Perspective

An occasional series in which contributors reflect on their careers and interests in psychiatry

Today's conviction – tomorrow's fiction

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Trying to put one's career into perspective is like selecting those eight records for the Desert Island; what should one choose? My recollections are more of people than events. A few individuals have had a lasting influence on me, many more have enriched my life, only rarely have I met somebody I would not care to meet again. People of all types have always fascinated me, and this is perhaps why I have greatly enjoyed my time in psychiatry. My career lacked any master plan, things happened, opportunities arose but my path was determined as much by chance as anything else.

At school in Bedford I was fortunate not to be among the most talented scholars who were channelled into classics and, armed with first class honours degrees, many became impoverished schoolmasters. Two of my friends failed all their examinations, one became a millionaire through broiler chickens, the other later became Head of Intelligence to an Eastern potentate. I had a modest aptitude for science, but no real idea about what I wanted to do in life. An uncle who had a successful medical practice in Calcutta said that if I qualified I could join him and enjoy the privileged life available to the British Raj in India before independence. My subsequent choice of medicine as a career was made not just on hedonistic grounds, but on the advice of a master who pointed out that medicine was an ideal choice for somebody who did not know what they wanted to do. You could join any of the three services which were popular before the war, and a medical qualification was then an admission ticket to a wide variety of well paid jobs in any part of the world. I chose medicine for none of the right reasons, but am glad I did.

I had just returned for my last year at school when war came, so I went straight up to Christ's College, Cambridge. John Crammer was already there, a graduate in biochemistry who was soon to take up medicine. A fellow freshman was Anthony Storr. Our director of studies was C. P. Snow, whom I regarded as a pure scientist, but Tony's artistic and literary talents endeared him to Snow and they subsequently became life-long friends. Snow was concerned about the cultural split between the arts and sciences and tried to persuade me that doctors should also be literate in the arts. At the time I regarded his view as bunk and it wasn't until long after I qualified that I came to see that he was right. I spent the latter part of my career trying to correct the imbalance in my education.

Two of the most brilliant undergraduates in my time at Cambridge were Phillip May and Desmond Pond; both got Rockefeller Scholarships to do their clinical years in America. May was to stay in California where he became an outstanding psychiatrist, but Desmond returned, with incalculable benefits to British psychiatry. It was clear even in those early days that glittering prizes awaited him. Helen, later to become his wife, was one of the few women medical students admitted at that time; they were frighteningly clever and did much better than the men in the Natural Science Tripos.

I got into St Thomas's for my clinical studies without interview and with a minimum of formalities. My father went to see the Dean and once he discovered they shared mutual friends in the Colonial Medical Service I was immediately accepted. I like to think that nepotism in medicine has declined, and that being a rugby playing 'WASP' with colonial connections would no longer be an advantage in getting into medical school.

My induction to psychiatry came at the hands of Henry Yellowlees, an ebullient man with a love of Shakespeare, who invited hungry students to his home in Harley Street; before being fed you had to complete a quote from the Bard that he commenced. Fortunately his daughter whispered the correct response in my ear. His demonstrations of lunatics at one of the local asylums were full of showmanship

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which we much enjoyed. I recall he provoked a hypomanic into a state of considerable excitement by switching his questions at breakneck speed. The purpose was to demonstrate the patient's distractibility. He informed us that this insight had saved him from serious injury for once, when about to be attacked by an angry maniac, he had shouted "kiss me quick" and the violent attack ended in a warm embrace. I was left with the impression that psychiatry was fun, but a subject not to be taken seriously.

A few months before the end of the war, I was called up for service as an RAF medic. The induction course at RAF Horton was run by none other than David Stafford-Clark, whose task was to introduce a bunch of newly qualified doctors into the mysteries of RAF procedures and form filling. He was writing poetry about his haunting experiences in Bomber Command when many aircrews failed to return. We argued late into the night about the doctrines of the Catholic Church which seemed to concern him at the time.

A short while later I was posted to the Far East and landed up in Seletar Air Base in Singapore under the command of Squadron Leader Morris Carstairs (it's a small world?). He told me of plans for an anthropological study in Borneo, and showed his considerable athletic prowess by winning the mile in an inter service athletic meeting. It was said that had it not been for the war he would have been an Olympic medallist. Morris took me regularly by jeep to sample Malaysian delicacies cooked by road-side food vendors. He struck me as really keen to go 'native', which he subsequently did in India by living in a disused goat shed for a couple of years while researching material for his book *The Twice Born*.

War-weary senior doctors were soon to be repatriated for demobilisation, leaving inexperienced MOs like myself to take their place. Overnight I was promoted to Squadron Leader in charge of hygiene and malaria control for South Asia, when I hardly knew one end of a mosquito from another. Fortunately I had a Tamil technician who saved me from making a number of ghastly errors. It was my first lesson in becoming an instant expert and taught me that if you are ignorant of something you are supposed to know, ask somebody lower down in the pecking order; they can be most helpful.

I had hardly settled into my new assignment when I received a signal saying that the VD rate was escalating and I must carry out a campaign to cut it down. So armed with a Canadian film, some posters and lecture notes I visited nearly every military and air force unit in the Far East. The film started off with the picture of the locked gates of a mental asylum. The message, to the tune of the Air Force march, was to the effect that if you indulged in illicit sex, you would go mad. My campaign of fear was a total failure and the VD rate continued to rise until a whole unit in Bangkok was closed down. Perhaps if I had not preached abstinence and given advice on how to make sex safer I might have succeeded.

Returning to London, I found most of the hospital posts filled by others who had been demobilised before me. It was 1947, and, with the NHS less than a year away, I thought, incorrectly as it turned out, that the prima donnas of the new health service would be experts in public health and preventive medicine. This led to a year at the London School of Hygiene and was followed by three years working as a research epidemiologist for the MRC. My major assignment was connected with measles prophylaxis, which at the time was considered a serious health hazard. The team's researches were progressing well when we were struck by a major tragedy. A batch of serum we used was contaminated and several children died of hepatitis. The unforeseen event was very traumatic and made me realise that medicine could harm as easily as it could help.

The event was probably instrumental in my turning to a career in psychiatry. I thought in my ignorance that psychiatrists were less likely than other doctors to harm patients, and it was only later that I found that psychiatry carries hazards for both patient and doctor.

I started my psychiatry at the Crichton Royal in Dumfries where I was awarded a Crichton Fellowship which was an euphemism for an SHO post. It was here that I fell under the spell of Willy Mayer Gross, the most unforgettable character I have ever met. A man of boundless energy and infectious enthusiasm who showed me the fascinating career I had been looking for but had yet to find. P. K. McCowan, the medical superintendent, had recruited some outstanding consultants to the staff. He had the power to cut out any dead wood and ran a fine hospital. He took to me, perhaps because I agreed to play in the hospital cricket team, which was one of his passions. He was the type of leader needed by such large institutions, and since then I have never been entirely convinced about the advantages which followed the later demise of superintendents, but then I have always rather hankered after the retention of some of the best mental hospitals.

A trip to Dublin and an Irish DPM under my belt, I felt I knew most of what was worth knowing about psychiatry. A view that was to be abruptly challenged when I was appointed as a registrar at the Maudsley. Starting on Dennis Leigh's firm, I had to see two patients for 50 minutes daily for six months. I am not sure they were much improved by my therapy but the intense exposure to patients had a profound effect on me. Concepts like transference and countertransference took on a new meaning.

When I rotated to the adolescent unit at Bethlem I took over from Gerry Vaughan (later Minister of Health), whom I first met on the roof of the girls' ward trying to dissuage a distressed teenager from

jumping. The ward sister (who later became my wife) persuaded us to withdraw our attention so we went inside expecting the worst, and in due course the lass came down of her own accord. The consultants, Kenneth Cameron and Wilfred Warren, were contrasting personalities who enjoyed jokes at each other's expense. I recall glancing through the window during Warren's ward round and seeing a girl scratching four letter words on Kenneth's new car. Wilfred's laughter ended abruptly when he saw his own car about to suffer the same fate. Many of those admitted were juvenile delinquents who had proved to be uncontrollable in other institutions. We found them equally uncontrollable. I remember one night when over 70 windows were smashed and the damage was such that there were rumours of closure. Warren told me later that our efforts were of little avail as follow-up showed many became adult recidivists confined to penal institutions. Murray Jackson, who was senior registrar in the children's department, left to pursue a career in psychotherapy and I was agreeably surprised to be offered the post. It was then that I worked with James Anthony and came into contact with Foulkes and group analysis.

There was a certain amount of gamesmanship around the Maudsley. D. L. Davies, the Dean, referred a depressed patient to Emanuel Miller (father of Jonathan) for analytic psychotherapy but was speechless when the patient was returned with a cryptic note "Have you considered ECT?" I recall presenting the case of an encopretic child to Clifford Scott, emphasising material which I thought would be bound to interest a Kleinian analyst, but he remained passively silent until right at the end of the conference he asked "Has he had his tonsils out?" I had to admit I did not know, but his many admirers thought his enquiry had some profound significance which eluded me.

I was pondering my future prospects in child psychiatry and making plans to get married when Mayer-Gross phoned me and said he was moving to Birmingham to help establish a new research unit at Uffculme with a large grant from the Rockefeller Foundation and suggested I might join him. My peers in London said it was madness to venture north of Watford into the psychiatric desert of the Midlands. Nevertheless, I found the prospects of working with Willy and escaping the therapeutic nihilism that surrounded Aubrey Lewis rather attractive. Most of the trainees and many consultants were in awe of Lewis, but he always seemed puzzled about why people were so afraid of him. I remember when I went to bid him farewell; Lewis. who knew full well I was taking up a full-time clinical research post, reproached me for leaving the Maudsley for the fleshpots of private practice. I had always wanted to upstage him by a cryptic response but missed my chance and remained tongue-tied.

I arrived in Birmingham in 1955 to find psychiatry dominated by neuropsychiatry with Philip Cloake, a neurologist with a DPM, at the helm. Myre Sim and Peter Tibbits were already making their mark in undergraduate teaching. A department of experimental psychiatry had been established in 1951 under Professor Joel Elkes, who was more of a neuropharmacologist than a clinical psychiatrist; though he and his wife Charmion had carried out the first controlled trial of chlorpromazine in 1954 at All Saints Hospital, where he had been given a lot of encouragement by J. J. O'Reilly, the medical superintendent. Joel had optimistic dreams and seemed convinced that a pharmacological solution to schizophrenia lay round the corner, and that we were well placed to discover it. I forgot the scepticism I had learned at the Maudsley and believed him. Shortly after I had arrived, other promising researchers were recruited including John Crammer, Felix Letemendia, and David Kay. Michael Chance opened the Ethology Department, Phillip Bradly opened the Biochemical Laboratories and things were just into top gear when, in 1957, Joel announced that he was leaving to take the Adolph Mayer chair at Johns Hopkins. Many people decided to quit; I considered returning to London, but Willy persuaded me to stay and without him the Uffculme Project would undoubtedly have collapsed. Most research projects went into limbo but clinically things were going well and we were getting more and more chronic neurotic patients referred for whom there was little provision elsewhere.

My low morale was boosted in 1960 by the award of an Astor Waldorf Travelling Fellowship, when I was able to spend three months in America visiting many of the best psychiatric research and teaching centres. My tour of the USA was a seminal experience and made me appreciate the great potential for psychiatric development in the Midlands which remained virtually virgin psychiatric territory, with a chance to go in any direction you wanted. American psychiatry was steeped in analytic psychotherapy, in contrast to Birmingham which had only had one psychoanalyst, Eric Haas, who had the distinction of knowing Melanie Klein before she became a Kleinian.

I remember telling Mayer-Gross about some schizophrenic patients I had seen at the Enoch Pratt Hospital near Yale who apparently made good recoveries following analysis with Professor Kubie. Willy grunted and said that he thought the patients would have done just as well with a daily chat with a friendly untrained nursemaid and strongly advised me not to take psychoanalysis seriously. I thought he was probably right about the analytic approach to psychosis but I was less sure about the neuroses, which we had been treating by abreaction, acetyl choline injections or gassing with CO_2, with little success. Such patients seemed much more responsive

to group therapy and relaxation techniques which we were starting to employ at that time.

I was deeply impressed by the strenuous efforts the Americans were making to organise postgraduate psychiatry, and saw a number of excellent schemes. I resolved to try and do something about this when I got back to Birmingham. With the exception of a few centres there was little organised postgraduate psychiatry in the UK at that time. I had been fortunate, but most trainees had to rely on a few tips gleaned from their seniors. There were occasional case conferences, mostly about the selection of patients for leucotomy. There were few structured training schemes so many junior psychiatrists relied on postal courses from Red Lion Square. Fortunately the DPM wasn't very difficult, which was a good thing as new recruits to psychiatry were hard to find.

Mayer-Gross died in 1961, a few days before he was due to return to Heidelburg, and the prospects looked gloomy for research and teaching. Midlands psychiatry was in the doldrums, but our fortunes were dramatically changed in 1962 when Bill Trethowan was appointed to a chair and the headship of the Department of Psychiatry in the University of Birmingham. His main task was to set up psychiatry as a main subject in the curriculum for medical students, but he did not neglect postgraduate psychiatry and asked me to help. As might be expected, he soon found that his small department was over-committed. With the agreement of the Postgraduate Dean and the Regional Hospital Board, a postgraduate office for psychiatry was set up at Uffculme.

Bill asked me to take over much of the administrative load for postgraduate activities and together we set up regular DPM courses, and refresher courses for GPs. In those days doctors willingly gave up all day Saturdays and Sunday mornings, as they were thirsty for training and there was not much about. Today there are lots of courses and many don't bother to attend. Scarcity makes a product valued, a point to be borne in mind nowadays. The most important innovation was Bill's scheme for clinical tutors in psychiatry to cover the whole region; a model which was to be followed later in many other parts of the country. All postgraduate clinical tutors were given official, although honorary, University appointments and became members of the Department of Psychiatry and the senior common room. This was a great leap forward. The 1960s were halcyon days. There were great plans for expansion and we were full of hope.

Recognising the almost total lack of any centre for psychotherapy, Bill asked me to develop Uffculme as the regional centre for psychotherapy. As incumbent director of Uffculme I became a psychotherapist by decree. I welcomed the change for I had always fancied myself as a bit of a psychotherapist, though I have always regarded myself as a psychiatrist first and have never seen psychotherapy as separate from mainstream psychiatry.

The Victorian architecture of Uffculme lent itself admirably to group therapy, which became the sheet anchor of our intensive programme for patients seriously damaged by neuroses or personality disorder. The orientation was group analytic but we did not hesitate to use behavioural techniques at the same time. It was gratifying to find many young psychiatrists keen to train at Uffculme and I convinced myself that many were significantly changed by the experience, but as with therapy we never found a satisfactory way of measuring change objectively. I am deeply grateful to so many who did so much to provide Uffculme with a cohesive therapeutic team.

In the mid 1960s I was flattered by frequent requests to take part in local radio and TV programmes. My colleagues hinted that this was little more than an ego trip but I rationalised such activity on the grounds that it would promote a more favourable view of psychiatry. While initially the requests were on straightforward psychiatric topics, I soon found myself asked to become an instant expert on subjects like motorway madness, children's toys, and the love of middle-aged ladies for bingo, etc. When I protested my ignorance, the producer would reassure me by saying that as long as I trotted out a few platitudes it didn't really matter what I said, as most of the audience wouldn't be listening and only paying attention to my appearance.

One Monday I had an urgent phone call saying there had been some violence on the terraces in Stoke and would I drop in to comment on soccer rowdies. I turned up at the studio to find Dennis Howell, the Minister of Sport, was taking part. I covered my ignorance by saying that little was known about hooliganism but this could be rectified by research. To my astonishment the minister asked me to investigate the problem and suggest possible solutions. Next day the national press hailed me as a government approved expert who would solve the problem by scientific research. I had no alternative but to embark on a rapid survey of the problem, and with the help of colleagues I spent much of the next few months going to football matches and gathering data from people like the police, who had a lot of experience in the field. Our report attracted widespread attention but few of our recommendations were implemented. Since then I have never been able to shrug off the label of hooligan.

In 1972 the DHSS approved plans for a new 120 bedded unit on the Queen Elizabeth Medical Centre site with 80 day places. It was confidently expected that this would complete by 1977 and become the centre of a 'Maudsley of the Midlands', with greatly expanded research and postgraduate teaching facilities. What followed was the closure of all the

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academic beds following three unrelated suicides; a major setback for Midlands' psychiatry.

I was fortunate in serving on the first College Council and its Executive and Finance Committee. These were heady days, full of interest and anxiety, for we were aware that if the College got off to a bad start the future of our specialty would be jeopardised. The lease at Chandos House was running out and we had to find a new home urgently. I recall a special meeting when a few of us had to decide whether or not to go ahead with the purchase of 17 Belgrave Square. I was convinced that we would all land in Queer Street but Wilfred Warren had handled our investments with consummate skill so we were able to make a down payment while Martin Roth got the necessary financial backing, thanks largely to Lord Goodman. Early Council meetings were given over to much free floating discussion interspersed by hilarious anecdotes from our President, who had many gifts but little sense of time. We were often still on 'matters arising' in the late afternoon, despite Trethowan's insistence that we only discussed 'starred items'. Things were to change dramatically when Linford Rees took over, when the agenda was efficiently dispatched well before lunch, but I found these meetings less therapeutic. Subsequent Presidents have each stamped College procedures with their personalities, a vindication of our democratic structure. Largely on the insistence of colleagues I spent the last decade of my career sitting on innumerable committees. I became overcommitted and felt I no longer did anything properly, but when I expressed my frustration I was told nobody had noticed any difference in my performance.

What have I learned during my psychiatric career? Not much really. To-day's conviction becomes tomorrow's fiction. We must be prepared to abandon our most cherished beliefs when evidence suggests they are myths but meanwhile we must continue to treat patients the best way we can. You have to stay in one place for a long time before you have much impact. A sense of humour is a vital defence for survival in psychiatry. My hope for the future? A better integration of the biological and psychological approaches to psychiatry.

Observations of mental health care programmes for schizophrenic patients in Toronto

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Toronto is a large multicultural society with a metropolitan population of several million people. It is mainly English-speaking, although it contains Portuguese, Chinese, Italian and other communities. Although similar in population to the larger industrial cities of the United Kingdom, and despite a common language, there are important cultural differences which are relevant when assessing treatment programmes. In particular, in contrast to the urban decay, high unemployment rates, and increasing number of elderly residents prevalent in UK cities, Toronto is a young, thriving city with a low unemployment rate and affluent population. There is a low crime rate, little evidence of vandalism, but ample evidence of an advanced structure, e.g. public transport, play schemes etc. Accommodation is, however, expensive and mainly in private ownership.

The Canadian Health Service is a liberal health care system with state and independently managed hospitals. This gives rise to fragmented implementation of policies but allows for innovative programme development. The business approach to health care is much in evidence. Good public relations are encouraged. Clients, i.e. patients, are provided with attractive settings for group and out-patient clinics, and public information films are available describing the content of particular approaches to patterns of care. Staff are considered to be valuable assets and the increased competition for their services results in a greater mobility of staff between hospitals. The working environment for staff is often arranged to promote maximum staff interaction with consequent advantages to the generation and discussion of ideas. The mode of practice of psychiatry has been greatly influenced by the American psychiatrists and in particular by psychosocial models of illness. The main approach to therapy is client-centred.

The financing of health care in Ontario is paid for by the working population under the Ontario Health Insurance Premium (OHIP). Those in receipt of welfare payments are also covered. There is no catchment area system for the independently operated hospitals. Patients may choose which particular hospital they attend, and thus to some extent the specialist who will look after them. The Canadian is a

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