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Perspective

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

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I have had the good fortune of having lived in three countries and of having had a mixed education and training. I was born in Romania but inherited Austrian nationality from my father and later became a British subject. And I was trained in Germany, France, Austria and Britain.

For my first 12 years my immediate family lived in Romania. But we lived there as strangers; we spoke German at home and I never really learned the Romanian language – this was the language of the servants and shopkeepers! I did not go to school but had governesses and then tutors and they were always German. It seemed as though as children we lived in a foreign community. None of our little friends were Romanian – they were all German, Austrian or other nationalities. I picked up a smattering of the local language and made only acquaintances among Romanians but this strangely sheltered way of life seemed perfectly natural at the time.

When I was 13 we moved to Germany and I was sent to a Prussian grammar school. This was quite a cultural shock for me but Peter, the little boy designated to show me around and help me in those first fearful days, is still a friend. Although he now lives in Switzerland we still meet and communicate from time to time. I did not enjoy the regime of the school but took the school leaving examinations – commonly called the 'Abitur' (as I believe it is still called) and when I was 19 I went to university. How different the system was then to the rat race of the fiercely competitive UCCA system which I see my grandchildren grapple with now. I enrolled at Berlin University as a medical student and lived for the most part in my family home. Lectures were huge and formal; there was no tutorial system or assessment of one's work. And it was perfectly acceptable – and quite common – to move from university to university as one pleased attending courses which seemed appropriate or interesting. The academic year was divided into two long semesters and I spent time in Heidelberg, Vienna and Paris during my undergraduate career.

From the beginning of my studies I was interested in neuro-psychiatry and paediatrics and this led me to sit at the feet of some of the greatest experts in Europe: there was Wagner-Jauregg (the only psychiatrist to be awarded the Nobel prize for medicine), Jaspers, Schilder, Guillain, Geratman, Laignel-Levastine, Marfan, Pirquet to name only the most outstanding personalities of the time.

I frequently attended Wagner-Jauregg's lectures in Vienna. He was a very striking man – of huge stature with strong features and a powerful personality. I once described his appearance to an artist friend who, on hearing the description, was able to draw a recognisable sketch. He had a strangely strong Viennese accent which sounded almost uneducated – which he obviously wasn't! He was clearly an able and highly intelligent psychiatrist and he was an aristocrat by birth.

For a recently trained psychiatrist it must be difficult to appreciate the impact that Wagner-Jauregg's malaria treatment had on psychiatric patients. Before his discovery the only treatments consisted of giving sedatives, occupational therapy and controlling violence. I believe that Wagner-Jauregg started from the observation that some psychotic cases improved after a physical illness. And by systematic observations he narrowed this down to the finding that patients suffering from general paralysis of the insane (GPI) benefited from an intercurrent feverish illness. After trying a variety of substances that caused a rise of temperature, like tuberculin or typhoid vaccine, he eventually tried tertiary malaria which produced fever that could easily be relieved with quinine. Although malaria did not cure GPI it usually arrested any further deterioration and led to a certain degree of improvement. Before the introduction of this treatment GPI was considered a fatal disease – most patients died within two years of the diagnosis.

The effect on psychiatrists' morale was dramatic. Here was a physical treatment which could arrest a mental illness and prevent further deterioration and death. This encouraged us to try to evoke all sorts of reactions by injecting different substances – insulin shock treatment, for instance, was one which seemed to produce results. While working at Runwell, Ström-Olsen, my chief, and I treated quite a large number of patients in this way – but we gradually

realised that the improvements which occurred were due more to the greater care and attention these patients were receiving than to the drugs. Soon after the introduction of insulin shock treatment came Meduna's technique of provoking epileptic fits by injecting camphor and then substances such as Leptazol. These techniques were effective but extremely unpleasant for the patient and were soon replaced by ECT. In spite of many objections this continues to be used for the treatment of severe depression.

Wagner-Jauregg's psychiatric treatment had many other facets. For instance I knew of a young woman whom he was treating for severe agoraphobia by making her go out for walks with a companion. He suggested that at first they walked together and gradually separately, making the distances between them increase just a little each time; he was clearly anticipating behaviour modification therapy.

Out of curiosity I also went to listen to Madame Curie giving one of her formal lectures in Paris. But what a disappointment it was to see her! She looked to me as if she could have been a French concierge and she sounded like a Polish emigré – not a very attractive combination. But she clearly had one of the most brilliant brains of her time; and even as I listened and watched her I became aware of her achievements and her incisive mind and less conscious of those initial superficial impressions. As we swarmed out of the lecture theatre I was aware that I had just been privileged to hear one of the greatest scientists in the world.

In 1925 I was in Paris when the centenary of the birth of Charcot was celebrated. At the Salpêtrière I went to a lecture during which Professor Guillain demonstrated Charcot's last surviving patient. A rather elderly lady was brought on to the podium and we witnessed the great hysterical fit just as Charcot had described: it even ended with the "arc en cercle" in which the body formed an arch and only the occiput and heels were touching the floor.

After qualifying, my first job was on a mixed ward – of internal medicine and neurology – under F. H. Lewy (Lewin) in Berlin. During this time I worked on my thesis for the MD which was on a neuro-physiological problem – measuring how much change in light was necessary to evoke a pupillary reflex. Later, in 1928, I went to Bonn with the intention of learning neuro-pathology from Alfred Meyer while also doing clinical neuro-psychiatry. But after a while I realised that neuro-pathology was not for me. It seemed that I was hopeless at dealing with the problems it presented but Meyer was an excellent teacher and I learned most of the neurology and psychiatry I now know from him. In those days neurology and psychiatry were taught together, a joint speciality.

Five years later I left Bonn and came with my wife to England where many of my relations lived. However, in order to practise medicine I had to requalify. I studied for a year at the Welsh National School of Medicine and sat the Scottish Triple in Edinburgh and Glasgow. For the next 34 years I worked in England, serving as a major during the war, seeing the introduction and establishment of the NHS and many changes in medical and social practices, until my retirement in 1967.

With such a chequered career it is hardly surprising that I should have become interested in national differences, particularly in medicine. There have been so many changes from those days in 1921 when I first became a medical student to 1988 when I am now an observer and a geriatric subject.

For a start, training differed so much between the countries. In Germany teaching was largely theoretical, consisting mainly of lectures, demonstrations and seminars; there was hardly any practical work for the student. And there was no clinical practice involved – the only work on the wards which was compulsory was one month in obstetrics. However, we were encouraged to spend part of our vacations working in hospitals, either as a dresser or on a medical ward but this was, of course, unpaid. As I was not really interested in surgery I managed to qualify from Berlin without ever having used a scalpel, put on a dressing or given an anaesthetic (this was usually done by anyone who was available – a doctor, a nurse or a medical student, and when I first worked in this country I was quite surprised to find that many hospitals had specialist anaesthetists even though some were part-time general practitioners).

And the whole system of studying also differed. Both Germany and England prized the idea of academic freedom but it had a different meaning in the two countries. In Britain it meant the freedom to teach according to one's convictions and beliefs. In Germany the term was not restricted to the teacher but also extended to the student – one was free to follow one's own life-style (there was no such thing as 'keeping term'), choose one's own method of studying (attending lectures, keeping notes, seeking clinical practice etc – or not!) and choose the subjects one wanted to study. One was even free to take examinations as and when one felt ready to do so. For instance, after five semesters (two and a half years) one could be admitted to sit the 'Physikum' which was the examination in the pre-clinical subjects (anatomy, physiology, physics, chemistry). In order to do this one had to produce evidence that one had attended two courses of anatomy, two courses of dissection, two courses of physiology and one each of the other subjects. The student was free to choose in which order and in which term he attended which course. Only if one sought advice would it be suggested that it might be better to know about the structures before

learning their functions; in other words it might be better to do the courses in anatomy before doing those in physiology but one was free to construct one's own programme of study. If one had the time one could also attend lectures on non-medical subjects – like philosophy, economics, literature or whatever took one's fancy. I heard Jaspers lecture on philosophy and psychology and attended my first formal series of lectures on Shakespeare given by Gundolf who achieved notoriety with his new translation (from English to German) – but this was no improvement on the familiar and classical translations of Schlegel and Tieck which all German teachers had used and which have stood the test of time.

When the time came for the pre-clinical examination, this was conducted orally and quite formally. For the final, one had to sit oral examinations in all the clinical subjects plus a few others – like medical jurisprudence, pharmacology and surgical or topographic anatomy. These non-clinical subjects were examined formally by *viva voce* – there were no written papers to sit. But in the clinical subjects one was examined with an informality which sounds surprising to those familiar with the British system: the student would go to the professor's secretary and ask, for example, when he could be examined in surgery. A convenient time would be negotiated individually – but if it could be arranged the professor would agree to examine a few (two or three) undergraduates at the same time. Each candidate would be asked a number of questions and if he answered them correctly he had passed the examination. If, as happened when a friend and I attended together for our surgical examinations, some questions were answered incorrectly then one was told to go away and come back to try again in six weeks' time. As far as I knew there was no record kept of a student having 'failed' an examination at any time. In my case, I was sent away, read all I could in the next six weeks and returned to be re-examined by the same man and the second time I passed. There were no essays and no such thing as multiple choice questions, but in some specialities one had to write up a detailed case study – though it did not seem as though these studies carried much weight. I seem to remember that there were 13 examinations to be taken in this way, after which we were required to spend a year in an 'approved' hospital before being issued with the 'Approbation' which was the official state licence to practise medicine. After this most students took the MD, which was a relatively easy examination and certainly not compulsory.

Once I had begun working in England I became aware of the different attitudes and practices between the two medical worlds. For instance, the attitudes towards testing seemed so different: here in Britain biochemical tests were usually done when a positive abnormal result was expected. But in many German hospitals, tests, like serological tests for syphilis or the sedimentation rate, were applied routinely to every in-patient.

Similarly neurological examinations were carried out in a much more pedantic way in Germany than in England. For example, to detect pyramidal damage it was not enough to scratch the sole of the foot to see whether there was an extensor response. An attempt would also be made to evoke this sign by squeezing the calf (Gordon) or by putting pressure along the tibia (Oppenheim). There were other reflexes affecting the smaller toes, which were also done as routine. When testing for sensation the British neurologist was usually satisfied if he knew there was, for instance, some loss of feeling of touch or pain in the perineal or ulnar region. The German neurologist would not rest, especially in a teaching hospital, until he had determined the exact boundary of the loss and marked it on the skin – if possible for touch, pain *and* temperature. This was particularly interesting to me because at that time English neurology was leading the world (Kinnier Wilson, Gordon Holmes, C. P. Symonds, Riddoch) while German neurology lagged behind.

In psychiatry, however, things were different; every German university had a chair of psychiatry and much academic work was done in their clinics. Although formally psychiatry and neurology were regarded as one subject, most practitioners inclined towards one or the other. I regarded myself as a neurologist since that was my particular interest – I had spent a year with one neurologist in Berlin and five years in the University clinic for psychiatry and neurology in Bonn.

My chief interest at this time was in aphasia, apraxia and agnosia. I had been very impressed with Henry Head's work on aphasia and applied his methods of testing to my own aphasic patients, subsequently publishing some papers while still in Germany. However, things were not so straightforward once I began practising in Britain; the first patient on whom I used this technique in Cardiff gave me a word for 'scissors' which I did not know. Was this a new English word which I had not yet learned? Or was he speaking Welsh? I decided to give up examining aphasics in this way until my command of English had improved! I then discovered that in order to become established as a neurologist in Britain at that time (before the establishment of the NHS) one had to find a practising neurologist who would take one on as an unpaid junior. One could spend years working without pay until one had built up a private practice of one's own. As a married man with responsibilities I found I could not afford this so began to look at alternatives.

Before long I realised that the psychiatric hospitals at that time were run by the local authorities and that

the medical staff were all paid. I also discovered that to have been trained in psychiatry in Germany or Austria was considered an asset – but that first I would need to be on the British medical register. The quickest way to achieve this was to obtain the Scottish Triple, having been registered at a British medical school for a year. This gave me my first taste of the differences between the educational systems of Germany and Britain: having heard that Guy's Hospital had a good medical school I went there and asked to be enlisted as a student. To my surprise they turned me down! And so did several of the other London medical schools. At that time on the continent all the universities were state institutions and one was automatically entitled to a place if one had the right qualifications. Not so, as I discovered to my wounded pride, in Britain! However, the Welsh National School of Medicine accepted me and by the end of the year after my arrival in Britain I had passed the finals in Edinburgh and Glasgow – written essays, clinical examinations and oral examinations – a very different system from the one I had been through on the continent.

There was no pre-registration year to be completed at that time in Britain and I was lucky to be offered a house job almost immediately in Whitchurch Hospital which was considered one of the best psychiatric hospitals in the country. One of the reasons for this was that it was, I believe, the only hospital of its kind to employ a full-time research worker – the biochemist J. H. Quastel, later to hold a chair at McGill University.

It was very interesting for me to see how the hospital was run; and I was very impressed, particularly by the nursing. The psychiatric nurses were much better trained than those I had been accustomed to on the continent. And I remember how astonished I was to see a grand piano living in a ward alongside some of the most disturbed patients – that it should have survived in such an unruly atmosphere would have been unthinkable in a continental hospital. The nurses I had been used to were more like rough 'warders' but in Whitchurch things seemed very different. I am afraid I had not taken much interest and had never been involved in the training of nurses before but I realised then that it cannot have been very good or very specialised.

The treatment of very violent or restless patients in both countries was a difficult problem for the doctors; I never saw a strait-jacket in use, but in Germany such a patient was given a 'wet pack' – that is to say he was completely wrapped in a few wet sheets and a blanket with his arms strapped close to his side. This was even more effective than a strait-jacket and probably much more unpleasant. But I, and others, thought that this barbarous technique was doing the patient some good. When I first worked in Britain very violent patients were not strapped up but were occasionally locked up in isolated, padded cells. They were dressed in tough, indestructible clothes (of rough, uncomfortable materials) but could only be assigned this treatment on a doctor's authority and strict records were kept of the time they stayed in the cells. Over the years this equally barbaric treatment was phased out as drugs and more humane therapeutic methods were introduced.

There were two kinds of hospital in Germany for psychiatric patients: the small teaching hospitals and the large places called Institutions for Cure and Care. The university clinics were the places where the undergraduates were taught by the staff who considered themselves far superior to the staff of the large institutions. Here in Britain most psychiatric patients were accommodated in the large hospitals which had been built in the Victorian era, usually outside the towns in rural and unsociable settings. For the wealthy there were some small private clinics which were usually prized for their privacy and comfort. Life in neither country was very pleasant for the mentally ill whose prognosis was generally poor.

It was agreed among all doctors in Britain and on the continent that advertising was not acceptable. But what constituted advertising was interpreted differently in the different countries. In Germany it was quite acceptable for a doctor to put a notice in the newspaper saying what date he would be going on holiday and when he would be returning. Similarly, the Germans did not consider it advertising to have a large plate on the outside of the surgery door announcing not only the name of the doctor and his speciality, but also detailing some of the special facilities or instruments he used, e.g. ultra violet lamps. And yet it was a great surprise to me, when I first came to London over 50 years ago, to see a red light at the entrance to a surgery or a large plate glass window painted green with the word 'surgery' painted on it. In Paris, on the other hand, I visited a number of well known specialists none of whom put up any kind of plate. And even general practitioners did not have anything more than the word 'médecin' discreetly fixed to their doors – though I believe things were different in the French provinces.

Communication between doctor and patient differed widely too. On the continent the patients were more used to being given details of the doctor's findings and also of the treatment. But in Britain this was not the case. Although things have improved recently I well remember a colleague telling me, perhaps 30 years ago, that if a patient asked him what drug he was prescribing he would reply that since he, the patient, was not medically qualified it would not help him to know. I was shocked by that attitude then and I believe (and hope!) that no doctor would get away with that kind of response these days.

Another area of differences was that of self-referral to a specialist; on the continent this was both common and acceptable and must have made treatment by general practitioners quite difficult. I remember that in the 1920s the doctor who looked after our family described himself as "specialist in internal diseases" but this did not prevent my mother referring herself to a well-known gastro-enterologist or my father to consult, off his own bat, a professor of medicine who was also well-known as an eminent cardiologist. However, this was 60 years ago and I don't know how things are now. But I do know that this practice was never common in Britain and was then – as it still is – strictly frowned upon.

Looking back, it seems surprising how little academic psychiatry was influenced in Germany by the analytical ideas of a Freudian or Jungian variety. To the best of my knowledge no German university clinic had an analyst as a member of the staff. And although Paul Schilder lectured on psychoanalysis in Vienna he was also a well respected neuropathologist, having described Schilder's disease. It seemed that there was no place for psychoanalysis in the German-speaking universities. So I was extremely surprised to be asked to explain the meaning of some analytical terms when I sat for the DPM in London soon after my arrival in Britain. Was it that these analytical ideas had gained respectability in Britain before Germany – or could it have been that my examiner was curious to know what I had learned, having been trained in the cradle of analysis? I suppose I will never know.

More than 30 years ago while I was physician superintendent at St John's Hospital, Stone, it became public knowledge that a new Act of Parliament about mental illness was due to be passed. I wondered what the members of parliament knew about mental illness and discussed this with the Labour MP, Kenneth Robinson (later to become Minister of Health). It was agreed that he, together with a Conservative member, would organise some all-party meetings of members of parliament for which I would provide the speakers. I did not try to persuade members to take particular action but rather to provide them with information, arranging lectures on such diverse subjects as schizophrenia, genetics, mental handicap, psychoanalysis etc. I hoped this would be helpful when they came to discuss matters of mental illness in the House. It did, indeed, prove a useful exercise.

Many years later I hoped that something similar would be done before the most recent legislation but by then I had retired from practice and felt I did not know who the bright young sparks of psychiatry were. I tried to persuade some of my younger colleagues to initiate some meetings, described what had happened in the 1950s, and hoped that something along similar lines could be established – but apparently this idea, like so many others, got stuck in the quagmire of committee meetings.

I know that medical administration is usually looked down on by clinicians but I quite enjoyed ten years (in the 1950s) as physician superintendent at St John's, Stone. It was an interesting challenge to try to change some of the worst characteristics of the hospital. One of my main aims was to increase respect for, and dignity of, the patients, as well as continuing to devote more time to the chronically sick. I once calculated that if the medical staff did nothing else during their working day but talk to patients (no meetings, no letters, no reports!) they might just manage to spend 15 minutes with each patient a week. The reality was that the hospital was so understaffed that most patients did not get even 15 minutes a week with their doctor. My ambition was to humanise St John's – how much I succeeded I don't know.

Apart from my interest in administration and patients' treatment and welfare I developed a fascination for the EEG. My interest in this technique did not come out of the blue. I had done some work on chronaxie when I was working under Lewy in Berlin and when I worked in Runwell I published a paper with Rolf Ström-Olsen on chronaxia in catatonic patients. But it was only later that I realised that to assess chronaxia was an unreliable measurement. I had read Berger's papers on EEG when they first appeared in German but was not very impressed. In 1936 I paid a visit to Adrian in Cambridge and asked him about the availability of apparatus to record the EEG. I got the impression that he was horrified by the idea of a psychiatrist investigating the EEGs of the mentally ill. However, Ström-Olsen, then physician superintendent of Runwell, encouraged me to try. And when Edison Swan built the first few recorders for clinical use Runwell Hospital bought one and I started to work with it in earnest.

There were several of us who had acquired the same instruments at the same time so we started to meet, under the guidance of Geoffrey Parr from Edison Swan. This little group, which consisted of Grey Walter, Denis Hill, Dennis Williams, Michael Saunders a crystallographer from Edinburgh, and me, formed the original core of the EEG Society. From 1950 I had a similarly equipped laboratory at the London Hospital and when I moved to Stone I established one at St John's as well.

Apart from doing the routine EEGs for the clinicians we spent a lot of time from 1951 at the London building a computer type instrument which did a frequency analysis of the EEG and stored the masses of information on punch tape so that the large amount of data could be handled. But I had underestimated the technical difficulties; and what we were in fact

attempting to do was to build a specialist computer with insufficient funds and personnel – we had the help of one electrical engineer and one untrained laboratory assistant. The instrument was finally completed just before my retirement in 1967 and was never used systematically as had been intended. It seems that in psychiatry the EEG has been somewhat of a disappointment, being rather a crude technique, but in the study of epilepsy it is still proving its use and the more elaborate method of evoked responses offers a useful, non-invasive technique. It was also the first non-invasive tool to be used in monitoring brain surgery but of course it has now been superseded by radiology and scanning techniques for working on brain tumours.

When I started to write this I thought that there were many differences in the practice of medicine between Britain and the continent in the 1930s–1960s which I would be able to record. When I first came to Britain there were so many things to adapt to – culturally, socially and professionally, that the medical differences seemed big and important, Yet, looking back it seems that the differences were rather superficial and that the actual practice of medicine in the countries where I have worked and trained is, fundamentally, the same.

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Keep up the pressure!

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In politics some things can happen very quickly when a sufficient head of steam has been built up, as we have seen in the recent European Community election results. The message from the medical profession about the proposed changes in the NHS may now have been understood by politicians but we should never assume that governments will withdraw foolish or damaging proposals, so the time is ripe for renewed pressure for their withdrawal.

Members of Parliament on the Government side are now in a receptive frame of mind so this is the right time for a concerted effort in support of the criticisms of the White Paper already made by all the Royal Colleges and the BMA.

Every individual member of the College should therefore write to his or her Member of Parliament expressing in plain terms how the psychiatric care and treatment of patients will be affected by the proposals and their effect on training and research.

Members of Parliament should also be asked to meet deputations of perhaps three or four psychiatrists working in their constituencies to explain the problems more fully. Most important, they should be asked to put down Parliamentary Questions for oral answer whenever the Secretary of State is first on the list for questions.

I should explain that only one Question from any one MP can be answered orally and it is the luck of the draw (or rather printer's pick) how near the top of the list he comes! If his Question is not reached, the Member will get a written reply the same day. However, he can put down any number of written Questions as many times as he wishes. There is no restriction on numbers or dates for written Questions, so your Member can have a field day if you let him have plenty of ammunition!

He should be asked to let you have a copy of the replies he receives to both oral and written Questions. If you are not satisfied with the replies, you can always ask him to put down further Questions.

Members can also put down Early Day Motions on the Order Paper for colleagues to sign if they are in support. As long as new signatures are added each day, the Motion will continue to appear on the Order Paper, thus attracting more signatures – and it is a very gratifying sight to see the list of supporters grow day by day!

Finally and equally important, do let your local Press know about the approaches made to your Member. They will be very pleased to see copies of letters sent and the replies. They will be interested to know dates of meetings with your Member before you see him and to have an account of what you said to him and his reply to you immediately after the meeting. Information about Parliamentary Questions and Early Day Motions should also be given to the Press. So keep the Press informed – they will love it! If your MP does his job, he will enjoy the publicity too! And you will be informing the public, your patients, of crucial changes that will affect their lives if they are enacted – and you may thereby encourage them, too, to lobby their MP!

Public pressure that is informed and persistent is the essence of a democratic society and I believe it would be particularly effective now. I would love to know how you get on!