Perspective

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

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September 1939 seems a good date to admit my growing interest in psychiatry. That interest had played little part in our curriculum in Edinburgh until the fourth year when, in that Autumn term, Professor D. K. Henderson gave a series of lectures and clinical demonstrations in the Royal Edinburgh Hospital. On Tuesday afternoons throughout the year the Professor's interviews with new out-patients were attended by 25 to 30 students in a small auditorium of the Royal Infirmary. D. K. Henderson had a remarkable gift for engaging his patients' rapport: he could suspend their discussion for a moment while he drew attention to particular features in the patient's distress, and then resume their conversation as though no one else were there.

At the outbreak of war many young doctors were called up so that we fourth and fifth year students found ourselves engaged in playing the roles of newly graduated doctors. I was one of three students who became resident clinical assistants in the psychiatric hospital. One of my tasks was to carry out evening rounds in five locked wards and to begin the next day with a short report—by telephone—to Dr Henderson, who kept in touch with more than 200 in-patients.

The first local warlike event was an attack on the Forth Bridge in November 1939. Two of the bombers were shot down, one of them into the sea where the crew of four were rescued by a fishing boat. Within a week or two a documentary film unit arrived to record the event. Four medical students were enlisted, dressed in Luftwaffe uniform, and pitched into the sea where we clung to the wreckage of a German plane. By now it was early December and we were glad to be hauled out after a bitterly cold swim in the Firth of Forth.

In the early months of 1940 heavy bombing was aimed against steelworks and shipyards near Glasgow. For a few weeks our hospital regime was disrupted by frequent air raid warnings during which the patients sheltered in cellars and underground tunnels. To our surprise the patients were calm and co-operative although we could hear German bombers overhead and the fire of anti-aircraft guns. During one of these raids a bomb was dropped by mistake on a distillery in Edinburgh. For some minutes the gutters were literally flowing with whisky, some of which was rescued by provident local citizens.

The most remarkable clinical innovation for us in 1940 was the introduction of electric shock treatment. At first it was administered without anaesthetic. Nurses gathered round the patient and held him (or her) firmly in order to control violent muscular jerking. To the onlooker this seemed to be a crude procedure but until then convulsions had been induced by intravenous injections. Patients remembered the event as profoundly frightening and struggled against it. In contrast, ECT patients had complete amnesia for the shocks and most of them were quite unafraid when it was repeated on several occasions.

Sir David Henderson was accustomed to test new treatments with great caution on small numbers and with a follow-up of many months. He departed from his usual practice, however, during the introduction of pre-frontal leucotomy, just after World War II. The immediate effect on chronic patients who had hitherto shown only mental deterioration, was a striking change for the better, leading in many cases to early discharge. Among these patients I remember a middle-aged teacher who had for years been subject to sudden outbursts of catatonic violence. Immediately after his leucotomy he became a different man, extremely civil and polite. We met him one morning in the OT room where as usual he greeted us courteously before we had time to speak to him. He was engaged in creating a curious, bulging parody of a child's stuffed doll. The patient responded politely to a number of speculations: 'Yes, it might be a whale', or 'It might be an elephant', until he smiled at Sir David, saying: 'It *might* be a very distinguished psychiatrist.' It was evident that he had not lost his sense of humour.

About six months after the first wave of leucotomies we began to observe that a number of patients were relapsing and again showing features of chronic schizophrenia. At this point Sir David called a halt in order to obtain a more detailed assessment of cases before choosing them for surgery. Since then the frequency of brain operations was much reduced.

After demobilization I spent one year in Edinburgh and another in Oxford, obtaining a DPM and an MRCP(E), and celebrated by spending a year in New York studying culture and personality with Margaret Mead. This was followed by living rough for two years in a succession of three villages in North India. The second of these provided the material for a book, *The Twice-Born*.

On my return to London, I realized that I had run the risk of falling behind where new ideas on clinical, social and biological topics were concerned. Fortunately Sir Aubrey Lewis was one of the few people who was critically informed in all these fields, but especially interested in social factors in relation to mental illnesses and their recovery. This led to my becoming a senior registrar at the Maudsley and then graduating to the MRC Research Unit of which Sir Aubrey was the founder. Our early studies were concerned with the rehabilitation of chronic mental patients. This was followed by demonstrations of the influence of relatives' behaviour upon a schizophrenic's subsequent recovery or relapse. In this field, Professor John Wing's 'Present State Examination'—improved by successive modifications—has given us a valuable instrument for achieving greater diagnostic precision.

In January 1961 I returned to Edinburgh to teach where I had been taught. There I found that the late Professor Alexander Kennedy had already paved the way by planning an

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ambitious eight-storey 'Tower' at the entrance to the Royal Edinburgh Hospital. The earliest occupants of these academic premises included Neil Kessel, John R. Smythies, Henry Walton, Frank Fish, Ian Oswald and others who in turn acceded to professorships either in Edinburgh or further afield. The great merit of the Tower was that it encouraged a mingling of clinical research and academic staff to their mutual advantage. At first I regarded the MRC Unit on Epidemiological Studies in Psychiatry as my special concern, but within a few years both I and the MRC saw the virtue of letting able full-time research workers (first Neil Kessel and then Norman Kreitman) take over the direction of the Unit.

During the 1960s and 1970s I continued to take part in the World Health Organization's growing support for improving mental health care. When the WHO was founded (in 1948) there were few effective psychotropic drugs in the pharmacopoeia, and trained psychiatric staff were equally scarce. From the early 1960s our Tower welcomed an increasing number of trainees aiming to achieve a DPM, an MPhil or, after the Royal College of Psychiatrists came into being, the MRCPsych. Postgraduate students and teachers had continuing one-year exchanges between Edinburgh and two developing centres of medical teaching—one in Kingston, Jamaica and the other in Baroda, India. Other trainees came from a wide spread of developing countries, especially from India and Nigeria.

My own involvement in the WHO's plans to bring mental health care to the developing countries consisted in helping to spread the idea that modestly-trained medical assistants could play a useful part in rural areas. In January 1971, two meetings expressed slightly different emphases: the first was a two-day meeting organized by the World Federation for Mental Health which emphasized the role of medical assistants; while the second (promoted by the New Delhi office for WHO) argued that more psychiatric trainees must be trained in large numbers before psychiatric care could be undertaken in the rural areas. Three years later, a meeting of leading psychiatrists from the developing countries proposed that pioneer demonstrations of rural mental health care should be carried out as soon as possible, as this was the best way of showing that mental patients can benefit from modern medicines. Already by 1980 five such programmes have shown good results: but these results remain to be achieved on a nation-wide scale.

In January 1974 I took up my new post as the Vice Chancellor of the University of York: but I did so at a time of financial crises occasioned by the sudden increase of the cost of oil from the Arab countries. The building of two additional Colleges could not be started, and the same was true of five other developments in the University. For the next several years, economy had to be the prevailing theme. I must admit that I felt envious of my predecessor, Lord James, who saw major new developments reach their completion in each of the first ten years of the University—lucky man! During 1974 one new head of department was appointed, in the person of Professor Peter Venables (formerly a psychologist in Sir Aubrey Lewis's MRC Unit), under whose leadership the new department thrived, in spite of some practical limitations.

As I approached my fifth year in York, I decided to return to the teaching and planning of psychiatry—but in my native 'developing country', namely India. This occupied my last three years before reaching retirement. I worked in turn in Bangalore, Chandigarh and finally New Delhi.

The first of these was modelled on the Maudsley Hospital and its numerous branches of research. When I arrived there in September 1978, I found that Professor Ravi Kapur had already launched research studies in (a) tracing the mentally ill in rural areas and treating them at home; (b) studies of disturbed children and guidance of their teachers and close relatives (here Drs Malavika Kapur and Ilana Cariapa led the way); and (c) studies of their clientele and discussion of their clinical methods with urban general practitioners. Professor Kapur was a pioneer in creating models for community psychiatry and attracted a number of young psychiatrists to learn about practice and research in his new field. One of the most dedicated young psychiatrists, Dr Mohan Isaac, frequently worked six days a week—and then spent half his Sunday in treating lepers in a slum section of Bangalore.

My second year was spent in Professor Naren Wig's Department of Psychiatry, an element in the Post-Graduate Institute for Medical Education and Research, in Chandigarh (within sight of the foothills of the Himalayas). Here Professor Wig had made himself an international reputation for the thoroughness of his identification of the mentally ill in rural populations and for his fellow-workers' perseverance in monitoring previously untreated cases. His leading assistant has been the young Professor Srinivasa Murthy, who is now Professor Kapur's successor in community psychiatry.

After having slightly prolonged my year's work in Chandigarh, I was happy to rejoin Professor Wig who accepted with some reluctance the prestigious Chair of Psychiatry at the All-India Institute of Medical Sciences, after his sixteen years of productive work in Chandigarh. He accepted the challenge when he realized that the AIIMS had done more laboratory and clinical research than field surveys of the mentally ill. It did not take long for Professor Wig and his colleague, Professor Nath, to find that they had a small town and rural area ripe for exploration of new researches. Soon after my joining the two Professors in a survey of the country town called Ballabhgarh, I asked whether they had visited a reputed healer of the mentally ill who had practised in a nearby village for 35 years. (I had visited him six months earlier to learn about his fame as an Ayurvedic traditional practitioner, but my colleagues knew him only by repute. However, we met on the same day and before long the old man was happy to refer some of his clients to the nearby Primary Health Centre. Shastri-ji, as he is widely known, is as conscious of the success of some of his therapy as he is aware that some others may be better treated by modern therapeutics.)

The three years of my recent work in India were interesting and rewarding—not least because of the cordiality with which I was received. So far I have paid only one return visit (in February/March 1984) when most of my time was focused on the three villages in Udaipur where I lived for periods from 1950–1952. Already I find myself seeking for a pretext to meet my former colleagues in community psychiatry and have little doubt that such a pretext will be found.

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