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Research in the field of psychiatry

M. SHEPHERD¹

While I appreciate very much the privilege of addressing this Academy I am aware that the compliment in the invitation has been extended as much to the state of psychiatry in my own country as to myself as a representative of it. Accordingly it would, I think, be helpful and appropriate to indicate both the background and the viewpoint which I bring to these discussions before addressing myself to the main topic.

As we know it to-day, organised British psychiatry dates from the second world war. Before that time it was practised principally in the mental hospitals which were separated by both geography and status from the academic and teaching centres: there the neurologists reigned supreme, making – as a wise cynic has observed – their reputations out of organic nervous disease and their money out of functional nervous disorder. Nonetheless, there had always been a small number of outstanding individuals who had fostered a tradition which has been well described in the following terms: “On the whole, British psychiatrists since the time of CONOLLY have not been innovators. They have sifted the contributions of psychiatrists from other countries, accepting or modifying what seemed to them sound, and often applying pragmatic tests of truth. The outstanding names – MAUDSLEY, HACK TUKE, BUCKNILL, FORBES WINSLOW, CLOUSTON, MERCIER, GOODALL, MOTT, TREDGOLD, MAPOTHER – are of men whose intellectual force is undisputed, but who did not give rise to new movements of thought. Never falling into extravagances, they practised and taught a humane, melioristic, commonsense psychiatry which was critically receptive toward fresh ideas” [1].

Humane, melioristic, commonsense: modest as these attributes may seem, their historical importance clearly appealed to the son of a Swiss Zwinglian minister and ADOLF MEYER, when he delivered the 14th Maudsley Lecture in 1933, paid tribute to what he called the “very definite biological comprehensiveness” of British thought “in contrast to the Continental interest in the cell and the isolated organ” [2]. MEYER’s intellectual debt to the United Kingdom has been amply repaid by the guidance and instruction which he gave to a long list of young British psychiatrists who made their pilgrimage to the Phipps Clinic in Baltimore. The majority of these men returned to the United Kingdom to teach the principles of psychobiology which to this

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day characterises the best qualities of much British psychiatry and constitutes one of the several links between our two countries.

Since 1945 psychiatry in Great Britain has undergone a spectacular growth and development which have entitled it to a prominent and respected place on the international scene. Though many factors have contributed to this metamorphosis the most important have been related to or dependent on the sweeping political and administrative changes which have transformed the social structure of the country since the war. The most influential measure for medicine was, of course, the passage in 1946 of the National Health Service Act whose socio-economic impact has affected every branch of medical practice, not least psychiatry. The National Health Service did not arrive overnight; it represented the culmination of a 35 years' struggle to obtain an egalitarian distribution of medical care and was preceded by a number of preparatory measures. One of the more far-sighted of these was the 1944 Report of the Inter-Departmental Committee on Medical Schools, under the chairmanship of Sir WILLIAM GOODENOUGH, which was devoted to the re-planning of medical education on the explicit assumption that "properly planned and carefully conducted medical education is *the* essential foundation of a comprehensive health service" [3]. The Committee acknowledged the size and relative neglect of psychiatric illness and attributed many of the previous obstacles in the way of development of the specialty to its relative isolation from the medical schools and teaching hospitals. To remedy this situation the Committee recommended a large educational programme for both postgraduate and undergraduate psychiatry which it justified as part of a wider objective: "The major and most urgent need is the training of specialist psychiatrists and particularly of teachers of psychiatry. If psychiatry is to acquire the same status as other branches of medicine and the right kind of practitioner is to be engaged in it, psychiatrists must be included in any arrangements that may be made for the recognition of specialists, and the postgraduate training and experience that intending psychiatrists are required to obtain must be comparable with the requirements for specialists in other branches."

The trend, then, was towards a closer integration of psychiatry with medicine as a whole, a notion summed up in the term "psychological medicine" which is widely employed in the United Kingdom. I would emphasise that the attachment has been with medicine rather than with neurology alone. For this reason it has been possible to avoid the difficulties which have come to be recognised in several European countries where the traditional links with neurology are only now being severed as the independent status of psychiatry becomes acknowledged [4]. Further, medicine in this context embraces not only internal or clinical medicine but also social medicine; indeed, psychiatry and social medicine have been referred to as "the inside and outside of the same glove". Within the framework of the National Health Service the social and public health aspects of psychiatry have inevitably come to the fore over the past 20 years. Not surprisingly, therefore, my country has probably made its largest contribution in the field of what has come to be called 'social psychiatry', which has focussed attention on the extra-mural dimensions of psychiatric morbidity and so on the community rather than the hospital. This standpoint underlies many of the provisions of the 1959 Mental Health Act, aiming as it did to "... increase community care (i.e. services outside hospital) and at the same time to reduce to a minimum any legal obstacles to the free exercise of psychiatric and associated skills within the hospital" [5].

What is the significance of these developments for our discussion to-day? Simply this: that as psychiatry has expanded it has come closer to medicine in the United Kingdom and has entered the orbit of large-scale medical research. Many of the general problems confronting modern research in medicine were fully discussed at the symposium organised by the Council for International Organisations of Medical Sciences in the 1950's. I need not enter into the several important issues discussed at length in the published

report – the relationship of research institutes to university centres, for example, or the difficulties of collaborative research within and between disciplines. I should, however, like to recall the simple, central conclusion of the conference as stated by its chairman, Sir HAROLD HIMSWORTH, who was at that time secretary of the British Medical Research Council, namely “... that the most important factor in research is the research worker” [6]. Of the many aspects of this theme which were developed by other contributors two can be reiterated to some purpose on this occasion. They concern respectively the needs of the flesh and of the spirit in modern research. The case for the former was expressed as follows: “Although it is true that workers with rare force of mind may triumph over all difficulties, it is equally true that the majority are dependent upon the circumstances in which they find themselves and are unlikely to develop their full potentialities – or even to realize that they possess them – unless they are given sympathetic and adequate support. To-day we can no longer afford to rely upon the unassisted emergence of rare genius.” The milieu in which research can best be undertaken was defined with equal clarity: “The most powerful incentive to potential research workers is undoubtedly the desire to emulate. When a student sees his teachers actively pursuing research, when he lives in an atmosphere where men are judged by intellectual achievement rather than material success, when he becomes imbued with high standards of intellectual integrity, then he will strive to develop any talent for the advancement of knowledge that he possesses. Unless, therefore, a country’s universities are active centres of research, the supply of recruits to research will inevitably be meagre.”

The report of this international group of experts made two things clear: first, that the demands of medical research are both exacting and expensive and, secondly, that these demands are still unsatisfied in most countries. No single participant analyzed his national situation more candidly than the then President of the National Research Council of the Swiss National Science Foundation. With regard to theoretical medicine Professor VON MURALT pointed out that the “... possibilities of advancement for the junior staff are not very promising and the number of available posts is very restricted ... A great deal of idealism and confidence is required of a young man entering the field of theoretical medicine ... In general, it may be said that the funds available for research are sufficient, but the number of men willing to devote themselves to research is restricted ...” As for clinical medicine: “... In the clinical departments of Switzerland, the demands of routine work on professors and assistants are very heavy. The number of clinical professors who are personally and actively engaged in research is unfortunately rather small. For a young assistant in an average clinical department, research work means a great deal of self denial and he is forced to work late at night and often into the early hours of the morning. A very small number of them do wish to follow this vocation, but the great majority seek comfort and end up as prosperous practitioners. The scientific output from the clinical ser-

vices is therefore usually not very remarkable from the qualitative point of view, even if the quantity is sometimes imposing and seems to prove that a lot of scientific activity is going on. Plenty of young men are available to take clinical assistantships in Switzerland, but most of these consider their work in the clinical services as a necessary completion of their training and are preparing themselves for private practice. Only a very restricted number are willing to devote themselves to the academic career and to scientific research work."

This description, which can probably be applied to most countries in some measure, is unusual only in its frankness and may well be less accurate now than when it was written in the mid 1950's. In the United Kingdom the delicate balance created between the private responsibility of the physician and the public responsibility of the profession affects the structure of research no less than medical care. It has been estimated that of the total sum of money spent on medical research about 60% comes from governmental sources and about one third from the pharmaceutical industry, the remaining 5% from private trusts and charities which are usually devoted to particular diseases [7].

The government money comes from three sources. Some flows directly from Health Departments, usually for specific operational or clinical projects. University medical research, by contrast, comes out of the block quinquennial grants to universities which are allocated on behalf of the Treasury by the University Grants Committee, on which the majority of members are academics. Here, of course, the medical departments must compete with many others, and once the money has been granted its distribution to individual departments has to be decided by the customary process of claims, counter-claims and compromise.

British departments of psychiatry have multiplied rapidly in the past 20 years. Numbers provide a crude index of change: in 1946 there were 2 chairs in psychiatry, to-day there are 19. Most of these positions, however, are relatively new and attached to small undergraduate departments. The major concentration of research activities within the university structure has been at the Institute of Psychiatry of the University of London which, in 1948, became the official psychiatric component of the British Postgraduate Medical Federation where Professor Sir AUBREY LEWIS established something new in the form of a psychiatric institution in which postgraduate teaching and research could be welded into one complex organism [8]. I should like to return later to the implications of such an institution for research in psychiatry.

The major method of granting medical research in Great Britain, however, is via the Medical Research Council (M.R.C.) which is specifically concerned with research applied to medicine on a broad front.

The detailed organisation of this large and complex institution need not detain us here but its history and its underlying philosophy can be profitably recalled in the context of this symposium [9]. The Council came into existence in 1920 as the successor of the Medical Research Committee which was created as part of the National Health Insurance scheme introduced in 1911. From the beginning the principal executive

officer of this Committee was a research scientist of distinction, a tradition which has been maintained ever since, and when a Ministry of Health was set up in the United Kingdom in 1919 the first Minister of Health, himself a physician, played a large part in ensuring an independent status for the new Medical Research Council, pointing out that any medical research organisation placed directly under the supervision of a political department would inevitably be constrained to study "problems which appeared at the moment to be of the most pressing practical importance" rather than the long-term fundamental studies on which advances in scientific knowledge must ultimately be based. This outlook also distinguishes medical research carried out under such auspices from research conducted by the pharmaceutical industry which, however liberal its direction, will usually concentrate on a more specialized segment of the research field and can never afford to neglect commercial factors.

On the basis of these foundations a central feature of the M.R.C. system is the building up of research units which can provide opportunities for an outstanding research worker, meet particular needs in an established field of research or help create or develop a nascent, potentially important area of investigation. In addition, with regard to its policy towards personnel the aim of the Council is "to provide the opportunity for careers in medical research which are equivalent in scientific and monetary status to those offered in the universities to men and women of equal ability and experience" [10]. In order to implement this policy, furthermore, it is accepted not only that many, probably most, workers will be without a medical training but also that research-minded physicians should be able to spend 2 or 3 years after qualification in which to acquire the necessary skills and techniques without losing either pay or status in their career prospects. This is altogether different from the more clinically oriented research which can be undertaken by all medical practitioners whose primary function is therapeutic but who are able to draw on what has been termed "that mysteriously elastic resource known as 'spare time'."

I should now like to discuss the bearing of these developments more specifically on clinical and experimental psychiatric research. Here again, an historical perspective is indispensable, and clinical research takes chronological precedence. The foundations of clinical psychiatry as we know it to-day were laid principally by European clinicians, men whose training and professional activities were focussed on diagnosis and treatment. The energy, purpose and skill which these pioneers brought to their refractory material resulted in the descriptive mapping of the major forms of mental disorder which necessitate institutional care. Their impressive achievement can be attributed to the notion of the clinician functioning as his own research instrument, which led to an insistence on careful clinical observation as the bedrock of the discipline. It also led, however, to the propounding of ambitious claims on behalf of the clinical method of which the following, advanced by an eminent clinician at the 1st International Congress of Psychiatry in 1950, is a fair specimen: "... la psychiatrie clinique est le centre inébranlable de la psychiatrie scientifique... A présent, à mon sens, la signature de la psychiatrie clinique est celle-ci que presque tous les courants qui se manifestaient séparément dans le cours des siècles (l'attention dirigée ou

bien exclusivement vers le côté psychique, ou bien exclusivement vers l'aspect somatique; ou bien l'intuition philosophique seule, ou bien l'empirisme avant tout; ou bien une compréhension au delà de toute éthique, ou bien une compréhension par les seules déviations éthiques) aujourd'hui sont réunis par le clinicien dans un seul lit de courant, dans une seule vaste théorie qui les comprend tous" [11].

With hindsight we must, in my view, take a much less inflated view of the clinical psychiatrist's function in research – and I hasten to add that I speak as a practising clinician. In this regard it is instructive to recall that in the field of internal medicine the growth of clinical science in the past two generations has so eroded the former authority of the clinician as to have stimulated a recent, spirited, defence of clinical judgement with one basic proviso: "The clinician can organise, classify, process, and analyse his data with exactly the same intellectual, statistical, and computational procedures available in every other branch of science. For these procedures to yield valuable scientific results, however, the clinician must also improve the scientific validity of the primary clinical data" [12].

In too many quarters this warning has been least heeded in psychiatry, where we have paid the price for self-indulgent complacency, the payment having been exacted in terms of an excessive preoccupation with the minutiae of symptomatology and with sterile arguments about classification which are reminiscent more of mediaeval schools of theology than of modern schools of medicine. On this topic academic pronouncements have been made in such terms as to recall NIETZSCHE's comment to BURCKHARDT that he "would very much prefer a professorial chair in Basle to being God". Challenges to such an attitude have, nonetheless, been proclaimed in the form of evidence from at least three sources which make it clear that the clinical psychiatrist should be prepared to exercise more modesty than he has been wont to do in the past. Work in these three areas question the traditional authority of the clinician in respect of a) his diagnostic competence, b) his therapeutic skills, and c) his familiarity with the full spectrum of clinical issues comprehended by his speciality.

a) The first challenge comes from the careful scrutiny of the subjective nature of many of the data employed in the classical descriptions of mental illness. Some of the fallacies inherent in an over-dependence on this category of information were exposed in the international study of observer variation carried out for the World Health Organisation in the form of an experimental approach to psychiatric diagnosis [13]. The use of standardised case-histories and video-taped interviews revealed disconcertingly large areas of disagreement between a group of experts from several countries, and demonstrated clearly that there are marked variations in 1. the observations and perceptions of the most experienced clinicians; 2. the clinical inferences drawn from clinical data; and 3. the classificatory schemata in use at the present time. It is becoming widely accepted that clinical psychiatry sorely lacks not only an acceptable schema of classification but also an accompany-

ing glossary of terms, a task to which the World Health Organisation is addressing itself at the present time.

b) The second challenge to the clinician arises from the field of experimental therapeutics. In every branch of medicine the clinical pharmacologist and the medical statistician can now supplement, and often contradict, the authoritative pronouncements of clinical experience with expert knowledge of not only the principles of pharmacodynamics but also of experimental design. Nowhere is such expertise more essential than in psychiatry, where a paucity of objective indices renders measurement difficult and clinical impressions treacherous. The importance of this point of view has been amply demonstrated by the development of a peculiarly British contribution to clinical methodology, namely the controlled clinical trial. This form of clinical experiment was largely developed in the 1930's by the Clinical Trials Committee of the Medical Research Council under the guidance of Professor Sir AUSTIN BRADFORD HILL. Accordingly, when the M.R.C. extended its activities to cover mental disease some ten years ago, the evaluation of remedies for mental disorder may be said to have come of age. The possibilities of the method were well illustrated by the first study conducted under this aegis, a large-scale, multi-centred evaluation of four treatments of depressive illnesses – electroshock, two drugs and a placebo – in which 250 patients were treated and followed up for six months by 55 psychiatrists working in 30 different hospitals [14]. The theoretical justification for so elaborate an investigation resides in the need to obtain and study a homogenous cohort of patients which is much larger than an individual clinician, or group of clinicians, can reasonably hope to amass. In this instance the practical justification proved to reside in unexpected results which confounded clinical opinion about therapeutic response and efficacy of treatment.

c) The third challenge is posed by the application of epidemiological principles to the study of mental disorders. It is now apparent that hospital-based psychiatrists have generalized about these disorders from what the statistically-minded critic would recognise as a grossly unrepresentative sample. Studies of mental illness in general practice in the United Kingdom have shown that the nature and distribution of psychiatric morbidity is very different from what is encountered in hospital practice and, still more to the point, that not more than 1 in 20 of these patients are referred to any form of hospital facility [15]. We are only now beginning to take cognizance of the full range of extra-mural mental illness as part of a deepening interest in community medicine. Further, the emphasis being placed on early discharge and community care has revealed that many of the phenomena of major mental disease have to be regarded as institutionally determined artefacts which can be modified by energetic intervention.

But while the formal application of the scientific method to the clinical data of psychiatry holds out great promise for the future, it is equally evident that as with other branches of medicine clinical research must also incorporate the concepts and findings of cognate disciplines. For even so percep-

tive a clinician as KRAEPELIN the disciplines in question were wholly identified with the biological sciences: "Clinical observation", he wrote, "must be supplemented by thorough examination of healthy and diseased brains, neurology, the study of heredity and degenerative diseases, the chemistry of metabolism and serology" [16]. The laboratory studies which established the neurosyphilitic basis of general paresis or the metabolic investigations of GJESSING on periodic catatonia can be accounted successful examples of research in this mould, but it is historically significant that even before KRAEPELIN expressed these views there had appeared the first group of the remarkable series of papers by JOSEPH GOLDBERGER which were to demonstrate the dietary aetiology of pellagra and its associated psychiatric disorders by means of a purely epidemiological analysis [17]. Nor is it entirely fanciful to assume, in the light of the clinical knowledge which had been amassed about general paresis by the second half of the 19th century, that an epidemiologist of GOLDBERGER's ability could have established that syphilis was a necessary link in the aetiological chain long before WASSERMANN and NOGUCHI had clinched the case.

Clearly KRAEPELIN's list of the basic sciences relevant to psychiatry must be regarded as incomplete. The experience of the past 50 years has now confirmed that these sciences are broadly divisible into two large categories: the biological group, which includes neuroanatomy, neurophysiology, neuro-endocrinology, ethology, neurochemistry and pharmacology and the psychosocial group, which includes psychology, sociology, anthropology and demography. Psychology is a bridging discipline between these groups: on the one hand it extends into the indisputably non-biological areas of social and educational psychology; on the other hand, the techniques of modern neuropsychology are often closer to physiology than to psychology in the traditional sense. In general, the psychosocial sciences are concerned with the identification of factors bearing on the causal associations and natural history of mental diseases, and the biological sciences with the mechanisms and interactions of such factors. In this respect, of course, the subject does not differ essentially from general medicine where the situation has been described in the form of an extended metaphor: "Medicine", says Professor MERTON, "is at heart a polygamist becoming wedded to as many of the sciences and practical arts as prove their worth ... as is often the case with polygamy, the first set of wives - say, the biological and chemical sciences - are reluctant at first to approve yet another burden to the menage. But there is still hope. As the burden of work plainly becomes more than can be managed by the present members of the household, they become ready for new accessions to help carry the load of what needs to be done" [18].

The complexity of the network of scientific disciplines which may contribute to progress in psychiatry emerges from any survey of recent advances in knowledge. To mention, for example, no more than human genetics, the neurochemistry of inborn errors of metabolism, learning theory, or the

development of the new psychotropic drugs is to indicate the dependence of modern psychiatry on a host of allied sciences. It follows that scientific research in the field of mental disorders must depend not only on the independent contributions of workers in a number of related disciplines but also on the interchange between such workers and clinicians. It therefore becomes imperative to provide the research-minded psychiatrist with easy access to other workers in related fields of research for a simple but good reason: "When psychiatrists are closely in touch with people conducting research in other medical or scientific fields, and are not isolated in groups wholly engaged in clinical routine, and when they are men whose training and interests are of a kind to make them ready to consider new information and to see old information in a new light, the chances that a train of discovery will be fired are high [19]." This point of view has been underwritten at my own institution where a university hospital in which postgraduate clinical psychiatry is taught and practised is brought into close contact with several university departments and research units where active investigation into the basic sciences relevant to psychiatry is being prosecuted. This arrangement ensures continuous and often fruitful interchanges between clinicians and research workers and, equally important, it helps provide the facilities which are necessary if young men and women of high calibre are to be attracted to psychiatry as a career.

Teaching and research are often interdependent, and the educational importance of research is reflected in the training programme which now lead up to the University of London's degree of Master of Philosophy in Psychiatry, the specialist examination for which our trainees prepare themselves. This examination is normally taken after at least three year's specified instruction and is held in two parts: the first covers neurobiology, psychology, sociology and genetics; the second embraces clinical psychiatry and clinical neurology. In addition, however, the candidate is also required to undertake a piece of original work under supervision, and for this purpose he is able to call on the skills of the specialised research workers within the Institute. Thus throughout his training period the graduate student is exposed to the notion of the 'research ideal' which plays a large part in directing his interests and energies towards investigative work at a later stage of his career.

From what I have already said it is evident that while many of these younger workers will find a niche within existing university departments others will look towards the M.R.C. – whether it be to the National Institute for Medical Research, to the new Clinical Research Centre, or to the Council's research units, many of which are also attached to universities where the unit director occupies an academic position. At the present time the M.R.C. supports several units which are directly concerned with psychiatry [20]. Some notion of their variety may be derived from their titles: The Social Psychiatry Unit, the Clinical Psychiatry Unit, the Neuropsychiatry Unit, the Unit for Epidemiological Studies in Psychiatric Illness, the Brain

Metabolism Unit, the Unit for the Study of Environmental Factors in Mental and Physical Illness, the Neuropharmacology Unit, the Psychiatric Genetics Unit and the Unit for Metabolic Studies in Psychiatry. Other units may also touch on psychiatric problems as part of their research programme; examples include the Neuroendocrinology Unit, the Developmental Psychology Unit and the Unit on Neural Mechanisms of Behaviour. There are also M.R.C. groups, established to help establish a research programme within a university department on the understanding that it be integrated into the department at the end of an agreed period of tenure, which include such aggregates as the Cerebral Functions Research Group and the Research Group in Applied Neurobiology. In addition, there are numerous individual grants to help gifted investigators develop their talents.

To give a detailed account of the programmes covered by the Council's units is not possible within the time at my disposal. I can only indicate their diversity and scope by referring to the topics covered by two widely contrasting fields of inquiry.

The Neuropharmacology Unit, for example, defines its objectives as "... studying the actions of drugs on the central nervous system, with particular reference to the correlation between electrophysiological and behavioural effects and to interactions with sensory stimuli, and also the sites of action of drugs in the brain, particularly in relation to synaptic transmission. The drugs studied are those with known effects on mental function and also substances that may be important as neurohormonal agents". At another extreme the Social Psychiatry Unit studies "... the influence of social factors on the occurrence, continuance and outcome of mental illness and mental subnormality. Special attention is given to the measurement and classification of social and clinical abnormalities and to the evaluation of the effects of social methods of treatment".

It is of further interest that of the 22 research workers listed as belonging to these two units only one third are medically qualified. Indeed, it has been estimated that research is the primary activity of no more than about forty psychiatrists in the whole country [21].

With so much to do and so few people available it would seem reasonable to assume that any large scale programme of psychiatric research will take some time to develop. This being the case, the problem of priorities must inevitably arise and so it is of some interest to recall that five years ago a W.H.O. Scientific Group in Mental Health Research not only surveyed research needs but estimated their relative priority for W.H.O. action. Naturally the aims of an international body must differ in many respects from those of any national group but the considered opinion of a group of experts must carry some weight in considering research strategy. In descending order to priority the listed topics were 1. epidemiology and social psychiatry; 2. the study of cultural and environmental factors; 3. the genetics of mental disorder; 4. mental retardation; 5. studies of childhood development; 6. geriatric psychiatry; 7. the application of learning theory; 8. biological psychiatry; 9. psychosomatic disorders; 10. psychotherapy; 11. alcoholism and drug abuse; 12. industrial psychiatry; 13. forensic psychiatry.

It would seem that from Switzerland we are entitled to expect major contributions to all these areas of research. A country which in the past has given us DUBOIS, FOREL, MEYER, BLEULER, JUNG, BINSWANGER, PIAGET and many others evidently does not lack individual talent. The problems would seem to reside in those organisational obstacles to which Professor MÜLLER and Dr. BENEDETTI drew attention in their review of Swiss psychiatric research 10 years ago: "The state undoubtedly wishes to encourage research in its hospitals, but only in rare cases is it prepared to make available the necessary funds. Thus, there are only scattered posts open in Swiss hospitals for psychiatrists whose main emphasis is on research. The research which has been accomplished in the last few years was, for the most part, conducted during the worker's leisure time or during leaves of absence, and was financed by private funds" [22]. I gather that this picture has already changed during the 1960's and that there is every prospect of the 1970's bringing greater opportunities than ever for research in psychiatry. In his generous tribute to Sir AUBREY LEWIS Professor BLEULER has well expressed the outlook necessary for this task – "im eisernen Willen, alles für den Fortschritt der Psychiatrie und das Wohl der Geisteskranken zu tun, dabei vor allem das Faßbare zu nutzen, jede Meinung zu prüfen, aus jeder das Wesentliche zu schöpfen und Maß und Kritik zu bewahren" – and has gone on to draw the moral: "Im kleinen ist uns Schweizern eine ähnliche Aufgabe zugefallen wie den englischen Psychiatern im weltweiten Rahmen: Wir stehen zwischen den großen psychiatrischen Schulen anderer Länder, und zu unseren psychiatrischen Aufgaben gehört es, die großen Bestrebungen in den großen Ländern mit Offenheit und Verständnis aufzunehmen und sie mit Maß und Kritik zu würdigen" [23]. I am certain that I speak for all my British colleagues in offering you our best wishes and support in this difficult but worthwhile undertaking.

Summary

The growth and development of psychiatry in recent years has resulted in expanding programmes of research which have involved the clinician and the basic scientist. Research in psychiatry can no longer be considered apart from research in other medical sciences, the organisation of which varies from country to country. An account is given of the situation in the United Kingdom, emphasis being laid on the education and support of the research worker. It is argued that the traditional authority of the clinician in psychiatry can no longer be maintained without regard to advances in both clinical and fundamental research. Examples of the former are provided in the sphere of diagnosis and treatment. The basic disciplines relevant to psychiatry include the social as well as the biological sciences: the modern clinical psychiatrist must therefore be familiar with a wide spectrum of knowledge, preferably with some research experience of his own, if he is to evaluate critically the numerous facts and theories from which established knowledge may be attained.

Zusammenfassung

Das Wachstum und die Entwicklung der Psychiatrie der letzten Jahre führten zu ausgedehnten Forschungsprogrammen, an welchen sowohl Kliniker als auch Grundlagenforscher beteiligt sind. Die psychiatrische Forschung kann nicht mehr länger von der Forschung in anderen medizinischen Spezialfächern gesondert betrachtet werden. Die Organisation ist von Land zu Land verschieden. Es wird hier eine Darstellung der Lage im Vereinigten Königreich gegeben und das Hauptgewicht auf die Ausbildung und die Unterstützung der Forscher gelegt. Man argumentiert, daß der Psychiater seine traditionelle Autorität als Kliniker nicht länger aufrecht erhalten kann, ohne die Fortschritte sowohl in der klinischen als auch in der Grundlagenforschung zu berücksichtigen. Für die erstere werden Beispiele im Rahmen der Diagnose und der Therapie vorgebracht. Die für die Psychiatrie wichtigen Grundlagenfächer umfassen sowohl die sozialen als auch die biologischen Wissenschaften; daher muß der moderne klinische Psychiater mit einem breiten Spektrum von Kenntnissen, vorzugsweise auch mit einer gewissen eigenen Forschungserfahrung ausgestattet sein, wenn er die zahlreichen Fakten und Theorien, die zu einem festgefügteten Wissen führen, kritisch auswerten soll.

Résumé

Le développement de la psychiatrie dans ces dernières années est le résultat de programmes de recherches qui intéressent aussi bien le clinicien que le scientifique. La recherche en psychiatrie ne peut plus être considérée comme séparée de la recherche dans d'autres sciences médicales, et dont l'organisation diffère d'un pays à l'autre. Le rapport s'occupe de la situation en Angleterre, en soulignant surtout la formation et le soutien donnés au chercheur scientifique. Il semble que l'autorité traditionnelle du clinicien en psychiatrie ne peut plus exister sans les recherches aussi bien cliniques que de celles des sciences de base. Des exemples sont donnés dans le domaine du diagnostic et du traitement. Les disciplines de base pour la psychiatrie comportent aussi bien les sciences sociales que biologiques: le clinicien en psychiatrie moderne doit par conséquent avoir un large spectre de connaissances, avoir fait de la recherche personnelle, afin qu'il puisse apprécier avec un esprit critique les innombrables faits et théories qui sont à la base de ses connaissances.

Riassunto

L'evoluzione e lo sviluppo della psichiatria negli ultimi anni ha determinato il nascere di estesi programmi di ricerca ai quali sono interessati tanto i clinici quanto gli scienziati che si occupano delle indagini fondamentali. La ricerca psichiatrica non può più essere considerata più a lungo separatamente dalla ricerca che si pratica in altre specialità della medicina. L'organizzazione varia da un paese all'altro. Nel presente lavoro si descrive

la situazione nel Regno Unito e si insiste specialmente sulla formazione e l'appoggio da dare agli scienziati. Si porta come argomento il fatto che lo psichiatra non può mantenere più a lungo la sua autorità quale clinico, senza tener conto dei progressi fatti, sia nella ricerca clinica, che in quella fondamentale. Per la ricerca clinica si portano degli esempi nell'ambito della diagnosi e della terapia. Le specialità fondamentali importanti per la psichiatria comprendono tanto le scienze sociali che quelle biologiche; per queste ragioni lo psichiatra clinico moderno deve essere munito di un largo spettro di conoscenze, di preferenza anche di una certa esperienza personale nella ricerca, se vuole essere in grado di interpretare i numerosi fatti e le teorie che conducono ad un solido bagaglio di conoscenze.

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