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What every psychiatrist should know†

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Abstract Psychiatry is the branch of medicine concerned with the diagnosis, treatment and study of psychological disorders. The role of the psychiatrist evolves to reflect developments in medicine, science and society. The scientific knowledge base required for the practice of psychiatry changes from generation to generation, but many of the fundamental principles of practice remain essentially unchanged. We attempt here to identify some of these (relatively unchanging) principles and explore their relevance to contemporary psychiatry. In particular, we focus on the work of some of the more reflective physicians of history (e.g. Sir Robert Hutchison, Sir William Osler) in order to identify and interpret principles of medical practice outlined in the 19th and 20th centuries and we explore the relevance of these conceptual frameworks to the practice of psychiatry in the 21st century.

On 30 June 1938 Dr Robert Hutchison, President of the Royal College of Physicians of London, presented prizes to medical students at the London Hospital Medical College. In his address, Hutchison stated:

> 'I don't know that I have much belief in giving good advice – especially if it is gratuitous – so instead … let me ask what gifts, were I a good fairy (supposing you were capable of that flight of the imagination), would I bestow on anyone setting out on a medical career? By that cunning approach I may be able to slip in some good advice without you noticing it' (Hutchison, 1938).[1]

The 'seven gifts' that Hutchison outlined were: good health, luckiness, brains, equanimity, a sense of justice, a sense of beauty and a sense of humour.

In the seven decades since Hutchison's address, much has changed in the day-to-day practice of medicine, most notably in the scientific basis for practice, in modalities of service delivery and in postgraduate training. Notwithstanding these changes, many of the fundamental principles underpinning medical practice remain the same. Here we discuss some of these enduring principles, as reflected in Hutchison's seven gifts, and relate these to the contemporary practice of psychiatry. We do not seek to ignore the impact of specific medical and scientific advances, but rather to identify the broader principles that might usefully structure and inform the knowledge base underpinning the teaching and practice of psychiatry.

Good health

Hutchison's first gift to the medical students was good health, because:

> 'medicine … is a dangerous profession and there is nothing so tragic, as Bernard Shaw said, as the sick doctor. But the kind of good health I would give is not what is commonly understood by that stupid word, so much overworked at present, 'fitness' … but that sort of wiry constitution which is able to resist fatigue and infection and which – and this may be comforting to some of you – often goes with quite a poor physique' (Hutchison, 1938).

Almost 70 years later, the practice of medicine still places considerable pressure on the health of the practitioner, and psychiatry places particular pressure on mental health, especially in terms of emotional exhaustion and depression (Deary *et al*, 1996). The suicide of a patient, for example, has substantial effects on both the personal and professional lives of psychiatrists (Chemtob *et al*, 1988) and may prompt up to 15% of affected psychiatrists to consider early retirement (Alexander *et al*, 2000). Specific effects on mental health may include low mood, decreased self-confidence, social withdrawal, disruption to relationships, symptoms of post-traumatic stress disorder, and feelings of anger, shame and isolation (Chemtob *et al*, 1988; Gitlin, 1999; Alexander *et al*, 2000).

†For a commentary on this article see pp. 469–470, this issue.

1. Quotations from Hutchison are reprinted from *The Lancet, ii*, Hutchison, R., Seven gifts, pp. 61–62, (© 1938), with permission from Elsevier.

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Despite growing evidence of the possible effects of psychiatric practice on mental health, training programmes in psychiatry place little emphasis on the maintenance of good mental health; where such training does exist, trainees generally report it to be helpful (Dewar *et al*, 2000). Hence there is a strong need for postgraduate psychiatric training programmes to include discussion of the importance of good mental health, especially in relation to specific stressors that trainees are likely to encounter in practice, such as patient suicide (Gitlin, 1999; Dewar *et al*, 2000; Courtenay & Stephens, 2001; Yousaf *et al*, 2002). There is a similar need to strengthen assessment and treatment programmes for doctors whose mental and physical disorders may result, at least in part, from their choice of profession and may impair their ability to perform to the best of their potential. There are few such programmes at present (Gawande, 2002).

This failure to acknowledge the physical and mental health needs of doctors may have tragic consequences (Meikle, 2003). Potential health problems necessitate not only deepened awareness and enhanced treatment programmes for doctors who are ill, but also a change in the culture of medical practice to acknowledge that doctors are just as vulnerable to illness as their patients. Hutchison's emphasis on good health remains just as relevant today as it was in 1938. In psychiatry in particular, the pressures that contemporary practice places on the clinician's mental health merit greater attention both during postgraduate training and CPD programmes. The extent of these pressures, and their possible remedies, is surely something that every psychiatrist should know – for their own sake and for that of their patients.

Luckiness

The second gift that Hutchison identified was luckiness, which he described as:

> 'one of the chief factors making for health and happiness. Luck in your background, in your home and parents; luck in your choice of medical school … luck in examinations and in appointments becoming vacant when you want them; luck in falling into a good practice; luck in your partner …' (Hutchison, 1938).

Although it is not possible to 'teach' good luck to trainees in any profession, it is certainly worthwhile acknowledging the role that luck can play in shaping medical careers, research interests and clinical habits that are handed down from mentor to student. In addition, the role of luck in scientific and clinical practice constitutes something that every trainee should know, if only to foster a sense of humility and help them to appreciate both the limits of present knowledge and the range of human experience.

Box 1 Austin's four varieties of good luck

- Pure luck or 'blind chance', which is independent of anything one might say or do
- Good luck that occurs in the context of general exploratory behaviour (i.e. persistence, curiosity, etc.), which increases the likelihood of 'happy accidents'
- Good luck that occurs in the context of the 'prepared mind' (i.e. receptivity and recognition when something promising occurs)
- Good luck that occurs in the context of our engagement in distinctive, individualised activities (i.e. personal activities that may appear removed from the topic of discovery)

(Adapted from Austin, 1979)

Some 40 years after Hutchison first dispensed his advice about good luck to the students in London, Austin (1979) took a closer look at the role of luck in scientific research and identified four different kinds of good luck (Box 1). Today, this categorisation appears to apply equally well to both scientific research and clinical practice. It is especially noteworthy that the first variety of good luck is blind chance, which is independent of anything one might say or do, but the other three varieties relate, in different ways, to general behaviour, habitual intellectual attitudes and engagement in distinctive, individualised activities.

On the basis of Austin's paradigm, what every psychiatrist should know about good luck is that the amount of good luck that one experiences might be optimised by developing persistent curiosity about many different and contrasting areas of life, preparing one's mind so as to best identify fortuitous possibilities as they occur and engaging in activities that may appear removed from the area of current endeavour but may still provide important inspiration for future discoveries. If, despite these measures, good luck remains elusive, Hutchison consoles

> 'that hard work and patience can make up to a great extent for the want of it' (Hutchison, 1938).

Brains

Having bestowed the students with good health and good luck, Hutchison noted that:

> 'it is customary on occasions like this to say that prize-winning doesn't matter much and that the man who only scrapes through exams often does as well as the prizeman in the end. Believe me this is cant.

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Other things being equal, the man who does well at examinations does best in after-life and it is dishonest to pretend otherwise' (Hutchison, 1938).

Today, most medical schools still use some form of academic assessment as part of their admission process and in some countries (e.g. Ireland) formal academic assessment remains the sole criterion for admission to most medical schools. Postgraduate training in psychiatry also places considerable emphasis on traditional academic accomplishment and retention of information, although emphasis is increasingly shifting to clinical abilities (e.g. individual patient assessment) and clinical problem-solving (e.g. case management problems). In the UK, the new training programmes outlined by the Postgraduate Medical Education and Training Board (http://www.pmetb.org.uk) and Modernising Medical Careers (http://www.mmc.nhs.uk/pages/home) are also designed to develop some of the interpersonal skills, such as communication and humility, that are critical to the practice of medicine.

These discussions and developments in training form a critical element of the broader debate about what constitutes a 'good doctor' in contemporary society; this debate is also informed by several useful professional reports, including the Royal College of Physicians of London's report *Doctors in Society: Medical Professionalism in a Changing World* (Royal College of Physicians, 2005). The development of competency-based training curricula signifies a broad movement away from examining deposits of stored knowledge and towards examining the application of knowledge and the conduct of the doctor in day-to-day clinical situations. The Canadian physician Sir William Osler was an early advocate of such an approach and wrote over a century ago that in

'the natural method of teaching the student begins with the patient, continues with the patient, and ends his studies with the patient, using books and lectures as tools, as means to an end' (Osler, 1906*a*).[2]

Although he placed significant emphasis on academic accomplishment, Hutchison did not focus on this exclusively. He certainly felt that he

'must bestow some brains – but not too many. It is unnecessary – perhaps dangerous – in medicine to be too clever' (Hutchison, 1938).

He went on to state that:

'if I had not many brains to bestow I should make up for it by an extra gift of diligence. The faculty of steady work, unhasting and unresting – not merely a rush of it just before the examinations – will compensate for almost any lack of cleverness, and although it comes to some naturally it is within the power of anyone to acquire. If then it is not born in you see that you attain it' (Hutchison, 1938).

This, perhaps, epitomises what every psychiatrist should know about the gift that Hutchison described as brains: the importance of diligent, mindful application to the deepening of academic and clinical knowledge bases. This principle applies equally to both psychiatric research (the steady accumulation of data and publication of papers) and clinical practice (the steady accumulation of clinical knowledge to combine with best evidence), and is particularly relevant to the increasingly important area of CPD for psychiatrists. Osler expressed this well when he wrote:

'the hardest thing to get into the mind of a beginner is that the education upon which he is engaged is not a college course, not a medical course but a life course, for which the work of a few years under teachers is but a preparation' (Osler, 1906*b*).

Equanimity

Hutchison's next gift would be equanimity:

'the *mens æqua in arduis* – the power, as Kipling said, "to turn a keen untroubled face home to the instant need of things." There is no quality of mind more essential to you as doctors for you will often have to face sudden and disconcerting emergencies and a fair share of it will also do much to preserve you from the corroding effect of those worries which are unescapable in practice' (Hutchison, 1938).

Almost 50 years before Hutchison addressed the students at London Hospital Medical College, Osler emphasised the same point at a valedictory address at the University of Pennsylvania. In a speech entitled 'Aequanimitas', Osler stated that:

'in the physician or surgeon no quality takes rank with imperturbability … Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgement in moments of grave peril, immobility, impassiveness or, to use an old and expressive word, *phlegm* … the physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients' (Osler, 1906*c*).

Unlike the past, contemporary medical practice accords an important role to evaluating levels of statistical and clinical uncertainty and acknowledging the limits of present scientific knowledge. This does not mean abandoning a position of equanimity but rather learning to maintain such equanimity in the face of imperfect information. Relevant strategies

2. Quotations from *Aequanimitas with Other Addresses to Medical Students, Nurses and Practitioners of Medicine* by W. Osler, published by McGraw-Hill (© 1906), are reproduced with permission of The McGraw-Hill Companies.

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include critical appraisal of scientific evidence, careful evaluation of the risks of alternative therapeutic options and collaboration with service users and carers in generating rational strategies in the face of uncertainty. As Osler pointed out:

> 'A distressing feature in the life which you are about to enter, a feature which will press hardly upon the finer spirits among you and ruffle their equanimity, is the uncertainty which pertains not alone to our science and art, but to the very hopes and fears which make us men. In seeking absolute truth we aim at the unattainable, and must be content with finding broken portions' (Osler, 1906*c*).

Piecing together these 'broken portions' is a task that confronts psychiatrists in all dimensions of their work, ranging from the evaluation of incomplete scientific understanding of the brain to the delivery of packages of care in underfunded mental health services. All of these fragmented, disparate processes present recurring challenges to equanimity.

In the end, perhaps what every trainee should know about equanimity is that an appropriate sense of equanimity can be developed over time. For those who do not possess a natural abundance of equanimity, Osler emphasised that

> 'with practice and experience the majority of you may expect to attain a fair measure. The first essential is to have your nerves well in hand … Natural temperament has much to do with its development, but a clear knowledge of our relation to our fellow-creatures and to the work of life is also indispensable' (Osler, 1906*c*).

Similarly, Hutchison comforted those

> 'who have been born anxious-minded, natural worriers, and with temperaments far from equable by saying that time and experience tend to produce a degree of equanimity in most of us. A distinguished judge once said that for the first ten years he was on the bench he was always worrying whether his judgements were right, for the next ten years he was always sure they were, and after that he didn't care whether they were or not. But perhaps that is to confuse equanimity with indifference, which is not by any means the same thing' (Hutchison, 1938).

Sense of justice

The fifth gift that Hutchison sought to bestow on the medical students at London Hospital Medical College was a sense of justice, by which he meant

> 'a sense of justice in the first place to your patient, so that you will always give him a fair deal, not scamping your investigation of his case and rendering him always full value for your fee' (Hutchinson, 1938).

Osler, in a similar vein, quoted from Sir Thomas Browne in a valedictory address to the graduating class at Montreal's McGill University in 1875:

> 'No one should approach the temple of science with the soul of a money changer' (Osler, 1875).

Osler also denounced the injustice of prejudice in medicine and elsewhere:

> 'What I inveigh against is a cursed spirit of intolerance; conceived in distrust and bred in ignorance, that makes the mental attitude perennially antagonistic, even bitterly antagonistic to everything foreign, that subordinates everywhere the race to the nation, forgetting the higher claims of human brotherhood' (Osler, 1906*d*).

Hutchinson went on in his address to stress another aspect of justice:

> 'This means, too, that you must make it your duty to keep abreast of the advances in medical knowledge, for it is unjust that your patient should not have the benefit of them … But a sense of justice is an intellectual as well as a moral quality and it will help to make you a skilled healer of the sick, for diagnosis is the major part of medicine and the art of diagnosis consists largely in giving due and just weight to each of the symptoms and signs that your patient presents. It is an exercise of the judicial faculty' (Hutchison, 1938).

Hutchison's emphasis on continuing medical education as a component of justice remains as accurate and timely today as it was in 1938. There has been a strong renewal of emphasis on evidence-based medical practice in recent years (Sackett *et al*, 1996), with initiatives such as the Cochrane Collaboration making current best evidence widely available to service providers and service users (http://www.cochrane.org). There remains, however, a dearth of evidence about the effectiveness of certain treatments and various models for delivering care. Hutchison defines these issues as questions of justice that need urgent resolution in the best interests of patients.

The development of a sense of justice is also relevant in relation to the resources devoted to mental health services. Although the process of de-institutionalisation has been in place in some areas for up to 50 years (Department of Health and Social Security, 1957), there is still considerable public and professional concern about the levels and equitability of resources provided to community services in many countries, including the UK (Fadden *et al*, 1987; Dyer, 1996), Ireland (O'Neill *et al*, 2002; O'Keane *et al*, 2004; Inspector of Mental Health Services, 2005) and the USA (Mollica, 1983). One of us (B.D.K.) has previously argued that the failure to develop adequate and effective models of mental healthcare represents a form of systematic social injustice or 'structural violence' against people with mental illness (Kelly, 2005). The extent of these injustices, and their distorting effects on our practice, is surely something that every psychiatrist should know.

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Sense of beauty

Hutchison identified a sense of beauty as one of the seven gifts he would bestow upon the students in London because:

> 'there is much in medical life that is ugly and sordid. When you hear someone say that he has just seen a "lovely" case of lupus, or rodent ulcer or cancer, he is not to be taken literally. Disease is ugly and many of you will be condemned to fight it in ugly surroundings … You will need a sense of beauty as a compensation and a way of escape; as a sanitising and steadying influence. It will not take the same form in all of you. Some will find their refreshment in art, others perhaps in music and happy are those of you who are able to practise either of these even in the humblest way. In others literature will be a refuge…' (Hutchison, 1938).

Osler also extolled an appreciation of beauty as he counselled students:

> 'nothing will sustain you more potently than the power to recognize in your humdrum routine, as perhaps it may be thought, the true poetry of life – the poetry of the commonplace, of the ordinary man, of the plain toil worn woman, with their loves and their joys, their sorrows and their griefs' (Osler, 1906*b*).

The seven decades since Hutchison's address have seen the steady emergence of the 'medical humanities' as a field of research in their own right and this is reflected by the development of dedicated journals such as the *Journal of Medical Humanities* (Oyebode, 2002). The relationship between literature and psychiatry (Oyebode, 2002) has received particular attention in the pages of *APT*, with various authors examining literary accounts of conditions such as dementia (Vassilas, 2003), substance use (Day & Smith, 2003) and death and dying (Skelton, 2003). The potential role of literature in medical education has also been explored, with an emphasis on the importance of the broader concept of 'medical education' rather than simply 'medical training' (Evans, 2003).

Veatch (2005) has argued that there is a particular role for the humanities in the field of medical ethics, pointing out that, for various reasons, the dialogue between physicians and humanists essentially ceased for a period between 1770 and 1980, with the result that the field of medical ethics was substantially diminished. For a range of political, societal and demographic reasons, this dialogue has been resumed in recent decades, resulting in a richer, more vibrant field of medical ethics that increasingly takes account of the complicated realities of our increasingly globalised societies (Kelly, 2003; Veatch, 2005). Literature and the humanities have a critical role to play in deepening our understanding of these complex, evolving realities, which affect the lives of psychiatrists and mental health service users alike.

These realities also affect the lives of carers, and whereas doctors may be in the privileged position of being able to explore these broader dimensions of human psychological experience, the carers of individuals with enduring mental illness may not: their lives may be dominated by the ongoing needs of the person they care for, compounded by the possible inadequacy of health and social services in the face of those needs. In his 1938 address to medical students, Hutchison did not explore the relationship of doctors with carers and groups such as social services which are involved in meeting the needs of people with mental illness. Any similar address today would undoubtedly emphasise the importance of being able to engage meaningfully with patients, provide psychological and practical support to carers, work effectively in multidisciplinary teams and communicate with other providers of care for people with mental illness.

Self-awareness

One key quality that Hutchison overlooked in his 1938 address is self-awareness, which is particularly important in the field of psychiatry, where the psychological concerns of the doctor need to be distinguished from those of the patient to optimise diagnostic and therapeutic processes. Self-awareness is increasingly important in light of the changing role of the doctor in the context of multidisciplinary, patient-centred healthcare services designed to meet the needs of populations from diverse ethnic backgrounds (Kelly, 2003). At a professional level, greater self-awareness may help to identify problems such as institutional racism and to develop balanced responses to the concerns of specific groups who perceive services as inaccessible or inappropriate to their needs. Such self-awareness would be usefully complemented by a broader understanding of the social and political contexts within which psychiatric services are developed and delivered.

Returning to Hutchison's 1938 conceptualisation of a sense of beauty, then, perhaps what every psychiatrist should know is that an appreciation of fields other than psychiatry (e.g. literature, social sciences) can prove beneficial both outside of and within the work environment, by broadening perspectives and improving clarity of thought. Hutchison concluded:

> 'I would urge you therefore not to allow your professional reading to crowd out general literature altogether. Take to heart the writing of Darwin, who deplored in his later life that he had quite lost his earlier taste for poetry. So close-linked too are language and

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thought that the cultivation of literature will make you think more clearly and express yourself, even in your professional writing, more accurately, and confused thinking and slovenly writing are, alas, all too common in our profession' (Hutchison, 1938).

Sense of humour

'My last and best gift would be a sense of humour … you may think it curious that humour should be a valuable gift for a doctor to possess, but I assure you it is so. It will help you to bear with the vagaries of your patients … and to derive amusement instead of annoyance from the eccentricities of your colleagues ... Humour, however, is a gift which is not to be cultivated in solitude, so if you wish to develop it in yourself you must mix with your fellows and take your part in all the activities – intellectual, social, and athletic – of such a College as this' (Hutchison, 1938).

The relationship between humour and health has been the subject of considerable medical study in the decades since Hutchison's address. There is now a moderate amount of evidence to suggest that a good sense of humour is positively associated with good general health (Boyle & Joss-Reid, 2004) and may be negatively associated with certain conditions such as coronary heart disease (Clark *et al*, 2001). It is also possible, although far from proven, that having a sense of humour may also be associated with longevity (Yoder & Haude, 1995). In terms of mental health, sense of humour is negatively associated with levels of worry (Kelly, 2002*a*) and related sleep disturbance (Kelly, 2002*b*), and may be positively associated with response to treatment in conditions such as post-traumatic stress disorder (Davidson *et al*, 2005).

For professionals working in healthcare settings, sense of humour is positively correlated with ratings of empathic concern (Hampes, 2001) and humour is often cited by healthcare workers as important for relaxation and avoiding burnout (Kash *et al*, 2000). One study of aberrant medical humour by psychiatric unit staff identified two major categories of joking in this setting: whimsical and sarcastic (Sayre, 2001). Staff tended to engage in more sarcastic than whimsical joking and Sayre concluded that professionals need to recognise the potentially detrimental effects of joking behaviours on the effectiveness of treatment.

However, Hutchison had little doubt about the value of humour in the practice of medicine:

'Humour will save you also from two great besetting sins of the doctor – faddery when he is young, pomposity when he is old – for if you have a sense of humour you will often hear the still small voice within you which at the critical moment whispers " humbug"' (Hutchison, 1938).

As the authors of a paper entitled 'What every psychiatrist should know' we are in no position to comment about either pomposity or humbug. The Chinese poet Lao Tzu, however, also highlighted the futility of pomposity by recognising that there is a time for action but also a time for inaction – a time when one must recognise one's limits, take a step back, and

'Act for the people's benefit.
Trust them; leave them alone'
(trans. Mitchell, 1988).

Declaration of interest

None.

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MCQs

1 Hutchison's seven gifts include:
a good health
b a sense of beauty
c excellent sporting skills
d a sense of hysteria
e equanimity.

2 The occurrence of patient suicide:
a has substantial effects on the professional lives of psychiatrists
b may lead to symptoms of post-traumatic stress disorder
c has minimal effects on the personal lives of psychiatrists
d may prompt some psychiatrists to consider early retirement
e may lead to decreased self-confidence.

3 Austin's four varieties of good luck include:
a good luck in the context of general exploratory behaviour
b pure luck or blind chance
c good luck related to genetic inheritance
d good luck in the context of the prepared mind
e bad luck in the context of general exploratory behaviour.

4 Equanimity:
a was seen as important by Sir William Osler
b cannot be learned to any significant extent
c is the same as indifference
d is incompatible with scientific uncertainty
e was neglected by Hutchison.

5 A sense of humour:
a may be associated with good general health
b has no relevance in medical life
c is negatively associated with empathic concern
d is positively associated with worry
e was highlighted by Hutchison as an important quality for doctors.

MCQ answers

1	2	3	4	5
a T	a T	a T	a T	a T
b T	b T	b T	b F	b F
c F	c F	c F	c F	c F
d F	d T	d T	d F	d F
e T	e T	e F	e F	e T

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