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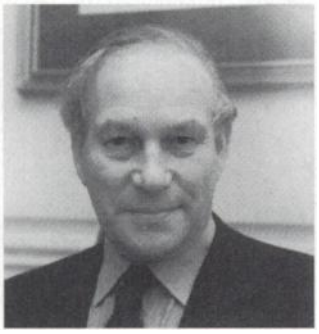
Interview

In conversation with Hugh Freeman

Greg Wilkinson interviewed Professor Freeman at The Royal College of Psychiatrists in October 1992



Professor Hugh Freeman
BM BCh 1954 MA
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Professor Freeman was born in Salford in 1929. He won an open scholarship to St John's College, Oxford and afterwards was a clinical student at Manchester Royal Infirmary. From 1956–58 he was a Captain in the RAMC and was a Registrar at Bethlem Royal and Maudsley Hospitals from 1958–60. He was Consultant Psychiatrist, from 1961–88 and has been Honorary Consultant Psychiatrist, Salford Health Authority, University of Manchester School of Medicine, since 1988. He has travelled widely, mainly on behalf of the World Health Organisation. Professor Freeman has contributed to the national press and learned journals and books he has edited include *Community Psychiatry* with Douglas Bennett and *150 Years of British Psychiatry* with German Berrios. He was an assistant editor of *The British Journal of Psychiatry* from 1978–83 and became editor in 1983.

When I look at your CV, the first thing I'm struck by is that it's absolutely massive. I would like to begin by asking you to set your professional contribution in some general context. What do you see as being your main achievements?

My main interest, over many years, was the development of a service for a community. That community was Salford in Lancashire, which is where I was born and, as many people know, has often appeared in paintings by L. S. Lowry, and in plays and films. It was an archetypal Industrial Revolution place, and when I started work there in 1961, still had a largely unchanged 19th-century environment. It was dirty, usually covered in a pall of smoke, and people were mostly living in very overcrowded conditions, but it had a tremendous sense of community, and that was something that largely disappeared in the course of redevelopment in the '60s and '70s. This experience was what primarily turned my attention, some time later, to the relationship of mental health to the environment. But in the '60s, most of my efforts went into integrating the very poor psychiatric resources we had there into a service that would respond to the needs of that population in the best way possible.

Most people will think of your contribution in the editing field.

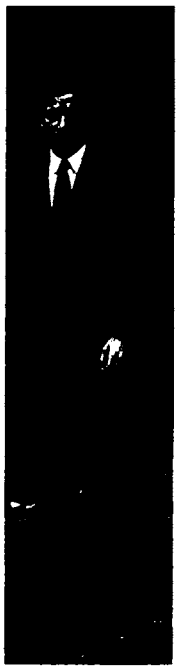
I should explain that I'm a rather reluctant scientist. I was an arts person at school, and went to Oxford with a history scholarship, but because of family influences, I changed to medicine. The arts subjects, though, particularly history and English, have always been my principal love, and so it was that side of medicine that I tried to include in my work.

I went up to Oxford in 1947, and two of my contemporaries as medical students were Michael Gelder and John Cooper. Our life there was nearer to the world of *Charley's Aunt* than to that of today's egalitarian universities. It was a privilege to live among the incomparable buildings and gardens of St John's College, and Oxford itself wasn't yet ruined by traffic and redevelopment. After the restrictions of wartime provincial life, I found it a cornucopia of new and exciting experiences.

After that, I was a clinical student at Manchester Royal Infirmary, which brought me back to reality with a jolt. There were some outstanding teachers there, including Robert Platt and Douglas Black, but also some very inadequate ones. Psychiatry was taught by Bill Trethowan, who was one of the best lecturers I encountered in the whole of my studies.

So there were strong social and community influences on your development. What took you into psychiatry?

There were three main things. When I was at Oxford, I did a degree in psychology, and one of my tutors was Oliver Zangwill, whose special interest was neuropsychology. Secondly, as a house surgeon, I worked in the department of neurosurgery at Manchester Royal Infirmary, which brought me into contact with Sir Geoffrey Jefferson. He had been one of the original neurosurgeons in this country, after being trained by Harvey Cushing in America in the 1920s. In 1955, he'd been retired for several years, but was still extremely active; one of the most impressive things about him was his unflappability if anything was going wrong in theatre. The techniques in use then were fairly primitive by today's standards, and anything like brain scanning was still in the realm of science fiction. I knew I would never be a neurosurgeon, but it increased my interest in the central nervous system.



At Oxford in 1947

But the main influence was my late uncle, Jack Kahn, who was one of the great pioneers of child psychiatry in this country, though I don't think he's been as well recognised as he should have been.

What was his influence?

He was a GP for 20 years in Yorkshire, before he even started psychiatry, and therefore he had an understanding of the realities of illness in the community, in a way that I think many doctors probably don't have, if they become specialists straight after qualification. He had also been in local government – Chairman of the Health Committee in Huddersfield – so that he knew how to deal with local authorities. He set up a remarkable community-based child psychiatry service in the East End, in Newham, which I believe hasn't survived all the upheavals of recent years. I was very much influenced by the kind of model that he created, and also by his writings. Two of his books – *Unwillingly to School* and *Development of Personality* – have been widely read for many years, and we will publish a new edition of the first one next year. We also republished his *Job's Illness* – a psychodynamic interpretation of that part of the Bible – which impressed biblical scholars as well as psychiatrists and psycho-analysts.

I'm struck by the obvious feeling that you had for that Salford community, and then for a community model of psychiatric service in the East End of London. These conjure up uncomfortable images in my mind. What does that tell us about you: that, your interest was in doing something positive, in these very difficult conditions for psychiatry?

You have to remember that I was a child of the 1930s, at the time of the Great Depression, and also of the rise of the dictators in Europe. So from the beginning, I was very much aware both of the terrible poverty that surrounded us, and also of the political dimension of things – that medicine couldn't be practised in a social vacuum.

My very humdrum, lower middle-class childhood, though, was interrupted by an extended visit in 1935–6, with my mother, to relatives in South Africa. At that time, apart from people in the Armed Forces or Colonial service, only the rich travelled abroad normally, so that this was a very unusual experience. Our journey then took us three weeks by sea; when I went back again for the first time, last year, it took 11 hours.

I'm drawn to the East End of London, I feel comfortable there, something to do with my Dundee roots. Is there an explanation why you didn't end up in Hampstead?

I think it also has to do with awareness of social bonds and of the kinds of communities that have a relationship to a particular place. This was very much true of Salford, because although to outsiders it appeared just part of the anonymous industrial conurbation that spreads across much of North-west England, in fact people identified very strongly with it as somewhere separate. There were long established kinship and friendship networks there, which often went back several generations. When I worked as a clinician among Salford people, I soon realised that one had to try and make use of these networks, rather than to see them as isolated individuals, which is perhaps what a traditional psychiatric training might convey. I became clinically committed to many patients, some of whom I looked after for more than 20 years. I think that one of the contributions psychiatry can make to medicine as a whole is a longitudinal view of illness, rather than focusing on episodes.

Then secondly, becoming involved in research, particularly with the case register, I was aware that it would take many years to produce information of value – which was indeed what happened.

You were at The Maudsley Hospital between 1958 and 1960. What were your impressions of that experience?

I came almost directly from the Army, with an interval of a locum for one month at Prestwich, a very large mental hospital, north of Manchester, where I later returned as a consultant. In fact, Prestwich was like the Army in some ways, and when I first encountered the Medical Superintendent, my instinct was to salute him!

I suppose one could describe going to The Maudsley as like being thrown into an ice-cold bath intellectually, because it was so totally different from anything I'd experienced before. It brought tremendous stress, but at the same time intellectual excitement and comradeship. For the first few months, I shared the residential accommodation at Bethlem with Michael Rutter, and I think we gave each other a certain amount of support with this new experience. My first job was with Felix Post, and what I particularly learnt from him, which I have valued ever since, was the need for the most rigorous attention to the details of patients' clinical states and histories. He demanded very high standards from that point of view. It was exciting to experience the interactions of so many outstanding people, concentrated together and engaged from time to time in bruising disputes on both theoretical and practical aspects of psychiatry.

As well as Felix Post, the people who impressed me particularly were C. P. Blacker, Willy Hoffer, Bob Hobson, Elliot Slater, the forensic pioneers Peter Scott and Trevor Gibbens, and David Stafford-Clark, who could always be relied on to liven up an occasion at which he was present. On the other hand, there were also some extremely mediocre figures, who contributed very little

The down-side of this intellectual excitement, though, was the paranoid atmosphere of the institution, and what I felt were the destructive influences which emanated from Aubrey Lewis. He and I had a rather adversarial relationship, and I left after two years because I felt that under his leadership, the institution was completely out of touch with important developments that were going on outside, particularly in the social and community fields.

We don't hear very much about this side of Aubrey Lewis. How did this adversarial relationship develop?

Maybe he sensed that I reacted against what seemed to me his preoccupation with unimportant details, and a tendency to favour activities which had no clinical relevance. Whereas if you were concerned, as I was increasingly, with the way that services were organised for populations, you received no sympathy or support. In spite of being at one of the world's leading postgraduate institutions, I had to organise my training in social psychiatry entirely myself, finding out where innovative work was being done and arranging visits to these places. These issues were never mentioned at the Maudsley then; it was only later, when Douglas Bennett arrived, that there was any change. Of course, Aubrey had started the Social Psychiatry Research Unit, but I don't recall the everyday activities of the Maudsley being in any way influenced by what that unit was investigating.

The reactions to Aubrey recorded in this series of interviews seem to follow a bimodal distribution. People either saw him largely as benign, helpful, and kind or as hostile, destructive, and sinister; I was definitely in the second group, much as I admired his intellectual qualities. (Incidentally, I found his lectures very boring). He made some people's careers, but destroyed other people's, unless they got away.

After I'd been there for a while, I felt that I would like to go into social research, and after speaking to Maurice Carstairs, I requested an interview with Aubrey about that. He said "Give me some indication of your capacity in this respect". I had heard that there were some interesting service developments going on at Oldham in Lancashire, so I contacted Arthur Pool, who was the consultant responsible for them, and a largely forgotten pioneer now. I took a week's leave and went up to observe how the service ran, as well as going through all the records I could find, trying to construct some sort of data from them. Then I wrote a long report about it and gave it to Aubrey. The only thing he ever said to me about it subsequently was "Thank you very much"; that was the last I heard of it from him.

However, I then sent the report to *The Lancet*, who accepted it, and I was in the perhaps unusual position of having an original, single-authored paper published there as a registrar. Though Aubrey didn't respond to it, Sir George Godber wrote to me from the Ministry of Health, as soon as he read the paper, and took a close interest from then on in the work that I was doing. So perhaps it's not surprising that he's my main medical hero. Having no idea how important he was, I invited him to visit the Bethlem Day Hospital, and he replied very graciously that it was difficult for him to get away from the Ministry!

As you will have gathered, I never had the chance of going into a research post, but in my second year, I had been registrar at Bethlem Day Hospital. This was a very powerful experience, because it was so much more involved with real life than the ivory tower atmosphere of the Maudsley itself. I was left

largely on my own there, to develop my own interests, and took advantage of that. I had also tried to get a research project going for a thesis, on social networks. This was then a completely new field, and I had help with it from George Brown, who had just arrived at the MRC Unit, and Lily Stein, who was a statistician and the sister of Jacob Bronowski. Aubrey gave me some encouragement at first, but it was eventually abandoned, for reasons which I've completely forgotten – I suppose I have repressed them. However, I keep coming back to this subject because I believe it's an important borderland between psychiatry and sociology, which is still scientifically neglected.

After the Bethlem Day Hospital, I was the first registrar of the in-patient psychotherapy unit, which Bob Hobson had started. Ironically, though, what impressed me most during that time was our first use of antidepressants – both imipramine and phenelzine. We were fairly sceptical about them, because the only drugs available up to then had been amphetamine, which did little real good to people with major depression. I was extremely surprised when the first patient on whom I had tried imipramine told me after the second week that he had begun to feel better; he had a chronic depression which had failed to respond to ECT or psychotherapy. Soon after, I admitted a woman in a manic state who had been intractably depressed for several years, until she started taking phenelzine. When, a few years later, the MRC antidepressant trial concluded that phenelzine was no different from placebo, I agreed with Will Sargant that the nation's combined academic brain-power had made a fundamental mistake.

I decided to leave at the end of my second year, and was appointed a Senior Registrar at Oxford. There was then no university department of psychiatry and I was based at Littlemore Hospital. Leaving the Maudsley turned out to be almost as much of a life event as arriving there, since even a very active provincial mental hospital – and Littlemore had some outstanding people then – was so very different from Denmark Hill.

Perhaps I should add that in the same year that my *Lancet* paper appeared, I had one in the *BMJ*, jointly with Don Kendrick – a clinical psychologist at the Maudsley – which reported the first case in this country of a phobia treated by behaviour therapy. This was of a lady with fear of cats and it was picked up by most of the national newspapers, the BBC, and *Time*; there was even a cartoon about it in the *Daily Mail*. So 1960 was something of an *annus mirabilis* for me.

I'd like to hear what you have to say about developing services and the development of psychiatry during the '60s.

I was fortunate in that I became consultant when I was 31, and I think it's very useful to have an independent command when one still has all the energy of youth. I had a very rapid rise through the ranks in psychiatry, which I started in the Army. My first experience of it, though, was as a locum at Wakefield, immediately before the Army. The neuroleptic era was just beginning then, but this mental hospital was quite Hogarthian in many ways, and some of the staff seemed to me as peculiar as the patients. When I first arrived there, on a misty January night, it was like the opening of a Hammer film.

Was your career good fortune or good strategic planning?

It wasn't strategic planning at all, because I certainly had no game-plan when I began. When I came to Salford, I found that I had enormous responsibilities in an extremely backward mental hospital, though at least it wasn't geographically remote from the catchment area, like most of the London ones. I also had duties in two general hospitals, in each of which there was an embryonic psychiatric department. But most importantly, I had an involvement with the local authority, and that was really where the strength came from – such strength as there was at that time.

What was the relationship between the local authorities and mental health services at that time, in contrast to the present?

In most parts of the country, it was very bad. You will remember that this was when the Medical Officers of Health were responsible for mental health, but nine out of ten of them had no interest in it. They just provided a skeleton service of mental welfare officers for compulsory admissions, and little else.

But there were a number of exceptions, and one of them was certainly Salford. This was due to two people. Firstly, the MOH – Dr Lance Burn – a great public health innovator, who never received any public recognition. The other was Mervyn Susser, who had a joint appointment between the local authority and the Department of Social Medicine at Manchester University. He subsequently became, of course, the very distinguished Professor of Psychiatric Epidemiology at Columbia, but at that time, his considerable energies were going into both service development and research in Salford. In fact, it was largely through his influence that the rather unique job to which I was appointed was created. The epidemiological work that was started then – both for psychiatric illness and mental handicap – was really innovative, though it was all done with virtually no financial support.

Can you tell me a bit more about your working life as a clinician, because this is something that tends to be rather neglected. People spend their life working very hard with patients and it's too often undervalued.

That's very true. I think in the professional stakes, you get very little credit for the quality and extent of your clinical work, which tends to be known to a fairly limited number of people. Some well-known psychiatrists have been rather poor clinicians, who never carried much of a case-load. Looking back, I find it hard to understand how I got through what I did at that time, dealing with huge numbers of patients at three hospitals, with a very high rate of referral and turnover. There were very few junior medical staff, and those we had were not always of a high quality; there were also very few supporting staff of other kinds. What I had to do was to try and create a more responsive service, primarily through integrating such resources as were available. I also cut out the conflicts and horse-trading that had been going on until then between the different bodies involved in mental health services, which had absorbed much of their energies. For the first five years, I was the only person through whom all these lines of communication passed; then I was joined in Salford by Michael Tarsh, and we had a very happy professional partnership for over 20 years.

I should add a word about E. W. Anderson, who was Professor of Psychiatry at Manchester when I was a student and when I returned as a consultant, since a couple of people have spoken very positively of him in their interviews. As students, we never had any contact with him at all. As a consultant in the region, I regarded him as a disaster. He may well have been very good at giving a small number of post-graduates a thorough training in psychopathology. However, what was needed for more than four million people in the region was a large number of trained professionals, since even the relatively few consultant and senior registrar posts that were established weren't filled. Yet the University Department was producing only handfuls of psychiatrists and PSWs until Neil Kessel came in 1965 – a situation for which I believe Anderson was largely responsible.

The President of the College has recently high-lighted the idea of a 'personal physician' relationship between consultant and patient, and this is attractive; you mention the word 'quality', and going back to your work in Salford, what do you think the quality of the service offered was then, under the restrictions that you've just described?

You have to consider what we offered in relation to the alternatives that then existed; one must avoid being ahistorical. For almost the whole of the country at that time, the only psychiatric service provided was in mental hospitals, and the general quality then both of clinical care and of accommodation for patients in them was extremely variable, but on the whole pretty bad.

At that time, the psychiatric profession here was very small, compared with today, and the greater part of it consisted of doctors who had grown-up in mental hospitals under the apprenticeship tradition. There was very little alternative to that, as the Universities and teaching hospitals provided only very few places indeed for those who wanted to train in psychiatry. So whatever we provided has to be seen in comparison with what patients' experience would have been in a large, very overcrowded mental hospital, where the average professional quality of the staff was, to be quite frank, rather dismal. I wasn't anti-mental hospital in general – a large part of my responsibilities were in a mental hospital, and I felt that what I had to do was use its resources, such as they were, in the best possible way.

The first thing I did was to take responsibility for every patient who came from an address in Salford – whether an acute admission, a chronic schizophrenic, or a case of senile dementia. This was the 'Dutchess County' principle, which I had first seen when I went to America, a few months earlier, and met Ernest Gruenberg. The second change was to set-up a system of screening before admission, so that people didn't just arrive in the mental hospital – sometimes on a Section Order, sometimes not – but usually out of the blue, and without any sort of organised relationship with those who were working outside. In this, I had to depend primarily on the mental welfare officers, because there really was no-one else at that time, apart from a minority of the GPs who were keen to co-operate. I was very fortunate that Salford had more mental health social workers, and these of much better quality, than any other authority in the north of England. Indeed, the city compared favourably then with almost any other part of the country in this respect.

The working principle was that we would use what we had in the most flexible way, so that people could be treated as in-patients, if they needed it, but so far as possible as out-patients or day patients. This may not seem very exciting now, but it was fairly revolutionary at the time. We had no special building for a day hospital, just one room in a child welfare clinic, with one untrained staff member (who was actually superb); otherwise, people came daily into hospital wards. There was one hostel and a weekly social club run by volunteers, with a mental welfare officer always present. That was all.

I find myself thinking that things don't change very much in degree, because what you describe is more or less what I see around me today. Do you look back at that period of service development with satisfaction?

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Yes, for one thing, there was a great feeling of camaraderie and of optimism, in spite of the enormous difficulties. This is the overwhelming difference from today. We knew that there was a huge amount more that we wanted to do, if we had the resources, but at least things were getting slightly better all the time. Now, it seems to be the opposite.

In Salford, there was a very high level of morale, which allowed us to do far more with the resources available than might have been expected. We did see rapid changes, for instance in the reduction in numbers of long-stay in-patients, and of those coming in under orders, with corresponding increases in out-patients, day-patients, and people seen at home. Psychiatric home visits were done together with a mental welfare officer in a large proportion of cases, and together with the GP in rather fewer. Today, with our rather greater sophistication, these sort of numerical changes are treated with some scepticism, but it did represent a real difference from the way things had been up to then, and most patients and families seemed to welcome it.

You have to remember that at that time, Prestwich Hospital, where the mental hospital part of our service moved in the early 1970s had well over 3,000 patients. You say things are the same now, but these vast numbers were then being looked after by a handful of professional staff, and many patients were there for very long periods. Situations like that no longer exist, and this is a very significant change – though perhaps in some ways the pendulum has swung too far.

What do you regard as the most significant developments, looking at your career in Salford in the '60s and '70s?

When I started, all we had in the general hospitals was an out-patient service, and it was a poor, fragmented one; it had no accommodation of its own, there were virtually no supporting staff, and a few beds had just been grudgingly allocated to psychiatry in a medical ward. It was agreed that we were to get a whole ward of our own in Hope Hospital, but that took more than ten years from the time I arrived. In circumstances like that, patience isn't just a virtue; it's a necessity.

After six years, we had a day hospital, a purpose-built out-patient clinic of our own, proper facilities for physical treatment, and four social workers jointly appointed with the local authority, covering both the mental and general hospitals. So there was the basis then for multidisciplinary teams. In the mental hospital, we had our own wards and unit office, which was an enormous change from the previous system, where everything was run in a hierarchical way from the Medical Superintendent's Office. Most important, I think, we had very close functional relationships with the hostels, day centres, social clubs, and domiciliary work which were being provided mainly by the local authority. All the pieces then fitted together into an integrated whole – and that was something you would have found in very few places indeed elsewhere. Visitors were often astonished by it.

There's a tendency now to devalue the kind of administration that was practised at that time, but in fact, we had a superb administrator in the Salford Hospitals, even before the 1974 reorganisation, and a superb Matron at Prestwich Hospital. They, and many other non-medical staff, were keen to do the maximum possible within our resources – not the minimum, as is often the case today.

What about relationships with other disciplines, and the growth of these disciplines within mental health?

When I started, they hardly existed at all. The first clinical psychologist arrived after I did. There was one social worker in the general hospital, and one or two in the mental hospital – not just for Salford, but for other areas as well. Occupational therapy was also in its infancy, and the community social workers were all untrained, although many of them had great personal qualities. So there was no tradition of multidisciplinary team working; that was one of the achievements of our efforts in the '60s. Another thing I did from the beginning was to respect the mental

The opening of the psychiatric clinic at Hope Hospital, Salford by Lord Balniel, MP, in October 1967.

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welfare officers as professional colleagues, and deal with them on that basis. In most places, at that time, they were treated as very lowly members of the MOH's service, which was run in a rigidly bureaucratic way.

How do you think this developed towards the latter part of your career?

Well unfortunately, the Seebohm Report brought the creation of generic social services, in which psychiatric social workers were absorbed into unified social services – a disaster for psychiatry. Lord Seebohm himself, in my interview for this series, admitted that his Committee really hadn't seriously thought about mental health. They just assumed that it was the same as everything else. Unfortunately, when the generic social services were created in 1971, it was immediately clear that mental health had a very low priority in their activities. This was partly because the Chief Officers nearly all came from child care, and they had to observe statutory responsibilities for children and certain other groups. On the other hand, mental health work was still almost entirely optional, and the relatively few experienced and trained mental health social workers tended to get fairly rapidly moved into administrative or teaching positions.

We certainly found in Salford then that there was a dramatic fall in the quality of work actually being done with patients, particularly with the severely ill and disabled. We also found that dealing with the enormous bureaucracy that had been spawned by the reorganisation meant the loss of the easy, informal working relationships that we'd had with the previous mental health department. There was also a deliberate destruction of specialisation nationally, so that specialised training in mental health work only remained in a very few places. The result was that we now encountered a shifting population of social workers, most of whom had very little knowledge of mental health work and not much more interest in it. The idea that generic area teams would devote much of their efforts to mental health work never happened in practice.

Even so, it was possible in Salford, for some years, to preserve an island of special experience in mental health work, within the generic social services, and such a situation had become fairly unusual by then. But things just weren't the same, and as Kathleen Jones rightly pointed out, the 'integration' of social work meant the disintegration of co-ordinated mental health services, where these had developed. There was certainly a need for change – the mental welfare officers were miserably paid and rarely given any respect as professionals – but it could have been done in a more constructive way.

There is an inevitable growth in professional autonomy and we've seen that in social work, in psychology, and in other professions. What can psychiatrists learn from this development?

The growth of autonomy in other professions has been largely at the expense of what was regarded as the 'imperialism' of medical psychiatrists, but I think one has to remember that psychiatry itself was, with great difficulty, establishing itself then as a recognised profession, with good standards of training and competence. Quite frankly, until the 1950s, most doctors working in psychiatry weren't very capable of getting on in any other kind of medicine, and it was from that very low level that a largely new profession had to be created. The fact that in Britain today, psychiatrists are one of the largest and best trained bodies of specialists is a tremendous achievement – one of the most important developments that's occurred in my professional life-time. It's also a great achievement for our College.

Looking back then, did you miss the clinical part of your life or is it something that you've just put behind you?

I would find it intolerable to work in the conditions of the NHS today. Having devoted virtually the whole of my professional life-time to the NHS, I'm extremely sad to see what has been going on, particularly in the last couple of years. I think this is the negation of the principles which went into the establishment of the service and indeed, which kept it going for years in the face of enormous difficulties and shortages. Re-reading Aneurin Bevan's speeches about the NHS from 1946–48, as I have been doing for my historical studies, I find it very sad that all the idealism and brave hopes of that time should have ended in the squalid commercialism that is ruining the service today. The NHS was one of the best things that ever happened in Britain.

I find that the shift in the philosophy of the service is, with a widespread loss of idealism and commitment, the most disturbing change of all. It derives mainly from the domination by managers and accountants, who seem to have no personal concern with the objectives of a Health Service, but of course, it's also part of a general cultural shift away from the liberalism and sense of community of the post-war period.

MENTAL HEALTH SERVICES IN AN ENGLISH COUNTY BOROUGH BEFORE 1974

by

HUGH FREEMAN

Medical History, 1984, **28**, 111–128.

Where are we going as a profession? It sounds as if we're moving away from health services, and the other end of the spectrum seems to be the private sector.

There is indeed a considerable shift in that direction, and I personally regard it as a disastrous one. I've travelled abroad a great deal, and seen a lot of health services in many parts of the world. I always used to come back here feeling that we had one of the best systems that was possible, in dealing with the realities of life. What it still needed was for us to give a rather greater proportion of the national resources to health than we had been doing, and so bring ourselves more into line with similar industrialised countries. But that never happened.

In spite of that, the achievements of the NHS, given its very limited resources, were incredible. One of the main reasons, of course, was its extremely low administrative costs, and this is something that has been completely thrown away with the changes of recent years. To describe them as 'reforms' is a perversion of the language. Costing every activity and negotiating between every purchaser and provider is extremely expensive, and all the money to pay for that is deducted from what could have been spent on the care of patients. In any case, most of the money quantities used are largely meaningless. Trusts are the negation of all the work that had been done towards integration of care for communities over more than 40 years.

You mentioned foreign travel, and looking at your CV you appear to have visited practically every country in the world over the years. Looking at it from a global perspective, do you have any views about the development of mental health services; you had a special interest in Europe, of course, but you've travelled all over.

I've spent quite a bit of time in developing countries, mainly for WHO. One of the biggest problems that one finds in nearly all these situations is the absence of an administrative structure that is capable of making changes, should there be a political will to make them in their health services – and that's not present very often. This was something which we did have in this country, to a remarkable extent; it was a legacy of the Victorian Civil Service reforms, which created a devoted cadre of public servants, to which we owe a great deal. One soon becomes very much aware of the lack of this in other places.

Another frequent problem, particularly in Europe, is the division between private and public health services, which often results in very unfortunate discontinuities of care, for instance, between mental hospital in-patient care and private out-patient treatment. Again, we had largely escaped this through the NHS.

Thirdly, I felt there was genuine devotion by NHS staff to serving the health needs of people as a whole in this country, which one simply didn't find in many other places.

Politically, health usually comes fairly low in the pecking order, so that Health Ministers rarely carry a great deal of political weight, and this is often a big obstacle to changing things for the better.

The longest spell I had overseas was three months in the West Indies, mainly in Grenada, for WHO, at the end of 1970. My assignment was to start a general hospital psychiatric unit, but as most of the essential supplies weren't there when I arrived, I spent a good deal of time in the mental hospital, where most of the patients hadn't been seen by a psychiatrist for several years. The hospital had been built by the French as a fort in 1779, and a few nineteenth-century wooden buildings had been added to that. The cooking, such as it was, was done in huge cauldrons over wood fires, underground. There was a very limited range of drugs available and the nursing staff were almost totally untrained – in fact, they were politically appointed, like all public service workers. At the general hospital, there was just one trained sister, who had arrived back from England; with her help, I started giving ECT, using some fairly primitive apparatus, and I believe we were able to do quite a bit of good. It was, of course, a great experience for my family, though we had none of the comforts that tourists in the Caribbean usually expect. I soon became aware that everything I did had political implications, and there were in fact some rather nasty riots while we were there. Unfortunately, the psychiatric unit, which became well established under a locally-born psychiatrist who had trained at Edinburgh, came to an end during the subsequent troubles in Grenada.

When one thinks of mental health services, one's drawn to the American experience, the Italian experience, Greece, Romania, and so on... Where would you place us internationally in terms of our mental health services?

We're still very near the top from many points of view, including the number of well trained psychiatrists that are available to people in general – not just to a privileged minority. I am concerned, though, that we may be losing this high world ranking. Firstly, through the consistent under-funding of health services for a good many years now, with a complete failure even to keep up with inflation. Secondly, through the loss of clinical autonomy, which has resulted from the newly dominant position of managers and accountants that I mentioned. Thirdly, through the ever-widening gulf between the Health and Social Services. The co-ordination which was achieved earlier in many

parts of the country has been lost, and there often seems to be an innate hostility coming from Social Services to psychiatry. What is the point of Ministers constantly talking about the importance of collaboration, when Social Services can unilaterally withdraw all the social workers from a child psychiatry clinic or mental health service? That is what has happened in a number of places – it would have been unthinkable in the 1970s.

Another worrying trend is of some developments in nursing, including a new curriculum which, as in social work, seems to start from a confrontational attitude towards medicine, rather than a co-operative one.

Mentioning that, you were involved with MIND, the National Association of Mental Health for many years, and I think that there was an unnecessary degree of unpleasantness coming from MIND towards the psychiatric profession. From the point of view of a campaigning group that was necessary, but I thought that this was not helpful. Can you say anything about your involvement with MIND?

That's a long and unhappy story. Very briefly, I became involved with NAMH, as it then was, soon after starting work in psychiatry, and was delighted to be asked to become Editor of their journal, which was then called *Mental Health*, in 1964. I continued doing that until the early '70s. During this time, NAMH was a mainstream voluntary organisation in the British model, and there was a significant involvement of professionals in it, together with volunteers, particularly in the local associations. There was a small, devoted headquarters staff, but things changed in the early '70s, partly because of the cultural revolution of 1968 and the subsequent growth of anti-psychiatry. I ceased to be one of their consultants, as did the others, when there was a new Director in 1973; that was not of my own doing. Subsequently, most of the other psychiatrists who had been associated with the organisation parted company with it.

However, I came back to MIND in the early '80s, when it seemed that some of those difficulties might have passed, and I was, in fact, Vice-Chairman for several years until 1987. By then, the organisation had completely changed its orientation, at least at the national level. It seemed to see its role as being a confrontational, antagonistic one to the mental health professions, particularly to psychiatry. Indeed, it took on board many of the tenets of anti-psychiatry, particularly those with a political, Marxist flavour.

I stayed on with the organisation for some time as a member of the Council, trying to preserve some link with psychiatry, but eventually felt this was impossible. By then, some extremely strident and hostile complaints were being made by leading people in MIND against psychiatry, which really made co-operative relationships unworkable. This is not to suggest that the excellent work of local associations in providing practical services should be discounted in any way, but there has now been, for some years, a considerable problem about the central organisation of MIND. Until there is some significant change there, I don't think it's going to be possible for psychiatry to re-establish the kind of co-operation that used to exist with them.

I see, like you, quite a difference between the activities of the central and the local branches of MIND, but I'm still concerned about the lack of dialogue with MIND. Should we take MIND more seriously?

I can assure you this is not through lack of trying. Repeated efforts have been made, both in public and behind the scenes, to try and get that dialogue going, and up to now it hasn't proved possible. The basic problem is that MIND is dominated at present by people who simply do not accept the legitimacy of what psychiatrists do. For instance, they describe anyone who has experienced psychiatric treatment as a 'survivor' and ban terms like 'mental illness' or 'psychiatric disorder'. Until that situation changes, I don't see much grounds for hope.

One of the main difficulties comes from the activities of those who describe themselves as 'users' ' representatives. When you ask them what evidence they have that they are in fact representative of the millions of users of mental health services, they don't reply. My view is that they are totally *un*representative, but unfortunately, they have taken a very prominent position, not only within MIND, but also in a number of organisations.

I had a much happier experience of a voluntary organisation with the North West Fellowship for Schizophrenia, which is now called *Making Space*. That was a model for how an enthusiastic voluntary organisation can very constructively add to what the statutory services offer. I was one of their medical consultants until I moved to London.

Outside psychiatry, I've had quite a big involvement with environmental organisations. I was on the Regional Committee of the National Trust and the Manchester Historic Buildings Panel, and was Vice-Chairman of the Manchester Heritage Trust. I also started a campaign to save the world's first railway station – Liverpool Road in Manchester; this was taken over by other people, and was eventually successful.

The next area that I want to tackle is your experience of editing and you mentioned that this began in 1964 with Mental Health. *How did you take on that position?*

I suppose I should say my very first editorial role actually was with the *Oxford Guardian*, which was

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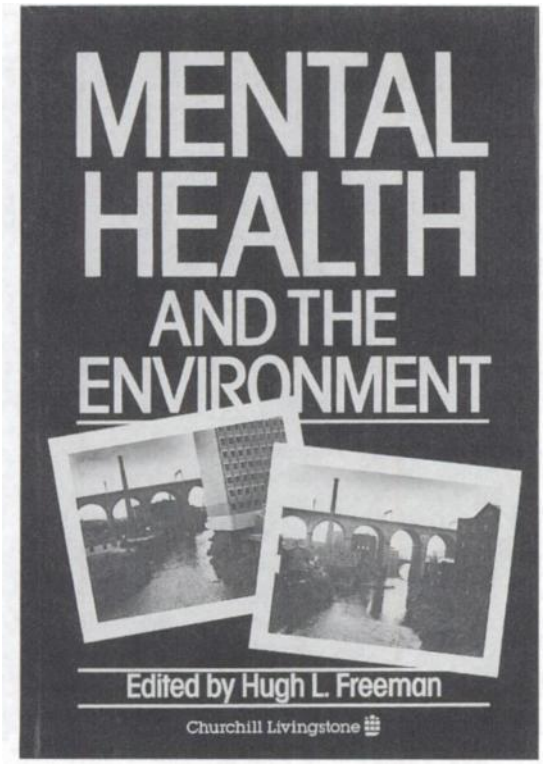
the journal of the Oxford University Liberal Club. I also became Secretary of the Club later, and worked with people like Robin Day and Jeremy Thorpe. But the editorship of *Mental Health* came about largely through the influence of Harvey Flack. I don't know if many people will remember him now, but he founded the magazine *Family Doctor* and associated publications for the BMA; for many years, these were extremely important in health education. I got to know him when I started writing some pieces for *Family Doctor*, and he felt I would be a suitable editor for *Mental Health*, when Roger Tredgold retired from that job at the end of 1963.

I think one of the things I learnt from him was the importance of keeping the goal of communication with one's audience always in the forefront, whether that was a lay audience, as in *Family Doctor*, a wholly professional one, as in psychiatry, or a mixed audience, which *Mental Health* was designed for.

Take us through your editorial career because you have been involved with a large number of journals, and have a number of books you have edited.

I started editing books in the early 1960s and the first two were done jointly with a hospital administrator at the Maudsley, James Farndale, who later became a University teacher. Although they've long been out of print, those two books are still in use by people studying the organisation of mental health services.



Since then, editing books has become something of a habit. The two I am most pleased with both appeared in 1991 – *Community Psychiatry* with Douglas Bennett and *150 Years of British Psychiatry* with German Berrios. I have very much valued my experience of collaborating with both of them. Probably my biggest project was producing *Mental Health & the Environment*, in 1985. This appears as an edited book, though in fact I wrote a good deal of what appears under some other people's names. It was then, and as far as I know is still, the only book in print on the subject. I am now preparing a second version, together with Stephen Stansfeld.

My journal editing, as I say, began seriously in 1964. *Mental Health* was a bit like a parish magazine when I started, but I did make very substantial changes to it, both in its content and its presentation. We found, though, that the readership for a quarterly journal like that, purely about mental health, but not for any one profession, was relatively limited. That situation has remained unchanged ever since.

I started getting involved with other journals, firstly by writing for them; my first paper was in the *Journal of the RAMC* in 1958. Later, I was invited onto some editorial boards and I wrote a good deal – anonymously – for *The Lancet* at one time. I also started doing book reviews for the lay press and for non-psychiatric learned journals. It's a very good way of making oneself read useful material. Before coming to this journal, I was Deputy Editor of the *International Journal of Social Psychiatry*. It was run and owned by Joshua Bierer – one of the most colourful characters of post-war British psychiatry who established the first day hospital here, in 1948 – but not an easy person to work with.

Was there a grand plan?

Absolutely not. As I said at the beginning, my interests had always been more in the arts than the sciences, so writing and editing were the kind of activities that followed from that.

What's really the impetus, is it, in a word, communication?

One aspect is that I like things to be expressed in a way that's both accurate and readable. That's why I've always tried to wage war on unnecessary jargon, which is such a virus in scientific literature. Perhaps it's a bit of an obsessional disorder, but I spend an enormous amount of time improving other people's English.

Here, I should say something about my involvement with the Society of Clinical Psychiatrists – known as the 'Oedipal Group'. John Howells

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described some of the background to it in my interview with him.

It all sprang, in my view, from a failure in 1948 to adapt the old medical administration of mental hospitals to the role of consultants, who were then being appointed. In fact, an NHS consultant's rights and responsibilities were completely at odds with the powers of a medical superintendent, but there was a typically British compromise which fudged things on both sides. Supporters of the superintendent system pointed to examples of outstanding individuals like T. P. Rees and George Bell, but in fact, these were very atypical exceptions.

When in 1959 the Mental Health Act introduced the statutory role of the Responsible Medical Officer, the superintendent's role became even more anomalous – as it was also in relation to the lay Administrator. However, many superintendents were fighting in the last ditch to preserve the status quo.

I strongly supported the SCP from the beginning, because I was convinced that the medical superintendent system was obsolete and a bar to the kind of progress I wanted to see. The SCP was also lobbying on behalf of a College for us, whereas many of the 'leaders' of our profession were actively sabotaging the effort. They really wanted to be physicians, and were highly ambivalent about their role as psychiatrists.

The SCP eventually asked me to edit their *Newsletter*, which was produced by roneo in a mental hospital OT Department. I developed this as well as I could, but it clearly needed to be brought out in a more attractive way; on the other hand, the Society had practically no money to pay for it.

After some looking around, I got agreement from Astra Pharmaceuticals that they would take it on, and distribute it free to all psychiatrists in the British Isles. Believing that there was nothing to lose, I gave this publication a very gradiose title *The British Journal of Clinical & Social Psychiatry*. Apart from my very helpful NHS secretary, I ran the entire thing single-handed, and it was published quarterly for about three years. Unfortunately, Astra then left the CNS field, because zimelidine had to be withdrawn, and while I was wondering what to do next about it, I became editor of the *British Journal*. On balance, I think it wasn't at all a bad publication, and quite a few people were glad to get published in it, because the yellow journal was then very much smaller than it is now.

What about the balance between clinical art and clinical science. Did you have a view or have you now got a view about the balance between these two, about which there is sometimes tension?

That's quite true. In the case of the *British Journal of Psychiatry*, one always has to remember that it has two different audiences, as all general medical journals have. On the one hand, the majority of readers are clinicians who basically want to read things which are interesting to them and which will be helpful to them in doing their jobs. Secondly, there are the hard scientists, who are interested in publishing and reading original scientific data. Much of what they produce will be intelligible only to a very limited number of people in the psychiatric profession, but the scientific standing of the Journal, particularly in international terms, depends almost entirely on that kind of paper. The journal also has a very important role now in keeping all the different sub-specialities in touch with each other. It would be very bad for psychiatry as a whole if they only read their specialist publications.

As part of this role, I have expanded the number of specialist referees on our list to over 1,500, and this number will probably keep on growing. One of the most important things an editor has to do is to be constantly looking for new reviewers, while pruning the list of those who are unable or unwilling to go on doing the job. Peer review is the life-blood of scientific publishing, but unfortunately, some of our colleagues are not willing to play their part in it.

Do you regard your editorship of the British Journal of Psychiatry *as being the culmination of your editorial career?*

Well who knows!

How have you achieved the goals that you had when you started as Editor of the British Journal of Psychiatry*?*

I didn't start with a clearly formulated set of goals, though I had some ideas of the kind of changes I would like to make, and most of them have been accomplished. One project I have particularly enjoyed doing is the series called *The Current Literature*, in which several people comment on a paper published elsewhere. That was an idea that only occurred to me after several years in the editorial chair.

Are there any other changes or achievements that you would pin-point in your editorship of the Journal?

When I arrived, the College was still evolving out of the old and much smaller RMPA and, quite frankly, its administrative and financial structure was simply not up to the job. My predecessor, John Crammer, had tried to make some sense of the publishing finances, but had been defeated by the then College bureaucracy. After a few months, I came to the conclusion that we lacked the capacity to run and develop the Journal in the way that was needed, and thought we would have to accept one of the many

offers of partnership that were coming from commercial publishers. Almost at the last moment, Mike Pare, who was then Treasurer, suggested that we should seek help from the RSM, which had just reorganised its publishing activities. The result was that Howard Croft, who had become Managing Director of the RSM's publications, was appointed our business adviser. From then on, we never looked back. We were able to reduce costs steadily, while enormously increasing the output of printed material, and at the same time contribute substantially to the College's finances. When new senior appointments were made, including that of David Jago as Publications Manager, everything began to get on to a really efficient footing. An important development of the last few years has been computerisation of much of the editorial activity; this has already improved things greatly, but it is by no means finished.

Another thing I did early on was to introduce the section of Brief Reports. Not only because I thought this was a useful addition to the Journal contents, but also because I hoped it would provide an opportunity for younger colleagues particularly to get into print, and I think it has been successful in that way. I was also strongly committed from the beginning to starting a supplement programme, but I had to fight a hard battle, first of all to get the principle accepted, and then to defend the actual content of what was produced in some of the early supplements.

There's no such thing as a free supplement, and as you say, there's been controversy over some of them. What do you have to say about the economics of running a journal and the tension that there is between publishing and disseminating information in the best way and the fact that there is a cost attached to that?

The objectives of the Supplement Programme were basically two. The first, and I say that deliberately, was to have an extra opportunity of publishing useful scientific information for which there would not otherwise be space in the Journal. The second was to bring in extra income. Now, my taking-up the editorial chair coincided with a drastic curtailment by the Government of the money that pharmaceutical companies could spend on promotion, including advertising in journals. This resulted over-night in a loss of about £70,000 worth of revenue per annum; that was the situation I faced on the first day. It was equivalent to double that sum in today's money. At the same time, the subscription price had not been increased for several years, so that income from that source had been falling steadily in real terms. It was extremely important from the College's point of view to find some way of generating extra revenue, because the College is basically a poor organisation and the profits from publications have been one of its most important incomes. Now, there are a limited number of sources from which one can get money to support publications. One is official bodies like Universities, Government Departments, Research Councils, WHO, etc. The second possible source is charitable Foundations, and the third is the pharmaceutical industry.

Obviously, from the practical point of view, the third of those is the most important. Pharmaceutical companies are not in fact malicious and corrupt organisations, as some people seem to think, but they have a need to sell their products, or they won't have the money to develop new and better drugs, among other things. One of the most important ways to do this is to communicate information relevant to their products – but not necessarily *about* their products – to the largest number of psychiatrists. Therefore, some supplements have consisted of groups of papers in which some, but only some are related to a particular drug. I've never been able to understand why some colleagues have objected so violently to papers of this kind being published with the help of a company. If you pursue that argument logically, you would exclude any mention of any treatment method from the journal, because you could argue that eventually, some commercial organisation would thereby profit from it. Yet information about treatment methods is one of the things that readers want most of all.

My experience with the pharmaceutical industry is that they operate to a very high ethical standard. I have *never* been exposed to anything that I could regard as unethical pressure from any company. Indeed, it's not in their interests to have inaccurate information published or unhelpful data suppressed, because sooner or later the truth will come out, and they would suffer more than they would benefit from any pressure like that.

Pursuing the economic theme, my sense of you is that you have, to a certain extent, seen the Journal as subsidising the College; the College is a poor organisation, it needs the funds. Do you see this as desirable, and what are the consequences for the College if, say, the Journal didn't have an aggressive economic policy?

If making a profit was our primary consideration, we would do things entirely differently. We would put out a journal that was a fraction of its present size, as many commercial publishers do. We give very good value indeed for money, and my principal objective has always been the dissemination of information, in which financial considerations are secondary. But we have to live in the real world, and the fact is that the profits from publications, which increasingly in recent years have come from books and not just from the Journal, are an essential part of the College's

income. The College is very fortunate to own such a publication, which has outstanding international recognition and which is, at the same time, very profitable. No other British College has anything comparable, I believe, particularly not the older ones. It's probably not sufficiently recognised here just how much the Journal is read and highly respected all over the world.

I wanted to highlight the book programme because this is another area of growth. Where do you see this programme going?

For many years, the books were just an occasional off-shoot of the Journal. They came out at irregular intervals and there were very few of them. I felt from the beginning that this was something which ought to be developed, both in quantity and quality, and also that we needed to put it on a sounder financial footing. As you know, the programme has grown enormously in its scope, but one of my main objectives has been to keep all our books at a price which is affordable for members, and particularly for younger colleagues. We have, in fact, been able to do this quite successfully by looking for help towards the costs of publication, from a variety of sources. This has meant that we have kept the price of most of our books far below those charged by commercial publishers.

Apart from these general developments, for a couple of years now, we've been preparing a major new series called *College Seminars*, which are specifically designed for trainees. Although they are not, in any direct sense, Membership textbooks, we hope that those who make use of them will get most of the information they need for the examination, and that established clinicians will also find them very useful for updating their knowledge. Publication of the series began this spring.

In spite of a lot of effort, I have not been able to improve the psychotherapy content of the Journal as much as I had hoped. There's a widespread misconception that it's unfriendly to this kind of paper, which is entirely untrue; the problem is that we receive very few worthwhile submissions. With Bob Hinshelwood, Editor of the *British Journal of Psychotherapy*, we have been running a prize competition this year for original papers, and I hope this may give a permanent boost to the Journal's coverage of the issue. A frequent problem, though, is that many psychotherapists write in language that is unintelligible to anyone else.

There's one other important area which we're just beginning to go into, and which you will have the responsibility for. That is Continuing Medical Education, for which a whole new series of publications are going to be necessary in the next few years. I believe this will provide a great new opportunity for the College – not only in the British Isles, but throughout Europe.

Another thing I did was to be the founding Editor of *Current Opinion in Psychiatry*, which is one of a series of journals, established with the aim of helping clinicians and scientists to cope with the ever-growing flood of publications. As you know, it summarises the literature of the previous 12 months on a series of topics within psychiatry, also providing an annotated reference list, which is available on disk as well as in the hard copy. This has been very successful, as a result of special arrangements between the publishers and the College. I am also retiring from this post, and will be succeeded by Gethin Morgan.

Are you going to continue your editorial life, do you have any plans?

I have connections with it, in the sense of being a book reviewer, referee, or Editorial Board Member for a number of journals. I'm working on at least one other edited historical book at present with German Berrios, and I also act as a free-lance editor; I think I bring a fairly unusual combination of skills to that kind of work.

You've written or edited 12 books in the 1980s. Is that something that's going to continue?

I would like to, but to my shame, I've never written a single-author book up to now, whereas my wife produces them all the time. I think that's something that needs attention. In the later 1960s, I was pressed by several publishers to write a book on community psychiatry. I made several starts, and tried bringing in collaborators, but we were all much too involved in day-to-day work. It needed a sabbatical year, but I had no chance of anything like that.

You have a number of late-life achievements, so I'm sure that you are going to realise that ambition. You obtained your DM from Oxford in 1988; and you are currently doing a PhD, which no doubt will come to fruition in due course too.

The hoped-for PhD that you mention is on medical history, and this really takes me back to my academic starting-point in the arts. It's concerned with the evolution of mental health policy in this country in the post-war period, because I think there's a great deal that is still unknown about that. However, my research in the Public Record Office and the interviews I've done so far teach me that it's going to be extremely difficult to unravel the whole story.

Do you have a hypothesis?

I believe that this policy was largely the result of a decision by a small number of key people in the

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Ministry of Health, who in the mid-1950s came to feel that the existing mental hospital system was obsolete. They were influenced a good deal by the example of tuberculosis, where what had been a huge demand for hospital in-patient care disappeared almost overnight, with the development of the antibiotics. As a result, they felt the future lay in a system based in general hospitals, and this then got merged into the hospital plans which began in the early 1960s. I should add that I think one of the key people in that process was my main medical hero, Sir George Godber.

Tell us about Sir George Godber; why is he your hero?

He was Chief Medical Officer at the Ministry of Health, and then DHSS, for 14 years from 1960. One of my own interviews was with him a few years ago, but I think his modesty concealed the essential part he played in the development of the NHS, including the mental health services. His work and his influence represented what I have always felt to be the true ethical and ideological basis of the National Health Service – that its commitment was to the health needs of the people as a whole, and that other considerations such as private profit should be excluded so far as possible.

Another late-life achievement was your Professorship in the Department of Sociology & Anthropology at the University at Salford. Rightly or wrongly, when I think of you I think of someone who has been a sceptic about academia, and so there is an irony in your Chair. Yet, I think that this is something that you are very proud of. Can you say something about the Chair and what it means to you?

Well, I've never been very respectable from an academic point of view. I think I've always been a bit of a maverick in that sense. At the same time, I have great respect for scholarship and for scrupulous academic and scientific work. I was involved in Salford with the origins of the University; it was first of all a Technical College, then a College of Advanced Technology, and finally, a University.

At first, I was concerned in the sociological activities there, because my medical interests always had a strong flavour of that kind. Then, in the late 1960s, we started a joint organisation between the incipient University and the Salford Hospitals to form a postgraduate medical institute. At that time, postgraduate medical education in the North West of England was in a fairly terrible state, so that Salford clinicians really filled the gap that the established medical school wasn't providing for. It seemed possible at that time that a medical school might be established as part of the new University of Salford, but in the end that idea was dropped, and the Manchester school was expanded instead.

In 1974, Salford University provisionally offered me a Chair as Director of the Postgraduate Medical Institute, which was comparable to those in Exeter and Bradford. However, it was dependent on the agreement of Manchester University, and they refused to give this, so that the appointment never happened. It was obviously a great disappointment. I continued being involved with Salford University, though, doing some teaching in environmental sciences, and also postgraduate supervision and teaching in the Sociology Department, and it was as a consequence of that, rather to my surprise, that they made the offer of this appointment to me in 1986.

I was asking you whether you felt proud about it.

Yes. I was proud to receive this recognition particularly from an Institution that I'd been intimately concerned with for so many years, while remaining basically a clinician. But at the same time, I was an honorary member of the Psychiatric Department of Manchester University, because my general hospital became a teaching hospital for Manchester in the early 1970s. We had no university staff in adult psychiatry at the Salford campus of the medical school, so that all the teaching had to be done by NHS clinicians. We tried to give it a flavour of our own, and I think our students mostly did pretty well. I once took all six of them on a domiciliary visit – which the patient and relatives greatly enjoyed.

I should add that within a few days of hearing of my appointment at Salford, I was told that I had been made a Visiting Fellow of Green College, Oxford. Shortly before that, I had been enormously lucky in being given a four-month sabbatical there, through the generosity of Sir John Walton and the Nuffield Provincial Hospitals Trust. It was the longest break from clinical responsibilities that I had had since starting work in the NHS, more than 30 years earlier. It was wonderful to be able to get on with some writing, though I continued my editorial duties as usual.

I am also very proud of the fact that my wife was made a Professor towards the end of last year, at the new Middlesex University.

I want to turn now to some of your research activities. You've published a number of papers on a variety of themes, what were your main interests?

I think they all stem basically from clinical necessities. Most of the papers I published in the earlier period were about the organisation of services. Obviously, they should have had some evaluative data attached to them, but the fact is that

at that time, nobody knew how to evaluate services. Not only the methods, but even the thinking were at a fairly primitive stage, and I had no money at all to carry out any formal research activities then. So to a large extent, they had to be descriptive, but I think they had a value for that period – and perhaps historically – because what we did in Salford was to create a model for the later national programme, and this was embodied in *Better Services for the Mentally Ill* in 1975. That may seem rather an extravagant statement, but I think you'll find that the principles of what emerged at that time in the national plan were being carried out in Salford in the 1960s, as I described in a number of publications.

From this service interest, two main strands developed: one was epidemiology and the other psychopharmacology, particularly the treatment of schizophrenia. The second one related specially to the use of depot drugs, which I think is an interesting story. The services which I developed in the early '60s particularly focused on schizophrenia, because I thought that this was the single most important problem in psychiatry, and I still think that's so. What happened then was that patients would be admitted, improve in hospital on medication, go out, stop taking the tablets, and relapse. Towards the end of 1966, though, I heard about the first depot drug – fluphenazine enanthate – and started using it. I soon felt that this was one of the most important things that had happened in psychiatry for a long time. Through this interest, I got to know Gerry Daniel, who was then Medical Director of Squibb, and he was the biggest source of support and encouragement that I had. With that help, I began to do some research, which had to be fairly simple because the resources available were minute, but what I focused on was a comparison of schizophrenic patients before and after depot treatment, in terms of the time they spent in hospital. Obviously, this is a very crude and sometimes misleading measure of morbidity, but it was the only form of reasonably hard data that was available. In fact, when patients were switched from oral to depot treatment, it was possible to show dramatic reductions in their need for hospital care, which were comparable to those that occurred when lithium was introduced for patients with recurrent bipolar disorder.

Today, this kind of study seems methodologically simplistic, but its objective was a practical one – to show that using depot neuroleptics in the framework of a comprehensive service could reduce relapses and the need for long hospital stay. The fact that each patient was his or her own control meant that the results were not contaminated by the enormous variability of schizophrenics in their need for medication – which we have no means of predicting early in the illness. I did the early studies together with Donald Johnson, who was then starting in psychiatry, and went on to have an outstanding research career of his own that has always been firmly rooted in clinical needs. For a long time, Squibb did more to promote education and research in this area than any official body, but unfortunately, their interest eventually moved to other areas of medicine.

In America, NIMH carried out a huge and expensive comparison of oral versus depot fluphenazine in the 1970s, which showed no significant difference. However, they had made a basic methodological error, in that the conditions under which patients took oral medication in the trial bore no relation to those of real life – they were under intensive supervision, which came to an end as soon as the research did. You will find the same contamination in a number of American studies. Unfortunately, those who do important research there are so drawn into what one might call entrepreneurial activities that they soon tend to lose touch with actual patients. All this was discussed at a meeting which NIMH arranged in Italy in 1977, when I and Donald Johnson both presented our work. However, for reasons which I could never discover, the proceedings of that meeting were never published.

The Salford epidemiological work was started by Mervyn Susser, who then went to America in 1966. It resulted in the establishment of a case register, which was modelled on the Camberwell one, but was actually more comprehensive in the data it collected. This has continued ever since, and I used it particularly to do some population-based studies in schizophrenia. The basic problem with the register, though, was that it had just enough money to collect the data, which were of a very high standard, but practically no resources to make use of them. So unfortunately, this superb data base has never really been exploited to the extent that it deserved, and it failed to get the general support of clinicians, because it wasn't clearly helping them in their everyday work.

Do you think that you got the balance right in your output of clinical work, literary efforts, administration and research?

It's gone through different phases. The 1960s were mostly devoted to developing an integrated clinical service and seeing an enormous number of patients. It was very gruelling, routine work, with little support. In the 1970s, I had a great deal of managerial involvement. I was elected Chairman of the Medical Executive for the Salford Hospitals, and with the 1974 reorganisation, became a member of the Area Management Team. That was an important part of my work for the next five years, but unfortunately, suffering from feelings of omnipotence, I agreed to continue all my clinical commitments at the same

time. The result was that I did neither the administrative nor the clinical work as well as I should have done, because there was simply far too much of each. One of my administrative colleagues in management was Duncan Nicol, who has since become head of the NHS Management Executive.

Through learning that lesson, I decided to retire from the NHS at the beginning of 1988, and give virtually all my time to the Editorship. Before that move, I had been supported nobly by my colleagues in Salford, particularly Michael Tarsh and Som Soni. At the Regional level, I was elected Chairman of the Psychiatric Sub-committee of the Regional Medical Committee. The parent body was totally ineffective, but our Sub-committee did provide a meeting-place and collective voice for colleagues from every District, and in representing their views, I didn't always make myself popular with the RHA. Three objectives that I set were to start training arrangements in the North-west for child psychotherapists, to start similar arrangements for nurse therapists, and to get more consultants appointed in mental handicap. None of these were achieved while I was still Chairman, but two of them have been subsequently. I could never understand why the RHA didn't seem to want us to discuss anything important, but I have since discovered in my historical research that at the national level, the same thing happened with the Standing Mental Health Advisory Committee. Administrative bodies don't like professionals getting too closely involved in their activities.

Putting it all together, could you identify a singular success, and also an area where you perhaps didn't devote sufficient energy, or you wish you had developed further in your career?

When I was 31, I made the decision to go for a consultant job in which I had to work tremendously hard, and this meant that I never had time to establish a basis of major original research to my name. That's something I've suffered from since, both professionally and in terms of my own self-esteem. The thing I'm proudest of is the service work I did in the 1960s, but I discovered that in terms of professional advancement, it counts for practically nothing.

You say that with some feeling, but is there a sense of resentment about this, about how clinicians seem to be perceived by Establishment figures: clinicians are hard-working committed serious people, who have got something to say and give, but they're in the back-water, neglected, cannon fodder, the private soldiers, so to speak.

It's a fundamental problem, not only in medicine, but in other professions too, that those who are effective practitioners don't benefit much in terms of esteem from their colleagues. What I resented very much personally was the fact that the work that I and many other people were doing in the North-west of England wasn't really recognised on a national scale. When Ministers from the Department of Health, and other official bodies looked for advice, they generally turned to people who actually had very little clinical experience; some of them in fact had never worked in the National Health Service outside a teaching hospital. I think that's an unfortunate aspect of British life, but it also happens in other countries, to varying extents.

It's a formidable problem. I remember that in your manifesto for the editorship, you made a point of standing out for the consultant in the 'sticks' and you've hinted at the importance of an editor knowing the readership, or putting it another way, knowing who the electorate are. I wonder, linking it up with professional development, whether or not psychiatry as a profession has got more to learn about professional development and advocacy: that to a degree, one might blame those in the 'sticks' for not shouting out louder.

Those who are deeply involved in the hurly-burly of carrying large clinical commitments often have neither the time nor the energy to devote to blowing their own trumpets. But of course, to some extent it's a question of personality and choice; people make a decision either to devote themselves primarily to the care of patients or to what one might describe broadly as 'politicking'. It's not easy to combine both these activities successfully, and very hard indeed to combine both with research and academic work also.

I think that there are some professions close to us who have been more fortunate in their use of politicking and while I hear what you say and I agree with it, looking to the future, maybe all the management training that the senior registrars are having will be effective in making sure that whatever resources there are are kept within psychiatry and mental health.

I think the worst thing that happened from that point of view was the total failure of psychiatry to respond to the ideological challenge of the late 1960s, when anti-psychiatry developed from the political movements of that period. The ideas of R. D. Laing particularly were taken up then by the media, and to some extent, by political groups, which resulted in a wholesale attack on the whole legitimacy of psychiatry as a professional activity. There was virtually no response to this from the psychiatric profession. Of course, the RMPA was a fairly small organisation at the time, but it did nothing whatever to try and counter what I felt was a very sinister

movement, that could be very harmful to patients. I myself did enter the battle, in whatever way I could, but hardly anybody else did. Since then, I have got involved in many similar scraps, for instance, in the correspondence columns of the serious newspapers. I look over my shoulder, figuratively, to see who else has joined the battle on our side, but the answer often is no-one.

And so, to conclude?

In almost ten years that I have been Editor, the total profits on publications amount to nearly a million pounds in today's money. Combined with the scientific quality of the publications, I think that's quite a significant achievement. I haven't mentioned *Psychiatric Bulletin*, though I was joint editor of it with Alan Kerr for a short time, before moving on. I have encouraged the development of this other journal as much as I could, and I believe the result is greatly appreciated by most College members. It has now become an important journal of administrative and social psychiatry in its own right, as well as a record of the College's activities and views.

I was also keen to start a Trainee Editor scheme, and this finally happened last year. It has worked very well with our first two appointees – Tom Fahy and Tim Rogers – and I hope this will be a regular arrangement now.

Finally, I would like to acknowledge the tremendous help and support I have enjoyed during my time as Editor. Firstly, from the College staff, particularly David Jago, Ralph Footring, Judy Ashworth, and Elaine Millen; secondly, from my Associate and Assistant Editors, and thirdly, from all those colleagues who have helped as invited authors, as referees, or in giving advice. The job could never have been done without them all.

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