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The times

Who owns research?

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Once upon a time there were clear-cut career pathways for ambitious doctors, what are now called 'inside tracks'. Forward-looking people in the UK, for example, realised early that in order to become a consultant or professor in a teaching hospital, it was essential to be well qualified and published. In psychiatry, this meant proof of being truly renaissance with qualifications in medicine, psychiatry and research. How this was achieved was up to the individual. At places like the Maudsley Hospital people often arrived bristling with degrees. About half the entrants had passed College exams or had research doctorates. During psychiatric training the others went for the extra qualifications. They had to; otherwise they would not make it to senior registrar. Some characters practised brinkmanship and passed the MRCP on the umpteenth occasion. Thereafter things varied, with some moving into personal analysis (no degree) and others into wet and dry laboratory research. Many eschewed both and headed for clinical work. There was a period, perhaps between 1945 and 1975, although the limits are arguable, which was halcyon. Medical trainees were actually committed to research. There were twin pathways; the scholarly going to the MRC unit or the Chair and the entrepreneurial to the teaching hospital consultant job and Harley Street practice. The teaching hospital wallahs needed about ten papers to be acceptable. An engaging feature of the system was that the pay was not particularly discrepant between researchers and clinicians. The somewhat subfusc role of researchers was, in any case, redressed in the mid 1960s and parity achieved. Amazingly, then, it was possible to have a career in research without losing money. To what did it all add up? In modern parlance, was it cost-effective and efficient? Did the clinicians with their ten papers or the MRC medical scientists give value for money? After all, with what can they be compared?

Anglophones used to believe that they were 'better' and, accordingly, so was their research. I remember, as a registrar, translating French language papers for extra money. They always seem to deal with banal, open drug trials. Even now, 'foreigners' like to publish in English language journals and I doubt that this is a two-way street. Furthermore, English has become the language of scientific meetings so its science has a kind of face validity. What about competition within the English-speaking countries? In the 1945–1975 period the main competitors were choice centres and exceptional individuals in the United States, Canada and the Antipodes. Then, there was a lot of academic traffic between these countries. Commonwealth doctors went to the UK to train, and sometimes stayed, and the British often chose to emigrate everywhere. At one time most Australian chairs of psychiatry were occupied by British emigrants. The political special relation between the US and UK certainly had its parallel in medicine and the postgraduate BTA (Been to America) degree was relished by the British. MRC units, or something akin, were set up in all English-speaking countries. The Clarke Institute in Toronto was akin to the Maudsley (and analogous US centres). Sir Aubrey Lewis was actually at the opening of the Clarke in 1966. In their heyday these Institutes were full of fixed funding. In those days researchers probably read each other's journals and felt cosily *entre nous*. Journals like the *Milbank Memorial Quarterly* were read faithfully on both sides of the Atlantic. Rarely has there been a generation of psychiatrists who were so fortunate. In the UK it was a magnificent natural experiment with an incredible flowering of academic units and research programmes. But did the 1945–1975 cohort of psychiatrists who did research significantly add to the literature? Only one has achieved FRS, as far as I know, and there is only a sprinkling of knights.

Is there a control group for this natural experiment? Only the Americans were comparable during that period and, while substantially more wealthy, they were upended by psychoanalysis. American strength was shown only later in the last 20 years with the advent of DSM–III *et al*. Thus, a British academic advised me that the Americans had come to learn genetics with Eliot Slater in the 1960s whereas he had to go to learn from them in the 1980s. Some American schools were always formidable. Washington University Medical School at St Louis and Johns Hopkins at Baltimore, for example, were strong and maintained links with Europe, but were not typical. The Scandinavians did excellent research but were small in number.

Perhaps, then, only the present can act as a control. But caveats immediately appear. The English-speaking world has changed and diversified. Members do not relate to each other in the same way. It is difficult to get a licence to practise medicine in other English-speaking countries. Each has its own examination board with special national requirements and little reciprocity. Some Royal Colleges and Boards require diverse clinical experience, even neurology, but hardly one requires research training. Psychiatrists today go to teaching hospital jobs with few or no publications. Certainly not the 'required ten' of yesteryear. An argument has been advanced that teaching is equivalent to research. Many apply for promotion on the basis of their teaching. Raucous rows occur at promotions committees as to the equivalency.

Each English-speaking country then has developed its own style. In the UK, the post-war system is skeletally intact, although private practice is emergent and MRC units and their like are disappearing. Careers in research must be hard to find and pursue. In Canada, clinicians and medically qualified researchers work together, and have similar incomes, in the teaching centres (outside there is a considerable difference). Nevertheless, few psychiatrists do research, and promotion to professor in the best universities is becoming occasional. While drug trials continue, original clinical and basic research is not in abundance although some efforts are being made to reverse this. In the US, as usual, there is a wide spectrum with riches to be made in practice and yet always an influx into the national research institutes and university centres despite modest remuneration. American research, with its huge grants, is the most adventurous but not necessarily the most inspired. In Australia, private and academic practice have been divergent for almost 20 years with large differences in income. As in Canada, a few research units soldier on. Clinical investigators often feel isolated. What is apparent is that physicians may choose a teaching or peripheral hospital job in North America or Australia without prejudice. The main difference is cash. Snobbery alone may make the person choose academia. There, a psychiatrist may pursue promotion up the academic ladder to professor. This is, however, associated with little or no financial gain.

So where does this take us until the end of the century? For a start it would seem that few psychiatrists do research. This statement may promote indignation in senior registrars in the UK en route to the twin pathway. While their journey may be still necesary in the UK, it manifestly is not elsewhere. Why has this come about? There are a number of reasons: easy pickings in private practice; declining research funds; inadequate recruitment into medicine; the ascendency of women in medicine with too many demands on them; too much technology in medicine leaving too few 'natural experiments'. Whatever the reason, psychiatrists only occasionally do research and then their reason may be quixotic. Those coming to the graduate schools are generally non-medical clinical staff. They are nurses, social workers, occupational therapists, and other worthy professionals who, for one reason or another, missed the boat when young and in middle age decided to get qualifications commensurate with their intelligence. The results are sometimes pedestrian, with convergent thinking, but, occasionally, fascinating. These students are invariably good at statistics and this may leave their psychiatrist supervisors wanting. Generally, investigators in psychiatry do not think of unweighted linear regression as they develop research ideas.

Where does all this leave the psychiatrist? Obviously the bright will pursue research from curiosity and serendipity. I recall a distant relative who obtained his research data by fair means in foul times. A professor of geology early in the century, he was interested in fossils of the Jurassic oyster or Gryphaea (also known as the Devil's Toenail). When Hitler was threatening the UK with invasion in 1940, the government developed aerodromes throughout eastern England. At one spot they dug up a large number of Gryphaea and, on hearing this, the Professor rushed over with his sacks. For many years, until his death at over 90, he carefully brushed off the dirt, drew and described them. He published until his death. Clearly, those oysters had pearls of wisdom in them. Certainly a lucky find. No grant required and the data in sacks in the garage. What are his successors doing, particularly in the medical field? There is an uneasy situation with a decline in applications for medical school, at least in North America, less doctors doing research and less available money. Already, there are several significant consequences. Granting agencies and journals find it harder to get medically qualified peer reviewers and there is a similar shortage of qualified supervisors of graduate degrees. If clinical experience and curiosity mean anything they should be represented at government funding agencies, otherwise critiques are solely based on issues of methodology and statistical analysis. The lack of available supervisors is serious as it means having proxy supervisors. In North American universities, supervisors must be elected to the graduate school. In their absence, or in the absence of ones appropriate to the subject, the remainder are encouraged to take over. This has happened several times lately. Eventually, however, the PhDs will predominate and, regardless of their ability, clinical perspicacity will be less relevant.

Finally, the paymasters of research are changing. The MRC units and the like are on the wane and major grants from national agencies are not easy to obtain. Career scientist awards are disappearing and

the average grant is often small. In some countries, Canada for instance, the principal investigator cannot be paid out of grants. What is left? Contract research perhaps. Some of our last grants came from such non-medical agencies as the Ministry of Labour, pharmaceutical companies, and a Health Promotion Agency. In each case a serious academic question was addressed. Namely, does aluminium cause cognitive impairment? Is post-stroke depression treatable? Is there widespread care-giver grief in the community? It should be noted that these are all clinical questions of contemporary interest. Contract research, nevertheless, has its opponents. In his memoirs, Sir Peter Medawar (1988) totally deprecates the notion as enunciated by Lord Rothschild. It was "... not the proceeding that has given us penicillin, insulin, the discovery of the blood groups, the elucidation of myasthenia gravis, the transplantation of tissue or the discovery of the genetic code. Scientific discovery cannot be premeditated". Are these the thoughts of hallowed academia? Is contract research really crass? We need to bear in mind that Michelangelo, Mozart, and Wren all did contract work. What price the Sistine Chapel? Are money and the frontal lobe not the twin pillars of civilisation?

So research in psychiatry has changed. It is no longer the vehicle to getting a decent job or the pursuit of monkish scholars. It is done less by doctors and may become mission orientated. But, surely, there will always be poetry. As Browning said, "Ah, but a man's reach should exceed his grasp. Or what's a heaven for?".

References

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BROWNING, R. (1855) in *Andre del Sarto*.

Professor Lewis (1965)

Sir Aubrey Lewis Street

The Technology Development Corporation (Adelaide) is delighted to announce the street names selected for the thoroughfares at Science Park Adelaide (SPA), Australia's first Science Park. Of the three main streets at SPA, one will be named after Sir Aubrey Lewis, "a leading South Australian psychiatrist".

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Personal view

Gender dysphoria – an inside view

(*Name and address supplied*)

Burns *et al* (1990) considered that "core transsexualism" has, as a defining characteristic, a homosexual orientation. This means, of course, homosexual in respect of the original biological sex. This will be examined critically, suggesting areas which merit further research.

I can deal with this topic from both an objective and subjective view. I am a (recently retired) consultant psychiatrist who also happens to be gender dysphoric, and nearing completion of gender reassignment.

Gender dysphoria is ill defined, but encompasses all phenomena in which there is a distinct unease in the