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Perspective

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

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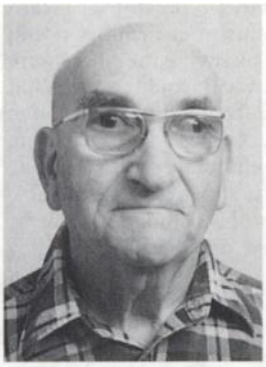

I have had a very busy professional career and have not been much concerned with its formative influences. I was born in Edinburgh on 2 October 1915 into an orthodox Jewish family which migrated to Scotland from Lithuania at the turn of the century. As my father was serving in the army during World War One I did not see him till he was 'demobbed' and as my mother had the responsibility of bringing up a family and running a small business on her own I did not see very much of her either. Yet, I consider that I was brought up in a very caring home. I attended Boroughmuir Secondary School where the standard was first-class and I concentrated on modern languages (French, German and English) and mathematics and was offered a place at Edinburgh University when I was 16 years old. I had also acquired a better than average knowledge of Hebrew as well as of Holy Writ and a smattering of Talmud. I then decided to study medicine so I spent an extra year at school to get the necessary grades in physics and chemistry and enrolled in the Faculty of Medicine at 17 years and qualified in July 1938 at 22 years.

D. K. Henderson (later Sir David) held the Chair of Psychiatry and excelled as a teacher and attracted medical students to his out-patient clinic at the Royal Infirmary and to the psychiatric hospital at Morningside. I was fortunate in that two of my classmates, J. A. C. (Hamish) Brown and H. B. Murphy, were also interested and we became friends. Murphy served with the army during the Second World War and when it ended he worked with the United Nations Refugee Relief Association (UNRRA) and published a book on *Dispersal and Resettlement* which was very well received and resulted in an offer of a research fellowship at Columbia University, New York and later an invitation to McGill University where he was given a chair in transcultural psychiatry which he held till his death a few years ago. Both Hamish Brown and Henry Murphy were voracious readers and Hamish was a very competent linguist being fluent in French, German, Italian, Serbo-Croatian and while in the Middle East he mastered Hebrew and Arabic. He wrote three very successful Penguins, *The Social Psychology of Industry, Freud and the Post-Freudians* and *Techniques of Persuasion* which dealt with brain washing in the Korean War. He also edited Pear's Medical Encyclopaedia.

We spent a lot of time together as medical students and when Professor Drever (*père*) offered a voluntary course in psychology to medical students we signed up and did very well in the exam and this reinforced our intention to make psychiatry our career. I met Hamish again in the Middle East when I was posted to the 41st (psychiatric) hospital and we shared a tent for nearly three years. We would talk into the early hours and Hamish was a compulsive collector of books. I caught the 'bug' and started my library while in the Middle East.

D. K. Henderson had advised me to get general hospital experience before starting my psychiatric career which I did but I then felt that I would learn more in London and did what many were then doing, which was to enrol in the DPM course which was dispersed as the war had started. I did get my six months in neurology at the National Hospital, Queen Square, and I spent some time at West Park where Alfred Meyer and Dr Mann had their neuropathology and biochemical laboratories and I took advantage.

I had been turned down by the army on grounds of poor vision but standards were lowered and I was later recruited in Category A! After a few months in York with Ivison Russell, a former President of the RMPA, I was posted to the Middle East as a trainee psychiatrist but was side-tracked and became a regimental medical officer with an artillery unit. I was later brought back to psychiatry and have been actively engaged in it every since. One's career can turn on a card which one has not played. While with the regiment there was a build-up of artillery before the Alamein offensive and the Assistant Director of Medical Services would ask me if I could take on another regiment and I accepted and I soon found I was looking after three regiments which meant visiting the gun sites starting at 7 a.m. and finishing at 9 p.m. When I was posted to the '41st' the ADMS

protested saying that he would have to replace me with three medical officers which he did not have. At that time the consultant psychiatrist to the Middle East was Bondfield James who had been in charge of the psychiatric service at St Mary's. He had a very distinguished war record in World War One and was awarded a double bar to his MC and he was very pleased that one of his psychiatrists should be so highly regarded in the field. He used me on occasions when there were disparaging remarks in the press about army psychiatry and I would draft a reply.

When the Birmingham medical school decided to start a department of psychological medicine I applied. Professor P. C. P. Cloake (neurology) had created a Division of Neurological Studies which included neurology, neurosurgery, psychiatry and neuropathology and I used Bondfield James as a referee. Cloake was not only a distinguished neurologist but had a good grounding in psychiatry having worked with C. S. Myers at Cambridge and he also got the gold medal for his MD (London) thesis which was on the psychiatric manifestations of von Economo's Encephalitis Lethargia which ravaged Europe after the First World War. (I was able to get his widow to give this medal to the Section of Psychiatry of the Birmingham Medical Institute as an annual token honour to the best original paper presented by a registrar.) When Philip Cloake retired I used to visit him after a post-graduate teaching round on a Sunday morning and he told me why he had supported my application for the job. He felt that psychiatrists were generally a lazy lot and he knew that if the department was to be a success it would require a lot of very hard work and Bondfield James' letter convinced him that I could to the job. I recall saying how disappointed I was as I had always thought that I got the job because of my erudition!

Cloake was right. To start a department in a teaching hospital one had to earn the goodwill of the staff and that could only be done by providing a useful service. Consultations were not delegated to the registrars though they were encouraged to be present for I took the opportunity to demonstrate the uses and limitations of psychiatry. Eventually, surgeons would request a consultation *before* they operated in doubtful cases. One's medical and surgical colleagues were also interested in results so hard work was directed into treatment and management. Because of the organisation of the division we were recognised for pre-registration posts and thus many of our best students were able to sample psychiatry and still be free to switch should they so desire. That many decided to continue in psychiatry and achieve great distinction has been a great source of pleasure, especially when they have outperformed the teacher. There is a Talmudic saying that there are two instances where one should not be envious if out-performed and these are the achievements of a son and of a student.

Most would have been successful without my help but some, who tended to underestimate their capacity and felt that the commanding heights of the profession were not for them, were stimulated to greater achievements. A useful instrument was the journal club. Each member was given a journal from which an article would be selected. A critical précis was typed on 5″ × 3″ cards and these were duplicated so that all members of the club could start building their own card index of references. As these papers had been critically assessed and either presented or discussed by the participant they represented a meaningful experience. A less industrious member would opt out of the presentation by saying that there were no papers of merit in his journal. I would counter that one could often learn more from a poor paper than from a well-written one. Critical faculties were sharpened and one learnt what not to do when one was researching or writing a paper. One would also learn that the reputation of the author need not be equated with a good paper and vice versa. They would warm to this and I recall that when Eliot Slater visited Birmingham to address the Section of Psychiatry he put forward his eugenic theories which had endeared him to the Hitler regime. He advocated that breeding should be encouraged from the best stock which he indicated were Oxford academics. The following morning he attended our grand round and one of our registrars presented a patient with a very malignant form of schizophrenia both of whose parents held chairs at Oxford. After the presentation one of our registrars asked Slater whether the parents of this patient were the stock from which he was advocating the breeding of a master race! I felt that I had not been wasting my time and I encouraged them to tackle me similarly and would deliberately provoke them with highly debatable assertions.

The writing of textbooks

Although I had been brought up on Henderson and Gillespie's *Textbook of Psychiatry* it was looking dated and while Mayer-Gross, Slater and Roth's *Clinical Psychiatry* had much to commend it, it was difficult to learn from and was too heavily committed to phenomenology. I felt that a book which was reasonably comprehensive and digestible had a place and I started on *Guide to Psychiatry*. I had no idea at the time to which publisher I should send it but events overtook me. The professor of medicine in Birmingham was Melville (later Sir Melville) Arnott and when he was in Edinburgh examining for the Membership he was approached by the Chairman of Livingstone's and asked if he would consider writing a textbook of medicine. He was not interested but mentioned that a psychiatrist in Birmingham was writing a textbook of psychiatry which could be a bestseller. A letter from Livingstone's followed and

the brother of the chairman who ran the London office, and who had been a couple of years ahead of be at Boroughmuir, said he was visiting Birmingham and could I meet him. It was arranged and he seemed interested so I was committed. If Willie Macmillan had not visited me every time he was touring the booksellers in the Midlands I doubt if the book would have ever been finished. My wife would prod me by saying that Willie would soon be visiting and that I had not added very much.

It was finished and well received in the UK and the 'old' Commonwealth and a second, third and a fourth edition have appeared as well as one reprint and a German translation of the chapter on Social Psychiatry. As each printing was around 5,000 there were 25,000 copies distributed in all, for each edition was sold out and, with a fifth edition in preparation, further sales are likely.

Livingstones used me as their referee for psychiatric texts and they were reviewing the future of *Psychiatry* which was in their Catechism Series. It was outdated and they intended to drop it. I felt that although outdated the Question and Answer method had much to commend it, especially for foreign students and for the less academic. I thought it could be salvaged and they agreed.

At that time Edward Gordon was my senior registrar and he was encouraged to apply for the job at Saxondale which was being vacated by Harold Merskey who had obtained Eliot Slater's job at Queens Square. I knew that Stengel's senior registrar had applied and as Nottingham was still under the canopy of Sheffield, Stengel would push for his man who was very well qualified. I asked Gordon if he would like to be co-author of an undergraduate textbook of psychiatry and he said he would. I told him that he would have to work very hard at it and I apportioned the chapters. I told him he could mention this in his application for the Nottingham job. I heard from another source that Stengel took up this point at the interview and referring to the proposed textbook of psychiatry asked whether he had found a publisher. Gordon answered that the book was commissioned by Churchill-Livingstone! He got the job. The book, *Basic Psychiatry* ran to three editions and was reprinted twice and was translated into Italian by a publishing house which translated *Classics of Neurology and Psychiatry*. I also wrote another little book for Churchill-Livingstone, *Tutors and Their Students: advice from a psychiatrist*. That ran to two editions.

Last year I wrote another book, *Compensation Claims: Insurance, Legal and Medical Aspects* (Sim, 1992). I offered it to Churchill-Livingstone who turned it down and rather than hawk it round other publishers and delay publication, perhaps for ever, I decided to publish it myself. I got it out in quick time and it is doing well and I am enjoying direct contact with readers. I could not have done this if I had not become proficient with a word processor. We were able to go straight from disc to template, and the final text is the most perfect I have ever had. I can strongly advise more doctors to take this route. I have two other books more than half finished. One is *Concerning a Physician* and consists of a variety of topics with which I have been identified. There is, naturally, a chapter on abortion and the title of another will give some idea of the tone of the book. It is: 'The AIDS Scandal: how not to control an epidemic'. The other book is *Clinical Research for Medical Graduates* and is a direct result of my philanthropy (*vide infra*).

Medical politics

I spent too much time in this area and although I regret this I also learnt a lot about the profession and what people are prepared to do to further their ambitions. I served on numerous BMA committees and chaired the Regional Hospital and Specialists Committee as well as the Regional Manpower Committee and at the urging of many of my colleagues I allowed my name to go forward for election to the General Medical Council and I believe I was second in the ballot out of the eight elected. That, too, was an education, for the GMC was then ruled by Lord Cohen and we clashed on several issues, a major one being an examination for foreign medical graduates. The junior doctors of the BMA had repeatedly shown concern over the poor standards of many immigrant doctors and had urged an examination. I decided to look into it and found that we were recruiting from those countries which had the lowest pass rate in the US entry examination and many had either failed this examination or had not sat it. I proposed that we adopt a similar type of examination. My motion was defeated by 42 votes to 2. I was grateful that the junior medical representative who had seconded me did not vote against it.

I then showed a quality which many who have opposed me have failed to recognise: persistence. I took up my pen and wrote an article for the *BMJ* with the title, The ECFMG and its relevance to British medicine (Sim, 1973). The editor accepted it with alacrity and returned the galley proofs by special messenger. The lay press got hold of it as well as *World Medicine* and the country soon realised that the GMC was out of step on this issue. Shortly afterwards Lord Cohen retired on grounds of ill-health and was succeeded by Sir John Richardson and the Overseas Committee then recommended that an examination be set which would be 'related' to that of the final year of medical examination. I had by then accepted an invitation to a chair of psychiatry at the University of Ottawa and as a parting gift Sir John

Richardson had proposed that my wife and myself be presented with an invitation to the annual garden party at Buckingham Palace. I was still concerned that the wording of the report was flawed. I rose and said that as I had tried for some time to get the GMC to sponsor an examination for immigrant doctors I should be pleased that I had at last succeeded. I added that I was still not satisfied with the word 'related' for I knew of two kinds of relations, rich ones and poor ones and I knew what kind of relation this one would be. I pointed out that we are a scientific profession and we should use language which can be accurately evaluated and I proposed that the term 'equivalent to' be substituted. Sir John Richardson said he could live with that and the amendment was accepted by the chairman of the Overseas Committee.

Philanthropy

Jews are generally philanthropic, particularly in the size of their commitments. As we had no children and my income was substantial and we lived well within our means I realised that we had more than we would ever need. In addition to my usual contributions to Jewish and other charities I started a trust for Jewish charities in 1972 and with additions it has grown and disbursements have been from £10,000–£20,000 per year. When Desmond Pond was President of the Royal College of Psychiatrists he visited Ottawa in late 1980 when I was about to retire to Victoria. We talked about the College and I mentioned that I was concerned about the very small percentage of doctors who are committed to pursuing research throughout their professional careers: less than 5%. I was prepared to donate £25,000 to support research by members and fellows who were not and had not been recently in full-time academic or research posts. He was not keen on these conditions and later wrote me that his colleagues felt that as there was a dearth of research funds in academic units the money should be directed to them. I refused and I later got an acceptance of my conditions.

At that time there was an article in the *British Journal of Psychiatry* by Michael Shepherd who was highly critical of my textbook which he did not mention by name but singled out one aspect describing my account of Karl Jaspers psychology as 'egregious' in the pejorative sense. I wrote to the editor pointing out that it was not acceptable behaviour for a person to make pejorative remarks about someone who is not named but can be identified by the information in the article. The correspondence editor said he would allow me a very short paragraph and obviously felt my complaint did not merit much space. Another issue was an article in the *British Journal of Psychiatry* on 'Suicide in high places' (Salmons, 1984) which attributed the large number of suicides in the psychiatric department in the Queen Elizabeth Hospital in Birmingham to its location on the top floor of the hospital. The situation had become so bad that the Coroner recommended that the unit be closed. I had run a similar unit on the same floor for 25 years with patients suffering from, at least, similar degrees of morbidity and did not have a single suicide. I pointed out that suicide in any psychiatric unit depended on an accurate formulation of the problem and the institution of prompt and effective treatment. People could commit suicide in a basement cell if these conditions are not met. The corresponding editor refused to print the letter so I wrote to the Editor-in-Chief pointing out that I had been running such a unit for 25 years in the same location without a suicide yet the coroner had recommended its closure six years after my retirement. I felt that my observations had scientific merit as I was able to provide a comparison with most of the variables covered. The explanation from the editor was that my letter could lead to litigation against the doctors and the hospital. Was that sufficient to withhold factual information? I did not think so. I therefore wrote that I no longer felt charitable to the College and withdrew my offer of £25,000. I offered the money to the Royal College of Physicians of Edinburgh and it was received graciously and I have since augmented it so that in January 1993 the Bequest amounted to £250,541 and an independent trust for similar purposes but ear-marked for Edinburgh medical graduates now stands at £210,000. My wife and I have also set up a Fund for Clinical Research for Edinburgh University with similar conditions which is already growing and will soon be operational and will benefit substantially from our estates.

I suppose that there is something in me resembling the motto of the Royal Scots Fusiliers: *nemo me impuni lacesset* which is translated into the Doric as 'Wha daur meddle wi' me'. At least, my resentment at my treatment by the College has done some good and if I can get more doctors committed to research I shall feel that my substance has not been wasted. I know that this tremendous leakage from research by those who are primarily engaged in clinical practice is a grievous loss to the profession and to the individuals as well for they are deprived of one of the richer experiences in medicine. Psychiatry is one of the most vulnerable of medical specialities as, for years, it has accepted that other professions have equal expertise and research investment in the field has been taken over largely by social workers, psychologists and nurses. We are regarded as 'anecdotal' while the others are regarded as 'scientific' because they apply irrelevant algebra to their communications. A return to research commitment is essential if we are to retain our professional status and contribute to the general corpus of medicine.

Why emigrate?

Most doctors who emigrate do so early in their careers because they feel they will do better elsewhere. I was not in that situation for I had a very senior post in the Birmingham Teaching Hospitals, had a very flourishing private practice and had served on the board of the Faculty and was currently on the GMC. The offer from Ottawa was very tempting. I had lectured there on two occasions and the department was developing rapidly. The chairman told me that I would be involved in the residency training programme with a very small commitment to undergraduates.

The department in Birmingham, as far as I was concerned, was becoming less attractive. We had been very selective with registrars and, on the whole we had recruited some of the best. Without consultation, we were now expected to open our department to registrars from regional hospitals who were seconded for nine months. I felt the time was too short, especially as I had made it a practice to involve my registrars in original enquiry so that they could have one or two good publications to their name. I was finding that I was back to my earlier practice of single authorship and that the arrangement was largely a device to provide staffing for the regional mental hospitals without any regard to the quality of the product. Other factors were the Salmon Report which took first-class nurses off the ward and had them patrolling the hospital with clip-boards to signify that they were now in 'administration'. In a teaching hospital where all the wards were highly specialised they served no useful purpose for the nurse in charge of the ward did not need professional help from somebody who was soon out-dated.

Another factor was vicious taxation. The year I accepted the offer from Ottawa the Chancellor of the Exchequer, Dennis Healey, added another 10% to the top bracket as he intended to 'squeeze the rich till the pips squeaked'. As this tax was already 83% this meant that we were now taxed at 93%. One would think that we were extremely rich to be so heavily taxed. In 1975 this penal tax was levied on anybody whose taxable income exceeded £20,000 per year. Like the old maid I could say that I had many offers in my day but I kept turning them down but now I was concerned that I may not be asked again so I accepted and my wife was sporting enough to come with me.

I found the tax situation in Canada charitable compared with UK and with tax shelters I paid very little tax for the few years I was in Ottawa. This sounds mercenary but I was able to indulge in philanthropy and in some way influence the medical scene in UK which I could not have done had I not emigrated. Furthermore, I am nearing my 78th year and am still gainfully employed. The Canadian Medical Association has a very good financial service for retirement income and I give their investment policy full marks. Victoria University does not have a medical school but the hospitals have excellent library facilities and with a modem I can access Medlars at any hour of the day or night. I still attend meetings in Canada and in USA and subscribe to and read journals and have a heavy writing commitment. The publishing side is not onerous and I have not spent nearly as much time as I have done in the past checking galley and page proofs and being dismayed by the printer ignoring my corrections on both occasions. I now consult from my home where the ground floor is converted to the most beautiful and spacious suite I have ever had. My library and computer are to hand and I am looking forward to seeing major works of reference on compact disc which I can plug into my computer.

Research

As I am devoting much of my substance to promoting research by doctors who are not currently in academic or research posts one may ask what I have done? I have had a life-long curiosity which has mainly manifested as 'operational' research into clinical problems. Here I must pay tribute to Birmingham which by historical and geographical accident found itself to be the only medical school in the developed world serving a population of five million people. This meant that in a short time one would see large numbers of clinical rarities. For example, in 12 years I was able to treat and follow-up 213 patients with post-partum psychoses and I was able to make a firm statement about the role of the psychiatrist in abortion (Sim, 1963). I was also able to investigate the primary presenile dementias and produce a valid clinical differential diagnosis of the 'Alzheimer' type from the others (Sim & Sussman, 1962; Sim *et al*, 1966; Smith *et al*, 1966; Gordon & Sim, 1967). I was able to report on the impact of a general hospital-based psychiatric unit on the mental hospital in whose catchment area it was located (Orwin & Sim, 1965). There were many other studies but here is not the place to list all one's publications.

A perspective of psychiatry

Where do we now stand? I wish I could say that we have made continuous progress since I first developed an interest as a medical student in 1937. There have been advances in diagnosis so that patients can be treated for what they have but this is by no means universal and many patients are still inadequately or wrongly treated. Suicide in patients who are undergoing psychiatric treatment is still far too common and refuge is being sought in the claim that it is

impossible to forecast who is liable to commit suicide. This is just not true and one finds that some psychiatrists have very few, if any, suicides while others are constantly in the coroner's court.

The drug houses have assumed a dominant place in psychiatric practice and they can now package a drug which is a 'pep' pill, suppresses appetite, can be mind-altering and is of little value in severe depression but displaces the most effective of the tricyclic antidepressants which has been responsible for the drastic reduction in the use of electro-convulsant therapy in the treatment of depression. This resembles the return of amphetamine through the front door. Benzodiazepines are lavishly prescribed whereas non-addictive and more effective measures are available at a fraction of the cost. The 'team' approach has not been adequately evaluated in terms of efficacy or cost and as a result large numbers are engaged in a duplication and triplication of services with little, if anything, to show for it. If one returned to one person management the major disadvantage would be the need to retrain the redundants for useful employment.

Turf protection is now a major concern but with the accountants now in the picture that battle ought to be lost. A more sinister development is 'turf promotion' where illness is invented so that the patient and doctor are involved in a compact rather than a contract. "You pretend that you have a problem and I'll pretend that I am treating it." As the cost is borne by the taxpayer or the insurer this is not medical practice: it is fraud. It has reached a new low when it is alleged that all cases of multiple personality are due to sexual abuse in childhood. A fictitious disease is bolstered with a fictitious origin. These few sentences show where enough money can be saved to provide all that is really needed for an effective psychiatric service. Add to these the tremendous investment in 'counselling' and other ineffective activities and it is clear that psychiatry has a lot to answer for. Until there is a clear-out of unnecessary lumber and a serious attempt to evaluate what is essential in current practice, progress in unlikely. Some psychiatrists will become redundant but mainly in areas where there is already a surfeit. What concerns me is that these colleagues may not be equal to the task of providing a service in unpopular areas. There is much to be done but do not expect those who have fostered the present state to make the necessary changes. I hasten to add that the situation is no better in North America though the 'winds of change' are beginning to blow there.

Is there anything good to say about the British scene? Of course! I am very impressed with the quality of contributions to the *British Journal of Psychiatry* and the *Psychiatric Bulletin*, and mainly the latter. A lot can be achieved with such resources which are better than their North American counterparts. What they need is a fair deal to allow them to reach their full potential and the opportunity to lead the profession.

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