

On leaving Columbia University's New York School of Social work although I remained within the psychiatric field, nevertheless in many ways I was on the move. I was appointed Director of Community Services with the Mental Health Association Essex County (MHA) in, New Jersey across the Hudson River from Manhattan. I was responsible for Information, Referral and Education services to the community. These were the days of the grey flannel suit, and President Eisenhower running for a second term. ("Vote 'No' for president and leave the White House empty for another four years"). New Jersey (which with some disrespect I came to identify as my first undeveloped country!) still instituted archaic social legislation that had its origins in the British Elizabethan (the First) Poor Law of 1601 However, in Essex County it was exciting; our MHA created a number of truly innovative programmes which aimed to serve those in psychological need; to inform and mobilise the public; and to influence programmes and policy on mental health issues and psychiatric services.

I ran a telephone service which was a version of my earlier British LCC work. I answered almost a thousand calls a year. These opened up opportunities to mount a wide range of community based activities, public presentations and projects. Much advice and referral was conducted over the telephone and information collected of a social history kind for a range of purposes. The social histories were not of the psychoanalytical orientation of my earlier clinical work, (starting with breast-feeding or toilet training and so on). At the MHA I was extending the community focus making a more thorough exploration about which, and for what, social services the caller had been in touch with, when, their experience and the outcome. It was possible to record such happenings on a grand scale. It meant that we were not mere armchair critics when, as was our intended community purpose we actively identified public issues to raise or defend. We had wide and in depth existing up-to-date material from these contacts with which to support our arguments. It was to annoy State government and others too, that we

were frequently much better informed than they were of how services in the State of New Jersey actually functioned, or failed to, at the receiving end. Our authority was also based on not merely identifying unmet need but having raised the necessary funds and established unique institutions to deal with them.

. Two of these attracted much professional and public attention. The MHA day-school for autistic children was the first in the USA and probably anywhere else and eventually was taken over by the public Board of Education. The Low-Cost Psychotherapy **plan** (LCP) was of both political and professional fascination and significance. The MHA Essex County area of operation contained some of the richest communities in America (and also some of the more dreadful). Many psychoanalysts and psychotherapists lived opulently in these very fancy areas of New Jersey, and a fair number of **them** conducted private practices in New York itself to which they commuted along the Polaski Highway¹ A majority of them were second and third generation from immigrant families and were perhaps a little uneasy with their affluence. As a possible antidote and to demonstrate their public good will, MHA invited them to donate their time. **- Private enterprise and God forbid not for free!** LCP would guarantee them 5 dollars an hour making sure that it was not taking patients who could pay the going rate then of \$25 four or five times **a week**. The LCP therapists (whose quality were accepted by a panel of their peers) would be offered patients from a financial social stratum with perhaps problems that they did not ordinarily see and who had diagnostically been clinically assessed as in need of psychotherapy. In addition because in private practice, therapists rarely got together professionally with each other, LCP offered them first-rate seminars with the most outstanding professionals that could be found in their field.

¹ The Polaski Highway (which gave access to the Holland Tunnel under the river into Manhattan) was elevated a couple of hundred feet above the ground. I decided that it had been built that way so that the wealthy commuters would not notice the miserable conurbation of the city of Newark below. In addition, just in case they might take a glance **at** the squalor and industrial blight, the scintillating skyline of downtown New York had been built to keep the travellers looking at the horizon rather than at the reality beneath them.

MHA provided LCP with an office, a secretary, the telephone, a psychiatric social worker, and a part-time consultant psychiatrist who provided the diagnostic work-up on the patient. Having concluded that psychotherapy was the treatment of choice, the case was offered to one of the therapists. If accepted he received his five dollars an hour but was required to refer back to the diagnostic team before closing the case. The patients themselves contributed according to their financial ability as little as 50 cents. MHA subsidised the difference and of course did the fund raising for this and all our other activities. In no time at all LCP was providing the largest outpatient facility in the State (somewhat to the State's irritation, especially as they were required to provide matching funds to the LCP) - 165 hours of psychotherapy a week of the highest quality and with few financial overheads because patients were seen in the therapists own consulting rooms.

Just one example of how a telephone call led to referral to our LCP service is that of "R". R sounded extremely cautious and diffident on the end of the telephone line in inferring he might need help. When I got round to asking him his name he hung up. This became a familiar pattern over a number of weeks of the caller cutting off however unenquiring with him I became in the longuets of the conversation. Eventually, although he was most uncertain that he could actually come and see me and could not agree a specific appointment, I offered three different times that I would be available if he felt he could make any one of them. One evening a young man of about 20 years of age arrived smiling rather constantly and bemusedly in a way that suggested to me possibly a hebephrenic² condition. However, when I said that he seemed to be amused about something he explained to me that having called the Mental Health Association and learned my name was Drucker he thought I would turn out to be an old German doctor. That I was young and British struck him as rather funny.

² A schizophrenic reaction characterised by silliness, delusions, hallucinations and regression, that has an early insidious onset and usually unfavourable prognosis,

This exchange seemed to relax him and then he recounted that he had gradually found it necessary to avoid a growing number of streets and that to come to me he had had to work out a very convoluted route. He was now becoming afraid as he was beginning to have an urge to shout obscenities to passing people especially elderly ladies. It turned out that he could not go up stairs and indeed had arranged his high school courses on the basis that they were held on the ground floor. (An odd **incongruous** collection of courses that apparently the educators had not paid **given any** attention to). He had not been able to work and his father was increasingly enraged with his idleness. He seemed to be of normal intelligence and clearly aware that his various obsessions were increasing and might get him into serious trouble. Gradually he was encouraged to see our psychiatrist and was placed with our LCP. He came to our MHA office for a while after I invited him as a working experience to join some other young people to help us in our annual fund raising campaign³, and in time he found a job in a rubber stamp making company.

Some months later he wanted to see me and was very upset, his mother was in hospital and dying, and his father as usual enraged with him. His most emphasised sense of disturbance surrounded the fact that he had saved up to buy his mother a Christmas gift with the first money he had ever earned and now she was dying before Christmas was coming. Indeed despite my initial doubts of what he was telling me, his mother really died and I commented that "... somehow the Christmas tree had been cut down". This excited R "That's it! That's it!" he said " the f...ing Christmas tree has been cut down". This outburst seemed to relieve him He continued his psychotherapy and his job and went to live with his sister. He proudly came to present me with a personal rubber stamp.

³ These campaigns included the usual envelope stuffing postal appeals and a strange stand at the airport at Newark. There in the main foyer we set up a great circle of fifty-two milk bottles each representing a State of the Union and passengers were invited to place there small change into the State of their choice and so "Ring the Bell for Mental Health"

The following year I had been away in New Mexico⁴ and spent some time in the Navajo Indian country and let my beard grow. On returning to work I ran into R on one of those streets he used to avoid. He looked at my beard and cheerfully commented “That’s more like it” meaning I now was now nearer to the old German doctor he had once imagined. For a long time after I had left America he sent me Christmas cards. I supposed that his Christmases had been somehow restored.

One of the ways MHA found to widen understanding and responsibilities with community groups was with the help of the local amateur theatre performing specially produced Mental Health plays. This became an amusing (but quite moving and with serious intent) popular contribution for such as Parent Teacher Associations⁵. Many instructive and entertaining evenings were mounted. I was not satisfied at becoming the focussed upon would-be-wise-one in the two-way discussions which followed with the audience. I hit upon the device of encouraging the actors to stay in character on stage after the performance. It was thrilling to conduct three-way exchanges, being able to turn to the characters to further explain and develop their motives and feelings. The **actors** were much intrigued by the audience’s variable interpretation of their roles. My café meetings with the actors afterwards assisted them to enhance the depth of their performance and to sophisticate their responses to mental health related questioning. These presentations often subsequently stimulated members of the audience to approach MHA for help.

⁴ During a number of summers, in line with my decision to find a way to move into the wider field of societal change, human problems and development, I spent time in the south-western States of the USA in American Indian country where the destruction of cultures was in dramatic evidence. Eventually I was to be offered a Federally financed post in New Mexico. However, troubled by the existing colonial attitudes in the State House towards the Indian and Mexican communities, on balance I declined.

⁵ Interestingly it was not just PTAs that responded actively to parent- child problem oriented themes but **audiences** found it difficult to take to the plays that featured the handling of the problems of the family with the aged

The telephone calls also led to offering seminars to professional groups who might recognise the usefulness of mental health concepts and approaches in their practice. Some such were the local Police Academy⁶ where challenges were examined **such as** ways to handle calls to domestic violence or crowd gathering at scenes of threatened suicide **from high elevations**. A growing interest came from the nursing groups; and from institutions like a Home for unmarried mothers. –

A telephone call one morning from the large city general hospital enquired whether we had something like mental health pamphlets suitable for the nurses. Offering to come and discuss their needs I was greeted by the imposing Nursing Matron in her starched winged headdress who invited me to join her in her regular inspection of the hospital wards. I was disarmed of my briefcase, donned with a white coat **and I followed** closely behind the Matron in full flight wondering whether I should have been suitably disguised with a stethoscope shyly dangling from my pocket. She swept me along department after department pointing out the various nursing and medical attractions as we went. As she sailed down corridor after corridor leading to each ward on the twenty or thirty floors, she imperiously threw open the doors on each side. Where she found an old mattress slumped in a corner she commanded its removal, and various other objects earned her displeasure. A little breathless as I trotted to keep up, what intrigued me was the number of cupboards or small rooms which contained a nurse or two. Some, to be sure, were busy folding things and putting them into their ordained places; others lurked drinking coffee, smoking cigarettes, or seemed to be engaged in general chat or conversation with **each other**. Needless to say, they were galvanised into activity at the sudden appearance of the matron. Although there seemed to be a large proportion of the staff thus engaged in cupboards, certainly in contrast to the surprisingly few nurses attending the patients on the ward

⁶ I was struck at the Police academy with the different cultural and intelligence interests of the White and Black recruits in training. So too I was alarmed at the intense anxiety among young police in threatening situations and the reassurance they gained from the ever-ready possibility of using their guns.

and certainly none in conversation with a bed patient, I would have given it no more than a wry thought had it not been for two subsequent events when my observation came to have significance.

The whirlwind tour resulted in an agreement for me to conduct a series of seminars with the nurses centred on the emotional aspects of the general experience of illness, hospitalisation, and nursing. At this time it was most unusual to have much attention given to anything but the physical aspects of medical care.⁷ I arranged a number of seminars with the nursing teachers and asked them to write for me an account of their own first day as nurses at the beginning of their professional career. What I had in mind was an attempt to begin by having us look at the teachers' task from their own student nursing day's point of view.⁸

I received back very interesting reports and was astounded at the number of times on the first day when the budding nurse had become upset at some of the smells and sights and sounds of the hospital, wanting to cry at the apparent frequent initiation of **having been required** to empty a patient's bed-pan. The debutante nurses would take themselves off to the toilet to regain her composure or was encouraged to go and have a cup of tea or a smoke in one of the cupboards by one of the older, experienced and more kindly nurses. It was hard to escape the conclusion that the cupboards of the hospital constituted a vital defensive position for the nurses.

⁷ An arrangement to accommodate my unfamiliar knowledge of what went on in the hospital teaching was to invite me to the regular staff clinical "demonstrations". It seemed that a gynaecological patient was demonstrated and on alternate weeks a psychiatric patient (brought up from the wire-caged semi-dungeon below where they were housed before being transferred to a psychiatric facility). The professors were told who I was and the demonstrations were normally scheduled in the **nurses'** curriculum following my seminars and before I was taken to lunch. The nurses seemed to enjoy the fact that after some particularly colour filmed gynaecological surgery I was somewhat green with no appetite for lunch. It was some weeks before a professor asked me to comment on one of the demonstrations. Then it was a gynaecological matter and not one with any psychological or emotional content.

⁸ **A version of my growing "bottom-up" receiving-end approach.**

About the time that I had been reading these assigned narratives I was also holding seminars with the staff of a home for unmarried mothers. On one of these occasions the receptionist at the home suddenly said: “You know, it’s funny but sometimes I see girls coming up the path of this house and when they get inside the front door you can literally see their bellies “pop out.” This telling observation soon led us to consider the Home as a hiding place, a place in which it was no longer necessary to hide one’s belly but was free to allow it, as the receptionist said, “to pop out”. At this point in their seminars I was beginning to wonder about the nature of the home as a hiding place. I had been intrigued that for three or four weeks, if I hadn’t known, there was no way of guessing that this was a home for unmarried mothers. My impression of the general **ambiance** had led me to think of it as some kind of Youth Club. I faced the staff in the seminar with this one day by asking them about the “Welcome Book”. The staff had produced a welcome book for the new girls as they arrived at the home. I asked the staff whether they would like to consider a welcome book for new members of staff. I wondered whether we would say, for example, that this was a Youth Club for girls who happened to be pregnant or whether on the contrary we would acknowledge that this was a home for pregnant women who happened to be in the main teenagers.

Although the staff was rather cross at this suggestion of mine, it did lead us to consider whether in fact we allowed the emotional bellies of the girls to pop out in the same way we tolerated the physical popping out. I was able to demonstrate how many of the staff were in collusion against the expression of the emotional pregnancy of the girls. We discussed hiding and unhiding operations in the home.

An example of a hiding operation came at Christmas, when the girls singing carols around the piano began to weep as they sang “Away in a manger”. The weeping became contagious and the pianist was unable to continue; one of the girls ran out of the room and a number of the staff, hoping

to save the day, took over at the piano and began to play a jollying up song to which the girls began to dance the twist and restore their equilibrium.

So it was I became particularly alerted and interested in the hiding situation both physical and psychological with the nurse in the hospitals.

The nursing faculty quickly appreciated my observation of the hiding aspect of the cupboards and jokingly suggested they might change the labels on cupboard doors from such as “linen cupboard”, “pantry”, etc. to “hide here” or “no hiding place here”. They acknowledged readily the need for the student nurses, indeed all nurses, to find effective ways to deal with their feelings and agreed to discuss where the feeling aspects of the nurses’ job could be freely and supportively approached.

We soon began to puzzle about two separate views of the nurses. The nurse tended to think of herself as helping, gentle, good, a giving person, and yet the patient often saw her as indifferent, cruel, hurting, demanding, a callous person. In an attempt to come to grips with this discrepancy and also to get the nurses to begin to appreciate the patients’ point of view, I asked them to describe their own experience as a patient in a hospital or in visiting the doctor. The difficulties that the nurses experienced in carrying out this assignment were discussed in terms of the difficulty of expressing personal feelings to strangers, (including perhaps in the present seminar the nurse to me the leader of the group) and from there we easily moved to the patient-nurse situation. We talked about the relief that people can experience in sharing feelings and the matter of confidentiality. There was also an interesting side discussion on what was meant by ‘patient’. We saw that the patient’s role was a changing one in modern medical practice and noticed the passive nature of the word “patient” – (patience) compared to the increasingly active role in their own treatment the patient is expected to play in recent times in which an element of impatience might be appropriate.

The nurses provided a wealth of rich experience in their ‘when I was a patient’ reports. The words that they used repeatedly were anxious, fearful, hostile, resentful, regressed, angry, immobilized, lonely. What seemed common themes were the widespread depth and intensity of their feelings; amount of anxiety involved in approaching the medical profession; the heightened awareness of smell and size and dread of the unfamiliar happenings and surroundings; the indignity; loneliness, helplessness and arising out of the fear a projection a host of negative, threatening, characteristics displaced onto the doctors, nurses and receptionists. These reports the nurses had

supplied opened up the opportunity to explore the nature of anxiety and the common defences, and the qualities of empathy and reassurance. A great deal of time was given to what was and what was not reassuring. We examined facts and fantasies about being ill, the way in which we could place limits on the patient's uncertainty and the value of realistic explanation.

After about four or five sessions on the nurses began to complain that much that we had been learning that might be of value to the patient they were unable to put into effect because of what was ordinarily expected of them on the ward. They hinted darkly what might happen to them if they were caught talking to patients rather than getting on with the job. They became angry at the hospital, the nursing sisters and the doctors. They were expressing their frustration quite heatedly and the feeling of tension in the group mounted steadily. Eventually one nurse exploded with anger about the patients also, and the demands that they made upon them. One or two nurses enthusiastically joined in this condemnation of patients, but other nurses quickly objected. "She doesn't really mean that", one of the nurses explained to me, and the group became somewhat divided amongst those who were getting some relief from being angry at patients and those who were obviously denying that such anger existed. I was somewhat astonished at the intensity of feeling and this had come at the time when I was about to ask them to write about their most difficult patients and the way in which they responded to them. However, I thought that in this heated atmosphere such an assignment was not particularly timely and instead I asked them either to describe their feelings and handling of their most rewarding patient or their most difficult patient.

It was fascinating to find when reading their assignments that 18 were about the most rewarding patient, one about the most difficult patient (who in the end turned out to be the most rewarding) and the remaining report seemed miscellaneous as it was difficult to decide from its content whether it was telling about the most rewarding or the most difficult. I commented to the nurses about this high proportion of rewarding patients and a useful discussion ensued about the problem in acknowledging failure and anger. The nurses glanced at each other and I wondered whether they were remembering the way they had felt the previous week. Eventually one nurse exploded: "We shouldn't feel patients are difficult." It was soon admitted that nevertheless we do feel these things and that we might as well recognize the truth of our feelings and learn what to do about them. One of the most rewarding patients was described as follows:

"Mrs. M is a pleasant woman in her early sixties with a diagnosis of a coronary. When I first met our patient I couldn't help the feeling of pity that struck at my heart. Mrs. M- was not only bedridden with a heart condition, but she was also crippled with arthritis. Her hands were so twisted

out of proportion that I doubted if she could use them. To my surprise, when I took her breakfast in to her and announced that I would feed her this morning, her reply was “Oh no, dear, I know you are busy, I can manage.” I went on to explain that it was her doctor’s orders to do as little as possible until she was well again. While feeding Mrs. M. I found that she was a quiet woman and only spoke when questions were directed to her. During Mrs. M.’s stay she rarely asked for anything. She thought of herself as a burden to the staff when she had to be fed and bathed.

One day a few weeks after her admission, one of the patients in her room called me aside and said Mrs. M. was in tears. When I went to her she quickly dried her eyes and smiled at me. I asked her whether something was bothering her, any pain, or maybe just a personal problem. Mrs. M. said, “I didn’t want to bother anyone but I have a terrible pain in my chest.” I assured her we would give her something to relieve her pain and told her not to be afraid to tell us if it should happen again. The doctor checked Mrs. M. and ordered oxygen and Demerol to help relieve her distress, as in fact she was having a life-threatening coronary attack. I can’t tell you how grateful she was, in fact anything that was done for her was rewarded with a smile and a thank-you. Mrs. M. was a favourite patient of all the staff on the floor. It was a pleasure taking care of her. The day she went home was a tearful and happy occasion.”

There were useful things to discuss in this account. One was the way the nurse explained about the feeding of the patient: “it was the doctor’s orders”. It is interesting to see how nurses divide themselves from the doctor by saying that the necessity for the nurse feeding the patient was his orders, rather than interpreting it as performed by the nurse as being part of the shared responsibility with the doctor for the patient’s care. The “might be just a personal problem” was probably a sop to the seminars that we were then holding. In this particular rewarding case I wondered out loud to the nurses that maybe Mrs. M. could only have been a better patient, if when she felt the pain coming on, she had given herself a good wash down and silently slid down to the morgue and laid on a slab quietly without bothering anyone. The nurses responded very angrily to this provocative suggestion. I felt that perhaps I had overdone it but one nurse smilingly forgave me and we quickly found ourselves acknowledging the ideas of the rewarding patient having emerged from their accounts as being rather the ones who gave the least trouble and was most helpful and grateful to the nurse. In summary, was therefore not properly ill at all. A corollary to this was the element of rejection of patients who were difficult for the nurses. It was noticeable at this and other seminars how punitive nurses often became to the excessively dependent and demanding patient. I never quite succeeded in getting nurses to understand the negative quality of the patient’s responses were possibly arising from the kinds of enforced dependence, isolation and emotional deprivation that the illness and hospitalisation involved.

In describing the most rewarding patients, the words that came most readily to the nurses were grateful, accepting, uncomplaining, tolerant, independent, devout, patient, co-operative, devoted. I put these on a blackboard, drew a line down the middle and then put up the words that they had used

earlier in our very first seminar to describe themselves as patients: anxious, fearful, hostile, resentful, spoiled, regressed, angry, immobilized, lonely. “Two different species of human beings?”, I enquired. The nurses recognized the contrasting good and bad in the two lists. It depended, one of them said, from whose point of view one was looking at it. When they were describing themselves they were describing from inside the person; now when they were talking about patients they were looking at it from outside. “Does this mean that inside one feels one thing”, I asked, “and from the outside can seem quite the opposite?” After some debate the nurses agreed that it was a mixture in and out and good and bad for all patients. Discussion continued on anyway how much feeling should be encouraged to be expressed, especially in a hospital setting. This debate centred round advantages and disadvantages to whom, the patient?, the nurses (“are nurses allowed to cry”)?, the family? A side debate grew on the nature of dependency, the dependency that happened in hospitals naturally and possibly some unnecessary excessive dependency, and its emotional meaning. In this context the nurses examined the word “nurse” and noticed its maternal feeding quality in the same way that we had noted the word “patient” and its passive connotation.

The nurses then grappled with the problem of people who look “as if”, that is, look as if they are going to be good patients or look as if they are going to be good nurses, but that the nurses and the patients, as we had discovered, don’t really feel the way they look from outside and this brought us full circle once more to the discussion of defences. Some attention was given again to the anxiety that arises from the element of uncertainty on the patient’s part, uncertainty about what is going to happen to him/her, its causes and outcome, and from the nurse’s point of view the uncertainty that anything she or the medical profession can do is uncertain in its outcome also.

The growing awareness of the feeling content of both nurse and patient inevitably aroused some wondering about the proper distance that should exist in the nurse-patient relationship and the discomfort of this self-awareness brought with it “a feeling of loss of spontaneity, having to think about everything before you do it”, as one nurse said irritably.

I discovered that at this time (1958) not only was it unusual to find any attention given to anything but the physical aspects of medical care but the matter of death and dying was nowhere in evidence in the medical and nursing curriculum. This was some years before dying became almost a literary subject and popular discussion on the media. Perhaps inevitably in the seminars, having brought feelings out of hiding, the problems surrounding the dying patient, to know or not to know, and so on surfaced. But here too, some nurses hid behind the idea that this was the doctor’s

responsibility and nothing properly to do with them. However, many nurses objected and resented this being thought the doctor's responsibility. It was the nurse who was with the patient for a longer portion of the hospital days of the terminal illness and it was they who were most visible to and approached ("besieged" one nurse said) by the dying patient's relatives. They were angered that doctors often avoided or seemed to avoid this responsibility around dying and that they were left in a very troubled state in facing both patient and relatives.

Having introduced the subject, the nurses were intrigued and uncertain about the value of their own feelings and insights in opening up something about patient's feelings. We lamented that we didn't have such an instrument as a "feelometer" but recognised that our own feelings, however inadequate, were what we had available in understanding and empathising with other people. In that respect our feelings can become a sensitive human tool in learning to meet, however imperfectly, other humans in need.

The nurses then began to look at the depersonalisation process that seems to take place in hospitals for both patients and the staff. Finding oneself one of many this exaggerates the sense of being outside one's familiar surroundings. One's very body takes on an unfamiliar quality also, the nature of one's illness or incapacity drawing attention to bodily functions which one has ordinarily taken for granted. For example we are hardly conscious of the movement of our limbs, and certainly not of the daily painful process of command to our limbs that arises if a limb is damaged or injured. There is a deep sense of disconnectedness about previously "natural" movements and a new conscious effort has to be learned and made. Temporarily at least, this damaged part of our body comes to be regarded almost as a stranger in our midst. This feeling of depersonalisation and unfamiliarity tends to further raise anxiety. For people whose ego strength is ordinarily not very strong this can be a very frightening experience indeed. Over and beyond this, the experience of being handled, washed, fed and placed upon the toilet re-awakens one's feelings of being a child and dependent. For normally independent people this can be traumatising, and possibly for those who have had to struggle for their independence or have had difficulty with this during their early years and through adolescence many emotional memory traces are stirred and increase the patient's anxiety. In addition, there is the fear aroused by suffering and the human condition of having to eventually recognise the finality of life which becomes only too real in the hospital and has not been so in their everyday outside world.

This of course is part of the daily ambiance of patient tension within which the nurse needs to function. Though she is constantly emotionally absorbing the impact of the suffering around her, she is challenged to find a comfortable way of dealing with her feelings. Building up some satisfactory reaction gets to work, which might be temporary as in the hiding in the cupboard kind or adopted long term in a manner which might seem to be indifference⁹. Overcome by her need to deal with such feelings without sufficient supportive recognition of this early on in the training process, might well be a factor in the loss to the profession of many sensitive young women, who are not assisted in finding a comfortable way of channelling their feelings and would have made very good nurses.

My very strong impression is that both in training and in practice, nursing has inadequately explored the most effective ways in the interest of their patients of using their own feelings and turning to creative use some of the responses that are at present defensive and use up valuable energy. This inadequate way of using oneself is not, of course, limited to the role of nurse. (I am reminded here of a recent article looking at the school situation in which the author suggests that many teachers settle down to a kind of chronic depression when they find themselves unable to use themselves creatively). I saw that medicine generally had not (and probably still has not yet) integrated modern knowledge involving human emotions, either in the organisation of hospital procedures, where a degree of bureaucratisation of the institution is probably necessary in the practice of modern organisation and techniques, but is also very marked in the role of the general practitioner. The general practitioner who traditionally prides himself on being the family doctor seems to have to rely upon a very rough and ready understanding of his patient and their families and uses himself intuitively. For the nurse the problem is not merely “Am I a good nurse, or not?” With regard to the emotional aspects of her work, she cannot model herself on the image of good professional nursing because a satisfactory model has not been available and held up for her to study and emulate. The nurse therefore finds herself confusing her own lack of knowledge and skill (which at least motivates her to learn and improve performance); with the situation where the knowledge and skills do not yet appear institutionalized either in the nurse’s training or sufficiently recognisable in the performance of experienced nurses. Here of course is a plea for a reorganization of training in the medical professions to include this new area of knowledge and skill, not merely as a specialised branch of

⁹ Despite all the work I had done with nurses, years later when my own mother died, I was moved to say to the nurse seemingly over-occupied in trivial hospital processes “This is the first time for me, I suppose you must get used to it” My insensitivity was properly rewarded by her responding “We never get used to it. It always feels a first time”.

medicine belonging perhaps to psychiatry, but as an integral part of all kinds of human contact involved in medical procedures, in diagnosis, in treatment and in follow-up care.¹⁰

This particular nursing seminar eventually moved to a consideration of the meaning of the patient's illness to their family. I found very useful a film called "Home again", which was produced to show the work of the "Home Help". This is an American film and its focus is on a young woman who has a heart attack and is taken to hospital rather dramatically, and shows the efforts of the father and the three children to cope with this unexpected situation. The home help enables the father to stay at work and keep the family together. In the process we see very beautifully the reaction of the children at different age levels, the adolescent, in the latency period, and the under-five, to the absence of their mother and the tension within the home. We see too, the return of the mother, both her initial gratefulness and growing resentment at the thought that the home help is taking her place in the house and in relationship with the children. This sense of loss of her former prized role leads to the mother's withdrawal into a depressive over-dependence. She is gradually assisted to take hold once more of the family affairs, although she has to change many of her, and the members of the family's ways, of going about things

The nurses showed a great deal of interest in this film and it stimulated an insight for discussion into the role changes for the patient and the role changes for the family members when they are threatened in this particular way¹¹..

We were then able to explore the idea that conditions of health and illness play an important part in behaviour in the total family dynamic and do not merely involve the patient isolated in the hospital bed. It is easy for the hospital to become, both for the patient and the nurse, a small world of its own, relatively unrelated to the outside. Certainly this is partly due to the intensity and depth of feelings that exist in a hospital and the deep ties that grow between the people involved in this life and death kind of atmosphere. However, if the hospital is to play its proper role in a society increasingly thinking in terms of community care and interested in the well-being of the family, it must begin to play a part in a continuum of care from the home through the generalist to the specialist

¹⁰ Refer to Balint

¹¹ Some years later using this film with quite a different group I had been intrigued by the work of demonstrating the genetic structure of DNA. I imagined the family as a similar model and what happened dynamically when part of the structure was taken away and needed to be replaced.

and back again, and which does not give priority of place to the rather more spectacular and dramatic aspects of care that take place in the hospital setting.

These seminar discussions ended with a general look at the changing role of the nurse in the past 100 years and a glimpse at the way in which the nurse's role has developed¹². These developments of course depended to an important extent within the nursing profession itself and it was useful to discuss with the nurses the constructive role of their and any other profession's organisation. We ended on the stirring note that the nurse in fact was in a position where she could make a very useful contribution from their unique place of observation of human behaviour to the development of social theory.

It will be noticed here that my role as group discussion leader and perhaps educationalist was influenced by areas of thinking emerging from my social work background. The use made in observing what goes on, in a hospital, at first hand, or through the accounts given by the nurses was/is in the tradition of social work, making use of the understanding of human behaviour drawn from very many different settings. Also it is an example of what became a special concept and practice of looking from the "bottom up" at the receiving end of services to determine what is planned usually from the top down. It also demonstrates, in this case with the nurses, some of the productive possibilities for consultation and a practical collaboration with other helping profession,

These seminars provided the opportunity to expand into such integrative work, still with nurses, but a step somewhat nearer to the social work field of endeavour, that of the Health Visitor or visiting nurse. The health visitor has long been a nurse who works in the community outside of the hospital atmosphere. Although still very much under the direction of the medical profession, she nevertheless finds herself faced with many social situations in which her activities cannot be so precisely prescribed as is a nurse's function in more traditional settings. The health visitor and visiting domiciliary nurse have long had an educational public health function in helping the families with many problems

Some years ago there was some pressure for the idea that the health visitor might become an all-purpose social worker. There seems to be some precedence for this kind of development; in countries like France social work has a very strong nursing

¹² See for example the very readable "Florence Nightingale" by Cecil Woodham-Smith

background. Certainly if the health visitor were to move towards becoming a general purpose social worker one would have to reconsider the whole basis of her training and try to distinguish how much medical and specifically nursing content she needed in her training, in contrast to the more traditional kinds of social work training. Her place somewhat outside of medicine and in local communities (government?) as a public health worker might well have to be reviewed and the possibilities of her working directly with the general practitioner, which is an idea currently abroad, would also have to be thought about. Certainly the focus of the general practitioner is changing and more interest in the family and its problems are being sought where the health visitor might well be of service. Health visitors have long shown interest in becoming more socially oriented and have pointed out repeatedly the ease of entry they have to many families and the possibilities that this provides of their becoming a preventive mental health worker. They often begin by pointing out their ability to identify situations where help is needed and see that they might act as a referring agent. Indeed they are able to identify situations where help is needed but two problems arise from this. Firstly, more often than not they identify the grosser problems, the bizarre kinds of behaviour, chronic social problems and often the psychopathic manifestations associated with problem families. It used to be said in the thirties that one could start a Youth Club by bouncing a football in any working class street. It is my experience that one can start a case work agency merely by bouncing in to any area and making it known that you are ready to receive referrals. Characteristically one receives those cases which have been the bane of all the other worker's lives for many years previously and the most intractable social problems. Here the referrer seems both to have the hope that this new kind of worker will solve the problems and at the same time a kind of satisfaction in anticipating the same kind of failure for the newcomer as she has experienced in the past. What the motivations here are perhaps only fit for speculation, but the point that arises is that identification of social problems which are amenable to help and the process of bringing in that help and preparing the family to receive such help is an extremely skilled process, and at best demands a very high level of skill. In addition, it is unproductive to encourage a large group of people like the health visitors to identify and refer cases given an inadequate supply of services to deal with such situations. Already overworked personnel will find themselves inundated. The health visitor, finding the cases that she refers either unimproved, according to her criteria, or faced with long waiting lists and

slow results, will soon view such services with a growing cynicism. She will returns to functioning as best she can without the help of the so-called experts. Unless one provides for her an opportunity to examine the situation and her own functioning and the emotional factors involved, she will find herself reinforcing the problems that I have discussed earlier in connection with her training as a nurse and in her role in the community will develop the patterns to protect herself against the situations that arise. Something must be done to help her.

I had something of this in mind when I was asked to help with a group of public health nurses in the United States. The American Public Health nurse is a cross between a health visitor, visiting nurse and school nurse. These nurses soon provided for me a host of social situations which puzzled and disturbed them. They looked to me for answers, somewhat swift and magical answers, to be sure. Here are examples of some of the situations the nurses brought to my attention:

- 1) "Mrs. H., age 71, a widow of 12 years, always independent, has been living with her brother (68 years old). They share rent, food, telephone and gas and electricity. Mrs. H has been able to do part-time work up to a few months ago. Her brother retired three years ago because of physical disability. His sister took care of his clothing, did the cooking, and both apparently enjoyed each other's company.

Three months ago Mrs. H. became acutely ill, was taken to the hospital, had surgery, and remained there for seven weeks. She returned home three weeks ago. The relationship is strange. Her brother tells her she is "alright", no need for her to be inactive as she is. He now has to make his own breakfast, necessitating for him to get up approximately one hour earlier. He also prepares his sister's.

???????

This patient cries a great deal, is very anxious about her condition and also her brother's attitude towards her. She has a fear that she is suffering from a malignant disease, although she has been assured by her doctor that she does not, she will be in good health again and will be able to carry on as usual. This apparently is not enough assurance. She looks forward to the nurse's visit. The questioning starts as soon as the nurse arrives. The visit lasts about one hour. The patient makes every effort to prolong the time by asking for favours, such as looking through her personal belongings for a certain gown, or getting a drink of fruit juice, etc. During the visit the patient is cheerful, smiling. As the nurse prepares to leave she becomes sad.

Her brother stays by himself in his room. Sometimes he goes out, or visits friends. When at home he may go to the living room when certain programmes are on television, and sometimes he carries on a short conversation. His sister said

he was never that way – always friendly and jolly. When the programme is over he retires to his room and closes the door. Mrs. H. has asked him to visit during the day; also, what can she do to make life happy for her brother? She has not changed in any way, she tries to be friendly. Her brother never married, always lived at home. Mother died 15 years ago. He then went to live with his sister. What can be done for this woman? Does this man need counselling?”

(2) “Recently I was sent on a call to Mrs. X, a woman 79 years old, who had her left leg amputated above the knee. I had instructions to give her exercise and teach her to walk with crutches. When I arrived, she greeted me with a smile from her wheel chair in the basement recreation room which is her apartment. I told her my name and asked her how she was feeling. She said “fine” and she also mentioned that she was anxious to learn how to walk with crutches although she thought she might have difficulty because of her age. Much to my surprise, she did everything with amazing agility. When we were finished she asked if I could sit down for a few minutes. I could see she was eager to talk so I sat down and she told me some things about herself.

She is a widow who had brought up a grandson since infancy and they lived together in her home. About one year ago she had been taken to the hospital with pneumonia and while there a blood clot developed in her leg. It was a great shock to her when told the leg would have to be amputated but her grandson assured her he would always take care of her and so she consented. At the time the grandson was engaged to a girl and a few months after Mrs. X came home from the hospital they were married. The girl was very congenial and Mrs. X would help her prepare meals and do whatever chores she could in the kitchen. But soon the girl asked her not to come into the kitchen while she was there as she didn’t want her help. And shortly after that she asked her to eat her meals in the sun parlour alone. Mrs. X did as she was requested because she wished to avoid any trouble.

Mrs. X then decided to sell her house as it was a two-story dwelling and the stairs presented a problem. With her grandson and his wife they jointly purchased the home in which they now live. This house was selected with the idea of converting the recreation room into an apartment for her. She agreed to this plan because she knew her only alternative was to go into a nursing home and this she was reluctant to do as she loved her grandson and wants to stay near him. In the new home, her grandson’s wife no longer speaks to her and she sees her grandson only a few minutes a day, when he brings her dinner to the basement in the evening. She prepares her own breakfast and lunch. She is very unhappy as her grandson is very indifferent to her and this situation in which she finds herself is always uppermost in her mind.

I felt extremely sorry for her but tried to cheer her up by pointing out the advantages of her living arrangement, such as having her own television for entertainment and being able to see her friends when they stop off to visit her. Her grandson’s actions, however, prey on her mind and she had a fixed bitterness towards his wife, whom she blames entirely for her present predicament. I do wish I could help her yet I am at a loss as to what can be done under the circumstances.”

One sees immediately the possibilities of working in situations of this kind as a case worker and how readily one might get health visitors to collaborate with such a worker in these situations. The nurse looks for a kind of prescription in dealing with such families or takes cover behind the idea that this isn't really her business. It is here that the lack of a model as to what the nurse should be creates difficulties. The nurse(s) described for me one day in the group the following situation:

She had been asked by a local doctor to call on an old lady who was dying from cancer. The old lady was at home and the nurse was instructed to clean up the patient in various ways. On ringing the doorbell a middle-aged woman answered the door and in a whisper greeted her with "I'm glad you came, nurse, etc., etc., mother's upstairs, she doesn't know what's the matter with her, you won't say anything, will you, etc., etc., as she and the nurse climbed up the stairs. The daughter, as it turned out to be, threw open the door of her mother's room and in a bright voice explained, "Here is the nurse, mother, it's a beautiful day, isn't it, nurse?", and then the daughter busied herself opening the curtains and chatting away non-stop for the next 20 minutes.

The mother, grey and hunched up, with eyes bright in her emaciated body, watched the nurse carefully. "It will soon be spring now, mother", said the daughter. "We'll be going down to the beach, etc., etc., won't we, nurse", and so on and so forth. The nurse proceeded with her task of attending to the patient's physical care and was eventually ushered out of the room with the daughter still gaily speaking. Once the door was closed the daughter reverted to her whisper: "What do you think, nurse, how long to you think she's got, etc., etc.", until the nurse found herself once more on the doorstep, not having got a word in edgewise.

The question of what could and should the nurse have done in such a situation. The nurses in the group were very undecided as to whether they had any responsibility for the climate in the home. Some suggested that this had to be reported to the doctor, and that this was his affair. Others thought that perhaps the nurse could do something about it, but didn't quite know what. What was clear was that the nurses, many of whom were experienced and had been in the field for many years, were unclear as to what their proper role was, even though they recognised that there were problems here. They looked hopefully to some social worker or mental health worker who might deal with this problem for them.

This question of what the nurse should do is one that has to be decided at a professional level and involves social policy. What they could do I was prepared to

explore, but it was remarkably difficult to get the nurses to consider what had been of relevance to these social situations out of their experience and training as it now stood. They tended to think that the understanding and skills required were quite outside their competence. As in the training of social workers' self-awareness and realisation of their lack of skills in some areas, seem to bring about a distrust of the things that they could do and already did do well.

One day one of the nurses began to relate a situation in which she was washing a patient. The patient looked up and said to her: "Nurse, when you come tomorrow, I won't be here." The nurses in the group fell silent at this point. "Yes, what happened then?" I enquired. "Well, nothing happened", said the nurse. "Nothing happened?" I said incredulously. "Well, no, nothing." - "What did you do?" I said. "I didn't do anything", the nurse replied. "Take my arm, nurse", I said. "Wash my arm. Tomorrow when you come, I shan't be here. What did you do?" - "Well, nothing", said the nurse irritably. "Well, did you vanish into thin air?" I said. "Of course not", said she. "Well, did you drop her arm and run screaming from the room?" "Of course not", the nurse said. "I stopped washing her arm but I kept holding her hand; if anything, I held it a bit more tightly." "What happened then?" I enquired. "Well, nothing", she said. "Well, how did you feel at that moment?" I enquired. The nurse thought for a bit, then said: "Well, you know, I was frightened, I think, and yet", she said, "... I felt full of respect for the patient; you know", she said, fighting for words, "a sort of sense of awe. I just stood there", she said. "Oh no, no I remember, do you know what the patient said to me?" "No", I replied. "Well, the patient said: 'Thank you, nurse, for not saying anything.' "

The group of nurses seemed to relax visibly at this point and I used this illustration to show how much the nurse had in fact done for this patient in doing nothing, as the nurse put it. This kind of nothing was one of the most valuable things that one human being could give to another. The nurse's response of respect, of fear and awe, and yet her unruffled presence had helped this patient come to terms with one of the most profound and lonely experiences that a human being has to face. I think I was able to make the point that it was this quality of empathy, of understanding and human response which was at the root of what the nurse might do for her patient with knowledge, understanding, courage and skill, certainly courage,

for it is not easy to stand on the edge of things with patients in this way. One's own feelings interrupt.

I am reminded of a young nurse's experience recorded in an article in the Journal of Social Work:

“Every day when she entered his room, she felt a strange upsurge of feelings of guilt. She was going to live, while he, of her own age, was about to die. ‘I know he wanted to talk to me; but I always turned it into something light, a little joke, or into some evasive reassurance which had to fail. The patient knew and I knew. But, as he saw my desperate attempts to escape and felt my anxiety, he took pity on me and kept to himself what he wanted to share with another human being. And so he died and did not bother me.’ ”

Seminars, the plays and professional meetings required my participation and formal presentations.

Among the latter was a paper “Paths to Main Street” given at our major annual conference in 1959. These conferences were both a contribution to the public's understanding of mental health issues and also served to bring attention to the work of the Association and to strengthen its regular fund raising campaigns^{13,14}.

¹³ Paths to Main Street was to be the opening presentation before the major paper by Paul Lemkau from Johns Hopkin Medical School.

¹⁴ This review took a long time to read which kept Lemkau waiting but it was appreciated by the audience and especially by Dr. Ralph Shapiro who sat smiling approval in the front row. Ralph's wife Alice, who served at Rutgers University, was a member of the Board of the Association. Ralph was a paediatrician with a left wing political turn of mind. He ran a public “Well-baby Clinic”, ‘Well’ because the medical profession would not allow a public facility to provide medical services and so make it possible for attract sick babies as patients and so avoid paying unaffordable doctor's fees. Ralph served the under-privileged and unemployed in his area with whom lay his sympathies. Ralph had been incensed during the depression when unannounced and unasked the medical association had placed a notice in his private waiting room announcing a raise in medical fees. This event was to have a resonance for him down the years.

He had kept working long into his eighties, he had a following of families as patients who continued to bring grand-children and great grandchildren to his office, he provided care to those in facilities for unmarried mothers, and in the prison service. No mean artist himself, he ran art classes and played tennis. It was during one of these octogenarian tennis tournaments that he had a heart attack and Alice decided it was time for him to retire and leave the harsh winters of New Jersey. She saw herself caring for the indestructible Ralph for many years to come and she went south to Florida and bought themselves a house.

When Ralph, always interested in theatre, had enrolled them for a summer theatre school in Oxford they came to us in South Wales and soon thereafter it was Alice,

Paths to Main Street addressed something of the history and attitudes to mental illness in the USA, and in New Jersey in particular, ranging from President Pierce's veto in 1854 that upheld the view that the Federal Government's intervention was unconstitutional in the cause of the mentally ill: the hiding and "snake pit" incarceration of the troubled and the demented; to the Community Mental Health Services Act of 1957 (which had provided matching dollar-for-dollar State aid for voluntary NGO services)¹⁵ from which the MHA was able to request funds had heralded bringing such matters fully out into the open onto our Main Streets. The MHA too was active in this movement of towards visibility (unhiding?) of mental health care by promoting, bringing pressure to bare, in establishing child guidance clinics and psychiatric wards in general hospitals

many years younger than Ralph who unexpectedly died, leaving Ralph somewhat marooned in what he described contemptuously as "Reagan Country" Ralph had been in the Navy as a physician in the Pacific during the war but somehow his politics and demeanour had apparently not endeared him to the military command and he was assigned to be entertainments officer! on an aircraft carrier, I believe, in the Pacific. He was certainly an entertaining man. I have a portrait of him at an advanced age, arms flailing full of animation. He described to me how a mother worn out with her babies feeding demands was asked by him "Why can't your husband give the baby his 2am feed?" The answer came back "My husband wouldn't get up to see the Statue of Liberty take a piss in the Hudson River"

When I last visited him in Florida, sharing his Jacuzzi he confided to me that after Alice's death he discovered that she had unbeknown to him continued paying insurance policies which he had accumulated during the pre-war depression years when unemployed fathers had come to his doctor's office and asked him to sign up to pay as little as 25cents a week endowment. Apparently he had subscribed at that time and Alice had found dozens of these policies and paid them up over fifty years. Ralph found himself (somewhat ashamed, given his left-wing sympathies, a millionaire!). At the time I suggested he might become the traditional theatre-world "Angel" and modestly finance the Public Service television production of the documentary play of "Bertha Capen Reynolds, (a radical pioneering USA social worker) I had written and had had performed. Ralph had already given away his unexpected fortune. He also related to me confidentially a sad account of how he had come to the conclusion that he had better give up dating.

When I was called away from Florida curtailing what turned out to be our last meeting he was trundling his three wheel bicycle (his children forbidden him to drive) to give his art classes to a local group

¹⁵ The "Freeholders" (the significantly archaic title of the elected who legislated for New Jersey) had established a maximum ceiling of 20 cents per capita provided by the Act for such aid. And this had been oversubscribed since 1958. (In comparison neighbouring New York State provided \$1.40) By 1962 after two years of pressure to raise the NJ ceiling by 5 cents it was still held up in the NJ Assembly).

One opportunity led to another. The seminars, plays, professional meetings, interviews and formal presentations, I have been describing, amounted to perhaps almost two hundred public appearances a year. This resulted in my beginning to be personally known widely in the communities of Essex County. I found that my Englishness was generally an asset ¹⁶ ranging from “cute” like the telephone operator who was moved to tell me “I luv your aax-cent”; through a benignly tolerated “eccentricity” (my, by USA standards very (ten years) old car, ““not really suitable to my status”! and the returning from New Mexico with a (just show it on Monday morning) beard;¹⁷ and on to those who seemed to respect and admire (USA ally) British political institutions, values, and sometimes what they actually knew of social services. 1958/61 were immediately post - McCarthy witch-hunt times. Americans (rather like nearly 50 years on in regard to Iraq) were loath to incite controversy. Being British I was deliberately used at the MHA in a role of USA “innocent” to selectively raise issues and to question and say what my colleagues might well know a lot better about, but were more locally vulnerable politically, and therefore wise (and it would be perhaps counter productive) not to get into .

There was the infamous occasion when I had been commissioned to present a paper at the annual National Social Welfare Conference in 1960. The conference organisers early in the year asked me to address my experience of psychiatric services in America from my British perspective, and I sensed or at least imagined being perhaps British ‘cute’, entertaining (as in the Mental Health Little Theatre events) as an item in the usual serious conference world.¹⁸ . The Conference was not to take place for some months and I was prepared to commit myself for more or less anything in so far a time in the future. Anyway it would be fine visibility for the Mental Health Association (and the small fee which was offered, as did all such, would go to the MHA). A long time later one early Monday morning as I arrived in the office, the conference organiser telephoned to ask me the title of my contribution. It had been a hard week-end and I wasn’t yet really awake. I answered, even surprising myself, “The Laggardly Eagle”. They wanted me to repeat it and asked me to spell “laggardly”. When I replaced the

¹⁶ Except for one bizarre morning when a minor car mishap brought me to the attention of Irish traffic cops and temporarily my colleagues dubbed me “Public Enemy Number 1”

¹⁷ a short account?

¹⁸ This thinking had been influenced by the American response I had observed to such as the British John Osborne’s play “Look Back in Anger” and soon after Jack Kerouac’s book “On the Road” It had seemed to me that once labels had been applied “Angry Young Man” and the “Beat Generation” the critical serious social content and challenges had seemed to become the entertaining subject for smiling dismissal at professional and social receptions and parties.

receiver I wondered what I had done and could hardly console myself with remembering that a psychiatrist had once told me that he never did his best work until he had fallen asleep during a psychotherapeutic session with one of his patients. Nevertheless I did write a paper entitled "The Laggardly Eagle - A Transatlantic Commentary on Mental Health Services" and as agreed, was paid the fee for supplying two hundred copies in advance. The local "Newark News" came to interview prior to the conference and the reporter said that they intended to produce a full page article in the Sunday edition. (US Sunday newspapers run to hundreds of pages).

The Eagle was not gentle but pointedly provocative, covered a great deal of ground, swooping down on many targets in what I saw as the paucity of attention and general miserable quality and quantity of services and resources for the psychiatrically in need, in this comfortable, affluent USA. It was not diplomatic but was intended as a wake up call relevant to the logo of the movement to "Ring the Bell" for Mental Health. The paper "The Laggardly Eagle - A Transatlantic Commentary on Mental Health Services" was delivered at Atlantic City. Oddly the discussant provided by the State to chide and refute, went some way to illustrate beautifully the attitudes and shortcomings I had raised. However, I was met with astonishing hostility from doctors in the audience some of whom stood and shouted. Later I received abusive and some obscene letters and happily some supportive fan mail from others. The full page spread never appeared in the Newark News, just four lines (misspelling my name) but curiously four items in its hundred of Sunday pages referring to Eagles. (I wrote a bemused letter to the editor which was partly published but became increasingly reduced in later editions).

There followed a serious complaint from the American Medical Association (AMA) sent to the Board of MHA. Asked to be specific in their objections, of all the possible controversial issues, the AMA picked up a minor point of information where I had described the gross differences of pay and conditions of physicians in the public services compared to the private sector The AMA declared "Remuneration of doctors was not a proper subject for public discussion"! What I believe really enraged was that I had spelled out how the vast majority of physicians in the public sector were foreigners and foreign trained (Professional supervision and such public service was a requirement for eventually being able to practice in the USA). I had provocatively said that looking at the figures of doctors working in the public service might lead one to conclude "It was an un-American activity"

Fortunately our prestigious MHA Board of Directors and supporters, who were regularly efficiently and fully briefed by Arnold Rabin our executive, knew our work, understood, approved and were always

ready to underpin and extend our endeavours. On this occasion, the Board diplomatically without necessarily approving all I had had to say defended my right to speak of such matters.

In all fairness I should say that some many months later when I moved on from MHA and New Jersey the Newark News printed my photograph and a very complementary account of my work which was not in the style of an obituary¹⁹

As an epilogue perhaps, some years later when Bob Stepney a British colleague wrote “Dickens in America” an article for an American professional social work journal, he quoted from the Laggardly Eagle showing how much was still the same as in Charles Dickens’ visit long before. The editor asked for the reference and sent to the National Conference who apparently denied they knew of such a paper. (This despite the two hundred copies I had supplied in the terms related to the fee they had provided).

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To remind me

One of the assignments to the nurses asking them to describe their own experience as a patient produced an account that showed nicely how her appraisal of the hospital staff changed when her anxiety was relieved. Not only that, but her symptoms seemed to undergo a change in severity. One may well ask, and in fact one in the class did, what treatment had the doctor given in this situation. In terms of the difficulties in making an adequate diagnosis we may note too that the patient’s secondary symptoms (“I thought he’d have to start treating my heart attack out of fear before the polio”) began to dwarf the symptoms that the patient had brought to the doctor in the first place.

¹⁹ . I remain much appreciative and derive much professional and pleasure from recalling my time in Essex County and have remained happily in touch with Arnold Rabin still now, for nearly half a century.

