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From the Editor's desk

By Peter Tyrer

Old messages

I have always remembered George Santayana's aphorism that those who do not know the past are condemned to repeat it, and there are some strong messages in this issue that reinforce his point. The history of effective treatments in psychiatry is a relatively short one but we can still learn from it. Almost the first patient I treated when I started my career in 1966 was someone to whom I had been asked to give insulin coma therapy. To say that I was unprepared for this enterprise would be an understatement; it was in a state of great apprehension that I gave increasing amounts of insulin to my schizophrenia patient with no apparent impairment of consciousness, only for him to succumb suddenly after several hundred units. This led to massive glucose infusion through every orifice available and I have never been so relieved to see someone wake, either before or since. Of course, Fernandez-Egea *et al* (pp. 434–438) explain why my patient tolerated such large doses of insulin and when McGrath[1] first noticed an association between schizophrenia and diabetes mellitus he was not to know that a new class of antipsychotic drugs would make this association much more common.[2] Recollections of the sort of wild practice that I undertook at that time were rekindled when reading Gazdag *et al*'s account (pp. 387–388) of Meduna's introduction of convulsive therapy to psychiatry. His initial dose of camphor did not produce a convulsion so he 'doubled it'; would this, or any part of his experimentation, have been permitted under any circumstances by a modern ethics committee? Indeed, could the studies that eventually led to the introduction of ECT have ever been formulated in such a way as to pass current, tight ethical scrutiny?

Most of the old advances – some call them deviances but most were advances – in psychiatry involved people being both bold and serendipitous. Most of the studies that were hypothesis-based tested the wrong hypotheses but knowledge advanced despite this. When John F. Cade discovered the antipsychotic effects of lithium[3] he was investigating the possibility of an abnormality of uric acid metabolism in patients with psychosis; lithium was fortuitously introduced to improve solubility, not as a treatment in its own right. The subsequent story of lithium is an amazing one, but if the results of Ohgami *et al* (pp. 464–465) are replicated we might well see the possibility of clean water with added lithium, like fluoride for dental decay, representing an advance for public health matching the achievements of John Snow in finding the source of cholera. If the work of Nunes *et al*[4] is also replicated, such an intervention could also reverse the dramatic increase in the prevalence of Alzheimer's disease. It would certainly reverse the declining use[5] of one of our celebrated drug treatments. Many would like to see a little more certainty in our prediction of mental illness than even these impressive results suggest, and the interest evinced by participants in the study by Wilhelm *et al* (pp. 404–410) suggest that the results of genetic profiling will not be viewed as the finger of predestined doom that some have predicted, possibly because the gene–environment interaction (see Highlights, p. A19) can be influenced by behaviour. This approach may be superior to standard screening (Baas *et al*, pp. 399–403) but we need more certainty before we gallop ahead with this methodology[6] and, while we evaluate these approaches, the old messages will continue to reassure.

Rowing for 28

So much for important history; I would like to add a more trivial personal one. Forty-three years have passed since my insulin coma patient. I have not had to repeat that treatment but I must have given hundreds of others in various combinations since. I have now finished my regular clinical practice in assertive outreach, have only had one day of sick leave since qualification, and can count myself lucky that I have had the opportunity to practise over a period when the two halves of psychiatry recently highlighted by Craddock *et al*[7] have merged harmoniously for most of the time. I have bridged the extremes of excessive therapeutic zeal – I too worked with a Meduna-like figure who was known as 'Dr Double It' for his attitude to psychopharmacology – and the detachment of others who have regarded all they do as no more than a holding operation on people who will inevitably proceed on a downward path. I have not often felt uncomfortable in my practice, but when I have, it has almost always been linked to the creeping influence of bureaucracy in public mental health. When I started out in practice I was told what to do, got on with it and had the opportunity of help when needed. I was rowing a boat with one guide at the tiller directing my efforts most efficiently. Gradually other people have climbed into the back of my boat *Severe Mental Illness* – team leaders, site managers and bed managers, health and safety officers, risk management strategists, commissioning team members, senior pharmacists, and evangelical professionals with an agenda I hardly recognise – and proceeded to tell me from their highly informed, but infinitesimally narrow, perspectives what I should be doing with the patients I used to see on my own. So there are now 27 people in the back of the boat, my end is high in the water and rowing is getting to be a real strain. Fortunately, I have had the support of the one major advance in the past 30 years of outcome research, the patients' own views about their care,[8] and in our joint struggle with the bureaucrats we give a little more than we take.

So I owe a lot to the many patients I have met over the years, and at one of several farewell dinners organised by my colleagues (and managers) I was just about able to get away with a raucous song including the following unctuous sentiments:

I've rowed my boat for 40 years and tried to stay on course
Doing what I can for mental health on many different shores
And though I may have erred at times I've stayed close to my dream
I've done my best and I've been blessed
By the patients I have seen

1 McGrath D. Spontaneous hypoglycaemia and diabetes mellitus associated with the insulin coma therapy of schizophrenia. *J Ment Sci* 1950; **96**: 285–92.

2 Smith M, Hopkins D, Peveler RC, Holt RIG, Woodward M, Ismail K. First- *v.* second-generation antipsychotics and risk for diabetes in schizophrenia: systematic review and meta-analysis. *Br J Psychiatry* 2008; **192**: 406–11.

3 Cade JF. Lithium salts in the treatment of psychotic excitement. *Med J Australia* 1949; **2**: 349–52.

4 Nunes PV, Forlenza OV, Gattaz WF. Lithium and risk for Alzheimer's disease in elderly patients with bipolar disorder. *Br J Psychiatry* 2007; **190**: 359–60.

5 Young AH, Hammond JM. Lithium in mood disorders: increasing evidence base, declining use? *Br J Psychiatry* 2007; **191**: 474–6.

6 Zammit S, Owen MJ. Stressful life events, 5-HTT genotype and risk of depression. *Br J Psychiatry* 2006; **188**: 199–201.

7 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

8 Shipley K, Hilborn B, Hansell A, Tyrer J, Tyrer P. (2000) Patient satisfaction: a valid measure of quality of care in a psychiatric service. *Acta Psychiatr Scand* 2000; **101**: 330–3.

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