Perspective

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

Reflections

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A game of chess, a novel and a career all have in common a beginning, a middle and an end. And there is usually a postscript or a post-mortem to round it off: this is, for me at the moment, the first of these.

A conventional training in Medicine in Edinburgh was aimed originally at some kind of reconciliation between following the family tradition of becoming a clergyman and a wish to be a doctor. The solution, I thought, was to become a medical missionary. By chance, and to make a little money, I heard of a temporary job at the Royal Edinburgh Hospital (Morningside) where they paid very well, in marked contrast to other hospital jobs in those days, when your rich father put you through your postgraduate years.

It was 1937, Professor D. K. Henderson (later Sir David) was the chief. It was a period of great expectations in psychiatry and we felt we were in a most privileged position since only Edinburgh and the Maudsley had Chairs of Psychiatry at that time. Thus almost every door was open to eager and ambitious young men—and women—leading to careers all over the world. It was the era of Sakel and the insulin coma treatment of schizophrenia, of Meduna and cardiazol for manic-depression. Freud's influence, though dominant elsewhere, was anathematized. Some bold spirits secretly read him omnivorously and some were even analysed. Those were the rebels. I was flung in at the deep end from the start and soon I was in charge of the Insulin Unit after a brief training under Pullar Strecker (who had trained under Sakel) and later visited Swiss centres to see others at work. This was the subject of my MD Thesis. It is often claimed by Sargant that he first introduced insulin treatment to the UK. He may be right in making this claim for England (he gives 1937 as his year), but in Scotland Pullar Strecker had begun in a small way at the end of 1936 and by April of that year I had started. But these are idle claims which seem often to be made south of the border. Slater made a similar claim about voluntary admission to mental hospital as having been introduced first in the 1930s, whereas it had been on the statute book in Scotland since 1867.

The reader will have by now discerned a certain Scots needle in the foregoing. This was a general trend in Edinburgh in those days *vis-à-vis* the Maudsley Hospital, which continues to this day.

Those early months were so full of incident for me that I abandoned the mission field in favour of psychiatry. There was so much obvious organic pathology in the hospital that there was little time for psychodynamics. Half of our patients were syphilitic, at least one in ten were tubercular. Deficiency diseases, cerebro-vascular and simple dementias, post-encephalitic states, cerebral tumours, and severe epilepsies were all presenting the most severe forms of behaviour disturbance. It was most plausible to consider other psychoses of the same organic origin, particularly since we could see quite dramatic changes occurring after heroic physical methods of treatment.

That was the beginning. It might have continued along these conventional lines with a Rockefeller Fellowship at the Massachusetts General Hospital under Stanley Cobb to study, primarily, EEG, but for the outbreak of war. The direction of my career was to change quite abruptly from then on.

I had been recruited into the newly formed 41st General Hospital by Brigadier J. R. Rees who was by then the Consultant in Psychiatry to the Army. He had been Director of the Tavistock Clinic and therefore 'something of a Freudian'. When we were fully mustered there were many distinguished analysts or analytically-oriented psychiatrists in our unit. There was Virginia Wolff's brother, Adrian Steven, all 6ft 5in of him, Editor of the *International Journal of Psychoanalysis*, Emmanuel Miller (father of Jonathan), William Herbert, J. A. Hadfield, and Dennis Carrol. Our regular seminars and case conferences were of a high order and I learned much, at least at an intellectual level.

For five years thereafter I became a psychologist having been drafted into the early experimental work on Officer Selection. I remained in that field from 1941–1946 during which time I suppose I interviewed over 10,000 young men of high calibre. It was a refreshing change from clinical work and also to find oneself a mere 'lay' junior officer in a professional military unit. During this time I was fortunate enough to undergo an analysis from W. R. D. Fairbairn whose insights have made such a profound effect on me personally and professionally.

As the middle game in chess is the longest and most complex, with many exchanges, gains and losses, so it was in my middle professional period. I can only comment on a few major events.

Douglas MacCalman was the first Lecturer in Psychopathology appointed in 1937. Sir Alexander Anderson, a noted Aberdeen physician, had invited T. A. Ross, author of *The Common Neuroses*, to give a series of lectures and to meet the Faculty of Medicine. J. A. Ross, the Chancellor's Assessor on the University Court and a local magnate, prompted by this initiative, persuaded the University to

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establish a Lectureship in Psychopathology, providing the finance to drive home the argument. The aim had been to bring to the medical student in Aberdeen the kind of every-day psychiatry he needed in general practice and that could be seen in the out-patient departments and wards of the new, comprehensive Royal Infirmary. By 1946 the department was promoted to full professorial status, changing its name to 'Mental Health', one of the earliest in the country. MacCalman held the post with distinction till he went to Leeds in 1948 when I succeeded him.

From small beginnings we gradually developed over the next few years. More teaching time was allocated to psychiatry—the neuroses, psychosomatic disorders and child psychiatry. A clinical psychologist and a psychiatric social worker were added to the staff. Some time was found for research and clinical facilities were extended. By 1953 we had a small in-patient unit in the Royal Infirmary and probably the first fully independent and staffed out-patient department serving the entire North-East Region. Research organizations had by then started support on a full-time basis. All doors were opened by colleagues to the general, children's and special hospitals, including the Maternity Hospital where the support of Dugald Baird was invaluable.

By 1959 the department was bursting at the seams. The new Mental Health Act was about to come into force in Scotland with the radical change in the status of the mental hospitals. Since our main psychiatric hospital, with its extensive grounds was adjacent to the Foresterhill complex (Royal Infirmary, Maternity Hospital and Children's Hospital), it seemed logical for the Professorial Unit to move into a much larger building just completed. It became the focus of clinical, teaching and research activity as the Ross Clinic, making a distinctive contribution as a complementary in-patient and day-patient service which was the natural development of all services built up in the general hospital. The entire clinical staff of the region held out-patient sessions here. There was also up-to-date provision for special staff meetings, conferences and so forth.

I have detailed this evolution of a split service to a completely integrated one to indicate that the current split in many parts of the country, as between general and mental hospital units, need never have arisen had it not been policy so many years ago to site so many large mental hospitals some distance from all other hospital facilities and even remote from city centres. This simple topographical fact has, I think, done more to create institutionalism than all other factors put together.

With the reorganizations came the world wide movements which were incorporated into routine psychiatric practice. We went through the excesses of leucotomy and intensive ECT until chlorpromazine in 1954–55 and the open-door policies about the same time transformed the entire apperception of the psychiatric patient. At last he/she began to emerge as a *bona fide* patient with a reasonable future back in the community.

One of the distinctive features of the Mental Health (Scotland) Act which followed the English Act a year later, was the retention, in part and under a new name, of the Board of Control. The Mental Welfare Commission was set out in the Statute as having as its main aim protective functions for patients suffering from mental disorder. I had been a member of the Committee advising the Secretary of State on the formulation of the Act and one of our strongest views concerned the retention of some powers of independent supervision in the interests of the individual patient. This has proved so much superior to the Tribunal System in England and Wales (in which the initiative for complaint was curiously passed to the patient) that it was only a matter of time before similar Commissions were set up south of the border. As a member of the Commission for fifteen years, I was to appreciate its value not only for detained patients but for the welfare of all in-patients in all the Scottish hospitals. Many problems of a general nature were disclosed by the investigation of single cases. Routine returns from the hospitals on suicides, for example, brought to light matters of drug security. Injuries or deaths of patients raised serious issues of staff maltreatment or carelessness. The very low standard of community services was brought to light when applications for discharge were considered. In these and many other ways the Commission acted as a watchdog but, in the face of so much central bureaucracy, efforts to change the system were frequently frustrated, leaving it to outside pressure groups to push protests further and bring about much needed changes in legislation allowing the Commission a greater 'inspectorial' function as had the old Board of Control.

By the early 1960s the national scene had changed dramatically compared with the dark days just after the war. New academic departments were being created in the provinces and eventually even London University created its first Chair at the Middlesex. I think it was probably the late Denis Hill's appointment then that brought psychiatry fully into the medical ambit. It was only a matter of time before the Royal Medico-Psychological Association became a Royal College (though many of us in Scotland were quite happy in our membership of the Edinburgh and Glasgow Colleges of Physicians and thought England should follow our example!).

My own commitments during these years in the 60s included a term of four years on the MRC, following Denis Hill. Much could be written about that institution, its Chairmen, Secretary (Harry Himsworth) and its members, but as the sole psychiatrist I can only relate that it was a manifold education. I did see much more investment in psychiatric research at that time and was reassured to find the standard of the Research Units well up to most other units. There were, of course, the élite, such as Perutz's many starred units at Cambridge, but these were exceptions. Individual applications were of very varied quality, mainly, I think, because so many applicants had no background

knowledge of how to prepare a case. The MRC's public relations were, in retrospect, appalling. The impression was widespread that only future Nobel prizewinners need apply. One odd experience I had with my fellow members may be of interest. Whereas I was supposed to understand the finer points of all the other clinical fields (and much of the basic sciences as well), when a psychiatric or psychological subject came up there was brazen ignorance smilingly displayed by all the others! It was, for them, a matter of honour to be mentally moronic. I imagine that this was gradually corrected by my successors, Martin Roth, Desmond Pond and Ivor Batchelor.

The gradual establishment of academic, clinical and research respectability has brought about its own problems. In the first place it has, I think, blurred vital distinctions between psychiatric practice and other clinical practices. It is increasingly apparent to me that psychiatrists, in their new found professional confidence, are becoming too discriminating in the type of patient they are prepared to take under their care. The criterion often is whether the patient is amenable to treatment, i.e. can be cured of his disorder. Many are now turned away initially or are prematurely discharged in the application of stringent therapeutic criteria: 'To cure sometimes, to relieve often, and to comfort always' has been dismissed as unscientific sentimentality. This is highlighted by the current attitude towards the psychopath who, in my view, should not have been singled out in the Mental Health Acts of 1959 and 1960. Since then his fate at the hands of the law, psychiatry and the community has been tragic. He is now so completely rejected that there is now less chance than before of scientific, especially psychiatric, studies being carried out to determine causes and point the way to treatment. And so the gutters of all cities are strewn with abandoned souls. This exclusive approach, in fact, does not go down too well with fellow clinicians and not at all with those members of the public who are now gunning for psychiatrists even when trying their best to treat their patients decently, for example, with ECT, which surely still has a place in therapy.

I have often been identified mainly as 'a bit of an analyst'. I remember when I was put on the Committee on Safety of Drugs by Robert Hunter, I was accosted by a well known author of physical methods of treatment outside his Harley Street rooms: 'What do you know about drugs?' Well, I was trained in Edinburgh, not in London, so it was always possible for me to see both the organic and the psychodynamic aspects of our patients' problems. However, I did start up the first Diploma in Psychotherapy which was aimed at adding a therapeutic dimension to others in the trainee psychiatrist's armamentaria. I still think that this was a reasonable aim and it seems to have had fairly wide acceptance, except by a rather ignorant *Lancet* leader earlier this year.

My other interest, since I had some mathematical bent, was epidemiology. This was promoted by the advantageous position of the Aberdeen area service which was of manageable size, homogenous and comprehensive. Our register under the late John Baldwin has now been well established and, with others in this country and abroad, will make its long-term contribution not only to our understanding of the natural history of mental disorder and its relation to general morbidity and mortality, but to planning of services.

The place of mathematics and statistics has, I think, been frequently misconceived in medicine. The double-blind trial was 'discovered' by medicine after the war, owing much to Fisher and horticulture. Now no clinical event of any sort can be reported unless it exhibits the proud stars of statistical significance. I wonder how many discoveries of the past (such as the spirochaete in the brains of twelve patients who had GPI) would have been lost or (more probably) indefinitely delayed by working out experimental design, applying for grants, waiting for results and even more tardily for publication and final recognition. So often the 'controlled trial' ends in failure because the strict criteria initially required cannot be met. Many MRC inspired trials (e.g. on antidepressants) came to grief in this way and through problems of investigators' co-operation. It seems to me that really significant developments, such as chlorpromazine, need very little statistical sophistication to establish their significance. Differences between drugs of the same general type hardly justify the effort to establish their relative worth.

Recent debate on 'informed consent' in respect of clinical trials appears facile in view of the random nature of the generality of therapies applied to patients these days.

At my stage it is difficult to see psychiatry except as it has been. Present trends and future prospects are for the active generations. And the 'end game', in retrospect, is reduced to a few pawns and one or two major pieces in one's own personal game. But there are a few enduring impressions. If I had to select one which has remained foremost in my own experience of clinical psychiatry it is that it is unique and quite distinct from other medical specialties. Partially this is related to practice in the traditional mental hospital and especially for long-term and elderly patients. This practice places a responsibility upon the psychiatrist for the overall management of almost every aspect of the patient's life. Only geriatrics and paediatrics compare in this respect. More profoundly this uniqueness has to do with the special relationship between doctor and patient, a relationship both objective and subjective to a degree rarely required elsewhere. Empathy is the *sine qua non* of psychiatric practice. Through it the patient becomes aware that the doctor not only understands his condition intellectually and scientifically but as though he had some fellow feeling as well. This concern, however, need not spill over into sentimentality. Nor need it—as it so often does—be presented by some gimmick such as becoming scruffy, using first names and playing at chumminess. It is a very serious professional approach and must initially spring from the closest insights into one's own aims and motives and the complex expecta-

tions of our patients. Empathy is so necessary because so much that is presented as mental or nervous illness is regressive, either infantile or primitive. Thus the psychiatrist must, through empathy, adopt the role of mediator as between the regressive inner situation of the patient and the demands of the real world.

I am not claiming that empathy is all that there is in psychiatry but only that it holds a central and necessary position in all psychiatric practice.

No one person's perspective on psychiatry has much validity but may be of interest to some. What others think of psychiatry, seen from within or without, will remain conflicting and confused as was the case, some years ago, when someone asked what my profession was: 'A psychiatrist'. 'How interesting—I am psychic too and regularly communicate with the souls of the dead.'

Problem Drinkers and Their Driving Licences

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As announced in 1983, the Department of Transport has issued new procedures for dealing with drinking and driving offenders deemed 'high risk', being those disqualified for the second time in 10 years for driving with a blood alcohol concentration over 2½ times the legal limit (i.e. 200 mg per cent) or failing to provide a specimen. The Driver and Vehicle Licensing Centre at Swansea will notify such an individual that when he applies for his licence on the expiry of the second period of disqualification (usually three years or more) 'consideration will be given to whether these convictions indicate a medical disability and, if so, whether he has managed to get his drinking problem under control'. He will be advised to seek help from an alcohol counselling agency and will be given a list of such agencies.

The first letters have begun going out to this group of offenders although the machinery for their medical assessment is still being set up, the earliest that individuals will be applying for restoration of their licences being 1986. When an individual reapplies for his licence he will attend a Department medical examiner for interview and blood tests. In cases of doubt a consultant psychiatrist specializing in alcohol problems will see the individual, although this may present the Department with difficulties since in a given city the local alcoholism consultant may also be currently treating the patient. Appeal via the courts will be allowed. These arrangements are possible within existing legislation concerning medical fitness to drive.

Clearly the definition used means that only the severe end of the spectrum of drinking drivers are to be affected. The estimate is 3,000 individuals per year. Since the results of the new procedures will be monitored, this will be an interesting pilot study of the effectiveness of intervention amongst drinking-driving offenders. Such a study has never been conducted in the United Kingdom. Unfortunately results in North America have in general been rather discouraging when repetition of the original offence was the outcome criterion.[1] We may have difficulty in extrapolating from the results amongst these severe repeat offenders to first offenders. In unpublished figures from the Département de l'Aisne in Northern France where medical referral of drinking drivers is common[2], the outcome in terms of future drinking and social and physical well-being is poorer among those who had the highest blood alcohol concentrations (over 150 mg per cent) at the time of the offence.

It remains to be seen how many of the 3,000 individuals per year will be advised to seek treatment and how many of them will follow that advice.

To the beleaguered Health Service workers dealing with alcoholism it is very attractive that the Department of Transport or the Courts might be routes by which early detection and treatment of alcoholism could be pursued. If alerted and encouraged the early problem drinker may be able to alter his habits before severe dependence or harm has ensued.[3] I understood that in general English courts regard it as outwith their remit to send a leaflet about alcohol problems to every drinking-driving offender, but the Department of Transport Medical Advisers plan in future to enclose an alcohol information leaflet with the announcement of revocation of licence. It would be useful to evaluate the effectiveness of such an exercise.

With regard to heavy goods vehicle and personal service vehicle licences, not all psychiatrists realize that the College Working Party, under the chairmanship of Donal Early, recommended in 1981 that alcoholism be grouped with acute psychosis and carry a prohibition of five years, even when no drink-driving offence has occurred. There will be many psychiatrists and general practitioners who will find themselves torn between loyalty to a patient whose employment may be crucial to him and his family and indeed to his recovery from alcoholism, and on the other hand consciousness of the safety of the public and of the Medical Adviser's duties within the Department of Transport. Occupational Medical Advisers usually feel in a less ambiguous position in relation to the patient than treating clinicians may be.

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