the Division of Mental Health, of which I was the first Director until 1993, when I retired to take a professorial post at the University Department of Psychiatry in Geneva. Much of the work that I did at WHO was done in the field, and during my years at WHO, I usually spent a third of the year travelling to the many countries that participated in WHO's mental health program or expressed their intention to do so.

I also had professorial appointments in several other universities in the USA (St Louis, New York, University of Florida), the UK (London) , China (Beijing) , Czech Republic (Prague) , France (Paris), Croatia (Zagreb and Osijek) and Serbia (Belgrade) and I was honoured by doctorates, awards and fellowships in other countries. In 1993, I was also elected President of the World Psychiatric Association, and in the year 2000, President of the European Psychiatric Association. Soon after that, we created a non-governmental, not- for-profit organization the Association for the Improvement of Mental Health Programmes, of which I am currently the President.

In the course of my life, I had the opportunities to see psychiatry and public health in action in most countries of the world and on the international level. I also had the privilege of meeting psychiatrists and others involved in mental health matters worldwide and the opportunity of leading a number of major international studies on schizophrenia, depression, mental disorders in general health care, the classification of mental disorders, quality of life and psychiatric aspects of health care in general. What follows is based on the experience and memories of the past fifty years of involvement in psychiatry, public health and international life.

GOING INTO PSYCHIATRY

I did not put psychiatry as a top choice for my postgraduate training – the same as I did no put medicine as a top choice for my studies. After some hesitation, I entered medical school because it was a family tradition to have at least one doctor in each generation and it looked natural that the oldest boy takes

this on. Once I completed my medical studies in 1958, I stood before the choice of specialty: I wanted to take on paediatrics – but did not because my mother was a famous paediatrician and I felt that I would be constantly compared to her; nor ophthalmology, my second choice because there were too many candidates for that and many were better placed because of their political credentials.

Psychiatry was the third choice: but there was also the difficulty that it did not have posts for which I could compete for: after some hesitation, I entered psychiatry as a volunteer and spent the first couple of years working without receiving a salary. This was not unusual: in the 1960s psychiatry in Yugoslavia was – as in many other countries – the discipline that offered fewest positions for specialty training because it was among the last on the list of priorities considered by the government and the medical establishment. There was also a limit to the numbers of volunteers – it was not considered particularly important to produce more psychiatrists regardless of cost.

EARLY YEARS OF WORK, PSYCHIATRY IN YUGOSLAVIA

All of this was happening in what was then Yugoslavia not too long after the end of the Second World War (1939–1945), which devastated the country and its resources. As promised during the war and as usual in countries of Eastern Europe after the Second World War, health care was provided free of charge for most patients. The exceptions were people in the 'free professions' such as artists or lawyers who had a private office and were not employed in government or its institutions and companies: they had to pay for their health care.

The resources offered for general and specialist health care were meagre but neither this nor the consequent hardships were surprising to anyone: the war had shown that survival is possible without too many of the amenities that we today consider as essential – such as clean water, decent clothing, regular food intake (occasionally including meat), medications, interventions and responses to other demands on time or at least soon.

For me, the tolerance of hardship was even easier. Having spent the second half of the Second World War with the resistance in the forests, I did not even know that things need or can be different: during those several years, scarcity of resources mattered little if survival was likely.

The first day of my service in the psychiatric department, in 1960, nearly ended my engagement. I came to the department at 7 a.m., at the time when patients with the diagnosis of schizophrenia were being awakened having been in an insulin coma for half an hour or so – this being in many countries then a popular form of treatment for schizophrenia. The awakening was accompanied by screams of patients and shouting by staff; other patients were seated in their rooms waiting for their breakfast apparently oblivious to the cries and shouting. I was profoundly distressed: what I was seeing and hearing was very far from psychiatry as we imagined it or for that matter from medicine as a humane discipline. The senior psychiatrist who received me spent a good part of the morning telling me about the benefits of insulin coma in the treatment of schizophrenia and of electroconvulsive therapy, both of which had been widely used for the treatment of schizophrenia and bipolar disorders in the 1960s. But I remained, to a large extent, unconvinced.

I am writing about the surprise that I had on seeing the department of psychiatry in action, to underline the fact that the education of psychiatry in the undergraduate curriculum did not include much contact with patients or presence in a department of psychiatry or in a mental hospital. In addition to some 30 hours of lectures of psychiatry, we did have to see a few patients and provide reports on interviewing them in the fifth year of our undergraduate studies – but, we saw these patients in a consulting room, for an hour or so; these patients were also often interviewed by many students that made the interview fluent, the patients volunteering information about their symptoms in a manner that made the diagnosis easy. Patients selected for presentation to students or to give them psychiatric history were decently dressed and generally well behaved.

PSYCHIATRIC SERVICES IN YUGOSLAVIA IN THE SIXTIES

The department of psychiatry in the university hospital had, despite these impressions, many attributes of a medical establishment. There were nurses and doctors, rooms usually with no more than 10 beds, clean towels and bedsheets, food served like in the other departments of the hospital, medications distributed at regular intervals. This was very different from the situation in mental hospitals where the number of staff was often small, the facilities were overcrowded and the treatment – if any – consisted of heavy sedation and various forms of shock – including Metrazol convulsive therapy, electroconvulsive therapy, insulin comas and 'stimulation' by smaller doses of insulin to 'awaken appetite and cheer patients up'.

The notion that patients had rights was not made explicit to patients, their families or to medical students; it did influence the treatment provided.

There were exceptions, psychiatric hospitals that were providing decent mental health care; these were of better quality because of exceptional people who were directing them and not for any other reasons. In a small town not far from the capital city of Croatia, for example, there was a hospital with some 800 beds, and one psychiatrist, also its director. The patients were engaged in farming and maintenance of the hospital. Women with chronic mental illness who did not have a family or anyone to look after them stayed in hospital and were given the charge to care for one or two severely handicapped children – and performed remarkably well. Apart from the chief cook and one assistant, all the kitchen staff were patients. All other hospital chores were done by patients. There were 2 acute wards but patients did not stay long in them – some of them whose health improved rapidly were sent home and others got engaged in work in the hospital. The director of the hospital did not believe in work therapy as it was practiced in many places – for example, by teaching patients from rural areas how to use a typewriter or how to produce toy animals from rags: he felt that people who were admitted to his hospital should be engaged in activities that have a meaning and immediate results useful to the patient and others.

Psychotherapy in Yugoslavia at that time, in all its forms and particularly analytically oriented practice was not considered appropriate for practical and theoretical reasons. Practically because the training in psychotherapy was expected to take much time and there were few qualified teachers who could provide it; and theoretically because of the then dominant notion in socialist block countries that mental illness occurs because of the impact of the malfunctioning (capitalist) society distorting relationships between people and leading to mental illness and that therefore in a socialist society the mental illness will not present many problems.

During the early 1960s, Freudian postulates were not formally accepted and some of the more unusual psychoanalytic theorems were considered ridiculous. The clinic in which I worked at that time had a small group of psychotherapists protected by leaders who were not only skilful in psychoanalysis, but also had solid political positions and links to the government. They were not fully involved in the work of the department usually overcrowded by people with psychotic disorders, delirium tremens and various other acute conditions but provided teaching to residents and medical students and treated patients whom they considered suitable for psychotherapy among those coming to the outpatient psychiatric department of the (general) hospital or directly to them sent by their friends or colleagues.

PHARMACOTHERAPY

The arrival of chlorpromazine in the late 1950s was wonderful news – followed soon after with news about other medications of varying effect and side-effects. The medications were supposed to be effective in controlling specific symptoms and we listened and read with fascination about the precision with which target symptoms could be eliminated. We felt that it has finally become possible to be like other doctors who could prescribe a specific medication to deal with a particular syndrome or symptoms. For a few years in the late fifties and early sixties getting hold of new medications was not easy in Yugoslavia but then pharmaceutical industry geared up and provision of several medications became steady.

The position of representatives of pharmaceutical industry also underwent a change during those years. In the early fifties, they were rarely seen at the department and when they came, they had to wait to see the chief physician, like anyone else. As years went by, their role changed. They were now offering help with attendance at congresses, provided money for research; they no longer waited with others in the waiting room but were seen as soon as they arrived. The early 1960s also saw an increased number of journals dealing with psychiatry and of other publications about medications and about various other matters. The avalanche of psychopharmacological tools and the prospect of finding biological causes of mental illness soon overtook all other approaches to the problems of mental illness. The excessive emphasis on biological psychiatry that was created at that time brought about a reaction of those who emphasized the importance of social factors in mental illness and of 'remaining a doctor rather than a pill pusher'. Emphasizing social factors and social psychiatry was dangerous for one's career in some countries where 'social', 'socialist' and related words were an indication of communist leanings: Senator McCarthy's court cases in the USA and other symptoms of the cold war touched psychiatry as well. Thus, for example, the first meeting of the World Association for Social Psychiatry in London in 1964, was convened at the same time and in the same city as another 'biologically oriented' meeting: colleagues from the West who attended the social psychiatry meeting were not telling others that they attended it. Similarly, but for different reasons, Eastern European psychiatrists were avoiding social psychiatry possibly to remain respected by the majority of psychiatrists in their countries with prevailing biological orientation in psychiatry.

ROLE PF PSYCHOLOGY

After completing my education in medicine and completing training for the title of a specialist of psychiatry and neurology (which were still the same specialty at the time in 1963), I continued studies to obtain an MA and PhD in psychology. The psychologists at the time – if not in teaching positions in schools or the university – were employed in schools, industry and the health system. In the latter, they served in a manner similar to that of a laboratory: psychiatrists would send them patients to examine their IQ and possibly give them some other tests. They would report on their findings and results of the tests without seeing the patients after that (unless a second assessment was considered necessary by the psychiatrist who was looking after the patient. The psychologists' opinion about the mental illness of the person who was sent to them was not requested nor necessarily considered cogent for clinical practice. They rarely came into the department where the patients were accommodated. I was interested in psychology because it provided information about normal psychological functioning and about research methods both of which were not covered very well by the graduate training in psychiatry.

In 1965, I obtained a British Council scholarship and spent the next 20 months in England where I made friendships that last to the this day and learned a lot, particularly about doing research in psychiatry.

THE YEARS WITH THE WORLD HEALTH ORGANIZATION

I joined the World Health Organization in 1967 (Sartorius, 2011) to work on the International Pilot Study of Schizophrenia (IPSS). After some months of working in Geneva, I was transferred to New Delhi where the Interregional Team on the Epidemiology of Mental Disorders (of which I was the only member) was to be based. The IPSS study had collaborating centres in Colombia, Czechoslovakia, Denmark, India, Nigeria, United Kingdom, the USA and the USSR, which I visited to help with the conduct of the study and to ensure a uniform application of assessment instruments in accordance with the common protocol of the study. The visits to the countries participating in the IPSS offered a wonderful opportunity to learn about the countries in which the centres were placed, about the cultures that prevailed in them, about psychiatrists who worked there, about health systems and about schizophrenia.

As time went by, I visited numerous other countries – almost all in the world – to talk about epidemiology and about psychiatry, stimulate or engage local institutions and individuals in international collaboration, to preach to government officials about the importance of psychosocial factors affecting health, to bring news about the treatment of mental illness and advise about the development of mental health services.

PSYCHIATRY IN THE DEVELOPING WORLD

What impressed me about psychiatry that I have seen in the low and middle income (then called 'developing') countries at that time was the remarkable similarity of service development. In almost all countries, there were mental hospitals, usually overcrowded, poorly maintained, located in buildings constructed during the colonial times. The number of patients usually vastly exceeded the 'registered bed strength'; in most places, there were two patients for every 'bed'; the beds often did not exist, and patients had sacks of straw or nothing, to lie on. Insulin coma treatment was still used in some places in the early seventies, although the evidence of the dangers (and lack of effect) was available and published. Food was poor, in quantity, quality and appearance. Patients were often naked or dressed in rags. Outpatient services were offered by some hospitals. Where this was the case, the psychiatrists were declaring that they were engaged in community psychiatry. The most amazing fact I saw – in almost all and particularly in poor countries – was that the total number of patients treated in these institutions represented only a minute proportion of the total number of patients that could be expected on the grounds of epidemiological studies. In India, for example, there were in all about 20,000 beds in government hospitals for a population of one billion: that works out to 0.02 beds per 1000 compared with the then usual European rates of 0.5 to 2 beds per thousand: a hundredfold difference. The situation was similar in other countries confirming the findings about the large numbers of vagrants with psychotic illness, the early death of people with mental illness, the hiding of (often chained) patients in their homes, the treatment of mentally ill people by traditional healers and various other ways of dealing with people with mental illness.

PSYCHIATRY IN THE DEVELOPED WORLD

In the seventies, in the developed countries, university departments of psychiatry and some private sanatoria provided care in accordance with the best of science and with an increasingly fair respect of patients' rights. The vast majority of patients, however. continued to be in mental hospitals in which their care was of poor quality and human rights received little respect. Mental hospitals in which care was of better quality – similar to the example of the hospital in Croatia described above – were rare but found everywhere, always due to the presence of exceptionally enlightened and able directors attracting also staff of good quality.

DRUG ABUSE

Approximately at that time, the use of opium and its derivatives was recognized as a problem of public health significance. The use of opium before that was tolerated in many countries not least also because its use and effectiveness in the treatment of diarrhoea, cough, pain and insomnia. In addition, tolerance of its use might have been related to the impact of promotion of the use of opium, particularly in the Eastern Asia in the preceding century and in the early years of the 20th century. The relatively sudden change of government policies, (in part influenced by the use of opiates by the soldiers of the armies that stayed abroad after the World War) and the persecution of both users and dealers of opium somewhat reduced the public use of opiates; but at the same time, the prohibition created an opportunity to create an illegal market supplying it with heroin and a variety of other drugs. Among synthetic drugs, amphetamine and its derivatives became a public menace, which gradually subsided. Use and abuse of other drugs followed. In the seventies and eighties of the past century, the World Health Organization convened special meetings to examine the situation concerning drugs and produced a definition of dependence; by that definition, which became accepted worldwide, many of the previous users of opiates would not have qualified for the diagnosis of dependence although they were using the drugs for years. They were just regular users. The strict prohibition of drug use linked to significant investment into the control of availability and into projects related to the treatment of persons taking them had also a direct impact on the field of psychiatry attracting a significant number of specialists towards the programs dealing with drug dependence (where it was easier to get money for research and better paid jobs) and away from general psychiatry.

NON-PSYCHOTIC DISORDERS AND VARIETIES OF TREATMENT

In most parts of the world, the fate of people with mental illnesses other than psychosis was not well known nor described, but what was probable was that some of them – for example, those with mild depression and anxiety states – were treated by traditional healers or by general practitioners who provided sedatives, laxatives, analgesics and various other treatments directed at the various somatic symptoms of mental illness – such as ill-defined aches and pains – which patients presented. The attitudes to the practice of traditional healers varied among countries: in some of them, healers were recognized as participants in the effort to respond to health needs (e.g., in Ghana and Switzerland); in other settings, they were prosecuted and their practice was forbidden often citing instances in which their interventions resulted in damage (e.g., the severe burns caused by holding the feet of persons with epilepsy close to fire to stop seizures). The systems of traditional medicine in Asia were better described, recognized by the authorities; and in some (e.g., China), traditional practitioners were working in the same institutions that provided care based on scientific medicine. In some countries, for example in Vietnam, instruction about traditional medicine was also introduced into the curriculum of medical schools

TRAINING

The training in psychiatry in many countries reflected the poor image of psychiatry and the disregard of mental health problems. In most developing countries, training in psychiatry consisted of a few lectures and in some instances visits to mental hospitals often treated by the students in a manner similar to a joint visit to the zoo avoiding closer contacts with the inmates. In many countries, postgraduate training in psychiatry consisted of working next to senior colleagues for period varying from one to several years: all that was not learned in that way had to be added by studying oneself.

COMMUNITY SERVICES AND THE WHO

Somewhere in the late sixties, the idea to shift the tasks of treating mental illness to the general practitioners and other primary care health agents re-emerged (proposals about task shifting in psychiatry were present in the late 19th century but never gained general acceptance) and gained popularity and general acceptance. This was a most welcome development. In 1973, we convened a World Health Organization Expert Committee meeting to consider ways of extending mental health care, which led to recommendations about the involvement of primary care staff in the management of mental disorders (Mental Health Expert Committee report, 1975). The report of the Committee was submitted to the Executive Board of the WHO, which approved the report and sent its recommendations to the WHO member states. To provide evidence that the inclusion of mental health care into general health services is possible, the WHO conducted a multicentric study in several developing countries (WHO Study Group report, 1984), which demonstrated that it is possible to provide knowledge about the management of severe mental disorders to simply trained staff working at the primary health care level and that they were able to provide care to people with disorders such as schizophrenia or depression. The ideas gained further ground and found a further confirmation in the report of the 1978 Alma Ata conference on primary health care – a conference that was expressing the decision of all members of the WHO

to strengthen primary health care and make it the carrier of universal coverage of the whole population by (elementary) health care. In the report of the Conference, the promotion of mental health is listed as one of the ten essential components of primary health care, which was a helpful reference for psychiatrists trying to convince their governments to do more for mental health.

POLITICAL INFLUENCES AND ABUSE OF PSYCHIATRY

Meanwhile, in the ninety seventies and early eighties, the cold war increased its extent and, in that framework, the information about the abuse of psychiatry for political purposes in the USSR and some of its satellite states gained considerable visibility. The evidence about the abuse of psychiatry for political reasons was presented to the World Psychiatric Association, which issued the Hawaii Declaration (Callard et al., 2012). The withdrawal of the USSR Association of Psychiatry from the World Psychiatric Association in 1983 added visibility to the situation. Abuses of psychiatry were happening elsewhere as well before and after those years: it was the cold war that made the abuse for political purposes widely known. Well documented and presented, it did contribute to the bad image of psychiatry as much as to the poor image of the political system in which it was functioning. The problem was that even after the cold war ended and the political system which permitted or used the abuse of psychiatry for its purposes had been replaced, the image of psychiatry remained marked also by its deviations of previous times.

ANTIPSYCHIATRY

About that time the psychotropic medications that were by then widely used also became stigmatized, not least because of their side-effects. The tenets of the antipsychiatry movement that swept the European countries in the late sixties and early seventies found their way into progressive thinking about the organization of mental health services and about human rights of the mentally ill. The spirit of the 1968 youth movement in Europe also had an impact on psychiatry when its activists begun to enter the profession not least in relation to the need to provide care for mental illness to all who needed it – as was the case in the UK, proud of its National Health Service – and not only to those who could pay for it.

THE 1980S AND LATER YEARS: BIOLOGY AND DE-INSTITUTIONALISATION

In the ninety eighties, biological studies of mental disorders further increased in popularity leading to the creation of societies of biological psychiatry and to a growing gap between psychiatrists (and other researchers engaged in biological studies) and those who were interested in social psychiatry and psychotherapy. Biological studies and psychopharmacological investigations drew significant financial support from pharmaceutical industry, which grew worldwide.

At about the same time, the mantra of psychiatry became deinstitutionalization. The reports of the poor condition of mental hospitals, disregard of human rights of people who were kept there as well as reports about the nefarious effects of long stay in institutions regardless of their quality were part of the deinstitutionalization drive greatly helped by governments, which saw it as a welcome manner to save money previously provided for institutional care. The example of the 1978 law and reform of psychiatric care in Italy, which led to the closure of all government controlled mental hospitals and the detailed description of the way in which psychiatry was reformed in the town of Trieste, received wide popularity and helped the movement as well. The fact that the number of beds in private psychiatric institution in Italy and elsewhere had grown at this time received little visibility.

In some countries and in some regions of other countries, the community-based services helped those discharged from hospital to live a decent existence. In many other places, the mentally ill people who were discharged from hospital without any support in the community fared badly, some of them being arrested and put in prisons, some survived in large cities homeless and others by turning vagrant.

ONGOING SHORTAGES IN CARE PROVISION AND STAFF

In the nineteen eighties, the low- and middle-income countries gradually increased the numbers of psychiatrists investing little into the development of services in which these were to work. Many left their country and ended in European and other high-income states. The clinical practice of psychiatry reflected the scarcity of trained personnel. The average duration of an interview in an outpatient psychiatric department often lasted no longer than three or four minutes serving to decide whether it was necessary to put the patient in a hospital and to decide which of the psychiatric drugs (most of which had a very wide diapason of action) to prescribe.

In inpatient facilities, there was often no more than 1 psychiatrist for 60 or more patients and apart from information and facts gained during an interview on entry, the psychiatrists' decisions relied mainly on what nurses told them about the patients' behaviour.

The practice in many European countries was not significantly different from that. It is important to realize that the role of the nurses and their power ranking was not the same in the countries of Europe (nor, by extension in the countries that were their colonies). The British system recognized consultants – specialist psychiatrists who made decisions about the treatment of patients admitted to hospital – and the nursing staff that ran the wards in which the patients were located. The continental system had a different arrangement: the psychiatrist was the head of the team that received the patients and looked after him.

The role of the Matron in the UK was very different from the role of the chief nurse in a hospital in, say, Austria or Romania. The matron in an English department of psychiatry made decisions about the ward and the psychiatrists were invited to give advice about the treatment; the role of the chief nurse in the central and eastern European countries was to execute the orders of the chief (the psychiatrist).

Private psychiatry and psychotherapeutic practices according to what patients and their families said and according to what could be heard in talking to psychiatrists who worked in private care operated differently. How exactly they functioned and what proportion of the people with mental disorders they helped is uncertain because information about the extent, form and quality of private psychotherapeutic practice was not included in statistical reports from countries or in scientific reviews.

BETTER FUNDING AND ONGOING PROBLEMS

As years went by and resources for psychiatry became more important, new developments became possible. In many of the industrialized countries, community care was appropriately funded and services were provided in the community with an engagement of the community. These developments were however also affected by the gradual weakening of community cohesion in many rapidly urbanizing countries, making it difficult to apply the concepts of community medicine. The fragmentation of medicine into ever more narrowly defined sub disciplines made it difficult to provide care to people with comorbid mental and physical disorders and the complexity of administrative and care arrangements resulted in the creation of a variety of professional groups, case managers, home visitors, work attendants, peers and others.

Recent times have also made it possible to see that some of the remedies that were offered in the second half of the 20th century to make psychiatry more useful to society have failed. Surprisingly, this did not reduce the zeal of those promoting them to continue doing so. Thus, for example, it became obvious that shifting tasks of psychiatry to general practitioners and other health workers is neither as simple nor easy as it sounded. The general health workers are willing to deal with some of the mental health problems but not with all and certainly not with the most difficult ones ranging from personality disorders to psychotic states. The strategy of task shifting, therefore, has to be reformulated to cover needs of people whom the general practitioners are unlikely to manage. The return of the patients to their families became more difficult in a time where divorce rates were growing and family size, stability and strength were on the wane. The life expectancy of people with mental illness grew but they are still dying 10 to 15 years sooner than the rest of the population (Nordentoft et al., 2013). Providing care for physical illness in people with mental illness has therefore emerged as a main problem for health services in the 21st century.

OUTLOOK

Time has helped to assess the outcome of most of the measures recommended in the past few decades but it has not created enough courage to discard all the useless and possibly even harmful notions of the previous years. Thus, for example, it would be important to recognize that the tasks of psychiatrists related to the treatment of mental disorders have to be redefined because of an increased acceptance of self-help strategies, which could deal with an important proportion of mental health problems currently brought to psychiatrists and psychotherapists and because of the adoption of the responsibility for the treatment of conditions such as mild depression and anxiety by the general practitioners. The energy saved by these changes should enable psychiatrists to accept their responsibilities in the field of public health, for example, to lead actions that will contribute to the primary prevention of mental disorders and to the acceptance of the importance of psychosocial factors in medicine as a whole.

It does take courage to jettison ideas that we promoted telling others and ourselves that they are excellent: It is to be hoped that the current generation will do so wisely preserving the useful and inviting all concerned – health workers, patients, carers, society to help in making psychiatry a truly useful and successful medical discipline.

This is where history of psychiatry has joined the present, which is best known to those who are living and working in it.

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