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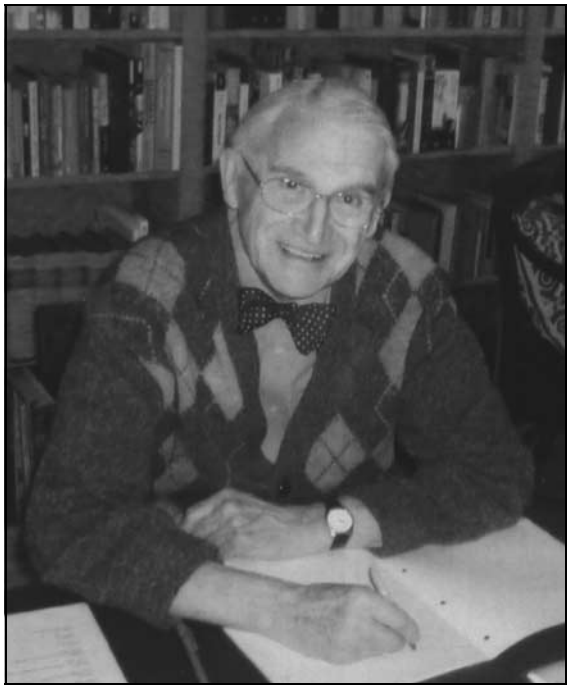
ALAN KERR

In conversation with Thomas Bewley



Thomas Bewley was interviewed by Alan Kerr at the Royal College of Psychiatrists on 10 March 2004.

Thomas Bewley was much involved in the early years of the College. He was first Sub-Dean, second Dean and fifth President, and was a member of Council until 1996. When he left Council he was asked to write the official history of the College and its forerunners. He is a graduate of Trinity College Dublin and his psychiatric training was in Dublin, London and the USA. He became Consultant Psychiatrist to St Thomas' Hospital and his professional career was much concerned with alcohol and drug dependence. His recommendations to the second Brain Committee led to the adoption of policies in effect today. He introduced the concept of 'harm reduction' as a pivotal principle in treatment. He was a founder of the Institute for the Study of Drug Dependence (now DrugScope) and a consultant adviser to the Department of Health and the World Health Organization for many years. He founded the College Research Unit and also started the Section (now a Faculty) of Substance Misuse. He was Screener for Health on the General Medical Council. His wife Dame Beulah Bewley is a distinguished epidemiologist.

You come from an Irish Quaker family, well known in Dublin in medical and café circles. Could you tell us a bit more about this background?

My great-grandfather was a Quaker. He was a millionaire entrepreneur but gave up one of his businesses when his partner wanted to sell alcohol. He then became a member of the Exclusive Brethren as he thought the Quakers weren't strict enough. He built an enormous meeting hall for them, and went bankrupt. This brought down Overend and Gurney, the largest Quaker finance house in that era. My grandfather, his only son, became a doctor and his first cousin set up the cafés. There were two streams of Bewley's in Dublin: the medical one was my grandfather, two of his sons, myself, my sister, two cousins and one of my daughters. The other branch is the café stream.

What decided you on a career in medicine?

My grandfather and my father looked after Bloomfield, a small Quaker mental hospital, which an earlier Bewley had helped to found on 'Retreat' lines. If I hadn't chosen medicine it would have been journalism, hoping to become a 'man of letters'. I thought psychiatry should be

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the most interesting area of medicine. I read anything relevant from my father's bookshelves, including some Sigmund Freud. I later ordered the works of Freud, one volume each year and the index 25 years later.

What led you into psychiatry?

This was an accident. Having qualified, I spoke to Norman Moore, who was the doyen of Irish psychiatrists for many years and a great enthusiast. He told me to '. . . go to England, take the MRCP and come back and talk to me again'. It was sensible advice but 3 weeks later I got a letter from him saying, 'you have been appointed SHO at St Patrick's.' I was chasing my wife (now Dame Beulah Bewley) at this time and she was just about to do a house job in Dublin which fitted in very well. Having started I found psychiatry fascinating and stayed in it for the rest of my life.

So you started psychiatry at St Patrick's Hospital, famously founded by Dean Swift?

Yes, I'm a great admirer and on the 250th anniversary of his death I gave a paper about his illnesses and health. Swift is one of my heroes. No one writes as well and as clearly as he does. He is a good example of how to write. There have been many misconceptions about him, starting with the opinions of Samuel Johnson and Walter Scott that he 'went mad'. He ended up with an Alzheimer's-type dementia and the last 3 years of his life were very miserable, everything went and he was aphasic as well. But otherwise he was fit and well, until he was about 72.

Did Norman Moore give you a particular philosophy of psychiatry?

Norman Moore had trained at the Crichton Royal with Willy Mayer-Gross. I learned all the basic skills of taking a psychobiological history leading to a formulation. Norman had no interest in research and was like William Sargant who believed that new and wonderful treatments had arrived and were effective. Norman Moore treated all his patients with enthusiasm and got them better even if the treatment effect was a placebo response. He was also one of the first to treat people with alcohol problems. I worked, when I was at St Patrick's, with the first member of Alcoholics Anonymous in the British Isles. I am the only person left who treated patients with alcohol problems before Max Glatt did.

After 2 years at St Patrick's you went to London, Maida Vale to study neurology and then to the Maudsley.

I applied to go to the Maudsley but I was seasick on the boat and sick on the train. I'd never had an interview for a job before in my life and I came across as a dull stick and they turned me down. I was very cross. Two jobs came up, one at St Thomas' and the other at Claybury. I had enough sense to go to Claybury because I didn't want to be damaged by Sargant. I had no experience of chronic mental illness so the year at Claybury was good value. I ended up with a curious rotational training scheme which I had invented myself.

And then you got into the Maudsley?

Yes, one way to get into the Maudsley was by being different from everybody else who applied. I believe I was the only person who ever applied four times, so they gave me another set of interviews. This time I was interviewed by three people and I absolutely sparkled; by then I knew the ropes. Three passes on this occasion, two fails at the first interview.

Who were your main influences at the Maudsley?

I worked with Felix Post who was a very sound clinician and one of the few people who understood what a formulation was about. He was the type of psychiatrist that I wished to be myself. The other was D. L. Davies as I was interested in alcohol problems. I had written my MD thesis on 'alcoholism', as it was called in the 1950s. I only came to know Aubrey Lewis well later in my life.

And then you went to a psychoanalytical institute in Cincinnati. What did you make of it and what did you get from it?

I learned little, apart from the difference in the way medicine was structured. We had general practitioners in England at that time and the USA didn't. The trainees in Cincinnati were aiming for private practice and they all learned how to get someone into therapy. Nobody was ever taught how to get people out of therapy, they weren't interested in that. The staff didn't go on holidays for too long lest their patients might go to someone else and then like the new therapist better. If you wanted to be revered by your patients you became a psychoanalyst in 1957.

Psychoanalysis was very dominant in the United States at that time. But you didn't really buy any of the Freudian theory?

Freud was a genius which is why he is alive and well today, mostly in the pages of the *Times Literary Supplement* and the minds of opera producers.

And you returned to England to become a consultant in general psychiatry?

I didn't become a consultant immediately. I spent a couple of years doing locum consultant posts for which I was paid as an SHMO (senior hospital medical officer). Those were the rules then. I took a job initially as an SHMO in Tooting Bec Mental Hospital, and then became a consultant there. It was the one London hospital that would take anyone who couldn't get in elsewhere. There were 2100 patients when I went there, of whom 1900 had dementia. The only reason they admitted younger patients was that they would have lost their nurse training school if they didn't. They had no catchment area but some vacant beds. I began to deal with patients with

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alcohol problems and when there was addiction to other drugs I treated these patients also.

Did you choose to work in a mental hospital rather than a teaching academic centre?

I wouldn't have had a hope of getting a job anywhere else I can assure you (my degrees were all Irish and I had left the Maudsley prematurely). I didn't want to leave London at that time and thought I should settle somewhere. It was fortuitous, I was very happy. It was a funny hospital but I enjoyed working there.

Within a few years of your appointment you'd become a national expert on opiate and cocaine, and also alcoholism, very new clinical fields then. Can you tell us how this came about?

There were very few people interested in these areas apart from Griff Edwards and Phil Connell. Griff was doing research on alcoholics on bomb sites and found himself embarrassed when one of his research questions 'Have you ever had any treatment before?' led to the reply 'No I haven't, but I'd like to have some now.' He couldn't bring everyone into the Maudsley so I suggested he send patients to me. I had a simple belief that much of what one does is care rather than cure. If someone gets better it's a bonus and you don't see them again. If they never get better, you will have a responsibility for the rest of your life. I never minded that because that is what medicine is about. When heroin addicts had problems the average psychiatrist in the 1960s didn't want to have anything to do with them. I ended up having admitted 20 when nobody else had seen more than two. I knew very little about dependence but as everyone else knew less, I was an authority. I had become a consultant in 1961 and I wrote about heroin addicts in the *Lancet* in 1964 and 1965. My recommendations to the second Brain Committee were the basis of their report. The next year I wrote three papers on the subject in the *BMJ*. Those five papers were the best I ever wrote. You do your best work when you're younger.

You were originally involved in treating people with alcohol problems. What was your approach?

One of the registrars explained it to me. He said 'I've discovered what you're doing Dr Bewley. You admit people who come in, quivering, filthy, with their tongues hanging out, who may have had a fit or be brought in by the police. You get them in to bed, tidy them up, with a good bath, detoxify them, check their physical health and send them to the dentist. You then send them out to work from the hospital until they have saved up enough to rent a room.' It's what I call the 10 000 gallon check-up.

What were the treatment strategies you employed with heroin addicts?

I was aware that this was seen as a new problem so the aim should be to get rid of it. Treatment would cure some and the rest should go to gaol and it would then disappear. This was nonsense. Dependence, whether it's on heroin or anything else, is the same as dependence on alcohol, and is a chronic relapsing disorder. Most of the harms experienced at that time were because of insanitary habits and the way people self-injected. We did a small study of 50 people and asked them how they injected themselves; the results were appalling. I advised people to try to give up injecting, but if they were going to do it anyway they needed advice, such as not sharing equipment. Our out-patients department began to dispense sterile syringes. This introduced the concept of 'harm reduction'. I tided people over crises with short admissions.

At that stage what national policies were you recommending?

The national policies at that time, for alcohol, were wrong. The view was that you needed in-patient treatment with group psychotherapy with the support of Alcoholics Anonymous. Although some people with mild problems may get back to controlled drinking, when a person is heavily dependent they won't be able to return to normal drinking. You advise them to stop completely and have to be prepared for the fact that they may fail to do so and have three or four attempts before becoming abstinent. Whatever you do, 10% of your patients, whether they misuse heroin or alcohol, or have schizophrenia, or depression, will die by suicide and you won't know who it's going to be. You should give sensible advice and support to help people to make a go of their lives despite their illness – when things can't be changed they have to be helped to cope.

Did you recommend specialist treatment units for opiate addicts?

We needed to get treatment out of the mental hospitals to more academic units where people could be trained. At that time, apart from Tooting Bec Hospital and the Maudsley, there was nowhere. We also needed a system of notification to see what was going on.

Can we turn to your involvement in psychiatric politics? In the 1960s you were a member of the Society for Clinical Psychiatrists which was set up to counter the considerable power at that time of medical superintendents. Did that indicate radical leanings on your part?

Quakers are always members of the extreme centre.

At all events, you eventually became a cornerstone of the establishment. What do you look back on as your major achievements and frustrations in those College offices?

I started accidentally by being a Sub-Dean. I'm a quick reader and among the masses of papers about setting up the College I discovered that I could stand as a member for South West Thames, which I did and was elected. When I got to the first Council meeting four names of

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RMPA (Royal Medico-Psychological Association) stalwarts were put forward for Sub-Dean. Having read the small print I knew I could be proposed by 12 non-members of Council, which I was, so that's how I became a Sub-Dean. It was an interesting time. The College was totally different from the old RMPA because there was a clean sweep of practically everybody. New President, new Dean, new Sub-Dean (and shortly afterwards new Editor). Two-thirds of the Council were also new. We rapidly took all the juniors on board, which was important.

What did I ever do as President? Proposals for research had been on the agenda for over a century but nothing happened. I thought this was absurd and it was high time to get on with it. I wrote what I considered to be a well-worded letter, taking a lot of trouble about it. It went to all members telling them how much we needed them to donate over 4 years for a research unit. I guessed that about 10% of people would respond and I was correct. That was enough to have some rebuilding in the College, with much extra space and enough money for a man and a boy and half a secretary. I had the simplistic view that if we had a small nucleus we should easily get grants and that was what happened. Within 15 years the income was about £2 million a year. I had thrown up an extra 12 spaces below a new College roof and added to a cottage, in the garden. Another thing I am pleased with was starting a group for substance misuse which later turned into a faculty. This was desirable because the average psychiatrist then was unlikely to have learned much about dependency problems when training.

Can we move on to your interest in the history of the College? From 1960 to 1971, the period leading up to the creation of the College, some psychiatrists wanted the RMPA to continue in its existing form, others wanted it to become a faculty of the Royal College of Physicians and others were pressing for Royal College status. Could you shed some light on this controversial and cloudy period?

There were many strong views, but most people had little idea what they were talking about. Academics were afraid that physician superintendents would come up in farming boots and trample over them in a grand new College. Juniors thought they were going to get a very expensive examination and be charged heavily for it. They were concerned that all the emphasis in the proposals was on examination and little on education (or training). A virtual insurrection led mostly by junior Maudsley doctors led to very significant changes in the charter. The physicians had thought that psychiatrists were not very bright and not fit to be let out on their own, so preferred to keep an eye on them. Academic psychiatrists were originally in favour of becoming a faculty of the College of Physicians. Lord Brain (then President of the Royal College of Physicians) was chairman of their Psychological Committee. The first time they met the psychiatric members of this committee agreed to support the faculty proposal, but there was a second meeting where the psychiatrists reversed their views. At the time nobody quite knew why, but the answer was simple. Lord Brain who chaired the meeting was so arrogant that many who intended to vote for a faculty voted for a College. From that date the Royal College of Physicians supported the proposal that the RMPA should become a College.

Irish members agreed in 1971 to join their UK colleagues in a Royal College. But there were some reservations and dissensions at the time. Could you tell us a bit more about this?

It was straightforward. The Health Department in Dublin did not wish to negotiate with a British Royal College, preferring to take advice from the Irish College of Physicians who were not interested. Some senior psychiatrists in Ireland wanted to set up a new college of their own, but it never took off. Junior doctors in Ireland did not want to cut themselves off from the College, as they wanted to take our examination and have training that was acceptable. They knew that many of them would be looking for jobs in England or around the world. The last thing they wanted was to be separated. Eventually the Irish Division divided into northern and southern branches. They had always been evenly balanced, with the same number from both, but the southern ones called themselves the Irish College of Psychiatrists which is also, it turns out, the old southern part of the Irish Division. They now have the best of both worlds.

Can we move on to your own sense of identity?

I am Irish. I've been living in England for 50 years but I describe myself as a Dubliner living in London.

What interest do you have outside psychiatry?

My family and friends. I also read a lot. As a Dubliner I was brought up to go to the theatre and am very much a follower of theatre and opera. One of the advantages of having the index-linked psychiatrists' pension is we can go to the opera as often as we like.

Declaration of interest

None.

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