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Interview

In conversation with Tom Lynch

David Healy interviewed Professor Lynch recently

Professor Thomas Lynch DPM (Royal College of Surgeons, Ireland, 1951) FRCPI (Royal College of Physicians, Ireland, 1962) FRCPsych (1971)

Professor Lynch was born in Dublin in 1922. From 1953 to 1961 he was Staff Psychiatrist, St Patrick's Hospital, Dublin, and Consultant Psychiatrist to Meath Hospital, Dublin. He was Resident Medical superintendent at St Otteran's Hospital, Waterford from 1961 to 1968. From 1968 to 1990 he was Professor of Psychiatry, Royal College of Surgeons in Ireland. He has been Chairman and Clinical Director of the Eastern Health Board, Chairman of the Irish Psychiatric Training Committee and Chairman of the Irish Division of the Royal College of Psychiatrists. He was a member of Council of the Royal College of Psychiatrists from 1980 to 1984, Junior Vice-President of the Royal College of Psychiatrists from 1981 to 1982 and Senior Vice-President from 1982 to 1983. He served on the College's Court of Electors from 1983 to 1988.

Tell me something about yourself.

I was the first to do medicine in the family. No-one else in the family studied medicine, however, I always wanted to be a doctor. My father came from a generation of national school teachers, his father and mother and grandparents were teachers. I only remember a few of his siblings and they were also teachers. My mother's family had a grocery business in Tralee but she was trained in teaching in England – which was unusual at the time.

They both became very involved in the Volunteer Movement for Irish Freedom. My father took part in the Rising in 1916. He was captain of the company in North King Street and he was eventually arrested and taken prisoner in the Four Courts. He was one of four sentenced to death and not executed (De Valera, Countess Markiewicz and Tom Ashe were the other three). He was subsequently transferred to prison in England – "Strangeways" (where he spent two years).

While in prison he was elected to the first Dail as a TD (MP). He was not aware he was a candidate but he was a good friend of Michael Collins, who was inclined to do this sort of thing – put one's name down and tell one afterwards. When he was released about 1917 in a general amnesty from prison, he took part in the Treaty Negotiations in London. He and Erskine Childers, father of the Erskine Childers who later became Minister for Health and President of Ireland, were two secretaries to the Treaty negotiations in Hans Square.

It all makes a good story. When we had the Spring Quarterly Meeting of the College in Galway in 1990, Tom Fahy organised a Professor's dinner out in Drimcong. He wanted to get each of us Irish Professors to say a few words and got up to introduce us. Starting with me, he said, "Of course you're not anything in Irish psychiatry, unless your father's been stood up in front of a British firing squad" – which was a typical Tom Fahy way to start things off.

We were brought up in a middle-class family environment. My father was a Minister for State. When I was born he was Minister for Education and later on Minister for Agriculture and Minister for Fisheries. To go to school I had to brush up on English because we all spoke Gaelic at home and all the staff at home were Irish-speaking girls.

My first memory of school (I was about 4) in Loreto, Stephen's Green, was of being collected and taken home in a tank, because at the time the IRA were kidnapping Ministers' families. I learnt afterwards that it was the week after Kevin O'Higgins had been assassinated – one of the Government Ministers. I then attended National School for a couple of years before being enrolled at St Mary's College,

Rathmines which is more renowned for its rugby. As I was reasonably good at tennis and rugby, I got on quite well there and I wasn't pushed for examinations. My father decided he would like me to study medicine in the College of Surgeons. I heard they had only a few dozen vacancies for students in 1941, so I realised it was important to get down to studying. I remember getting a bare pass in the pre-clinical examinations in Chemistry and Physics, but managed a 2nd honours in Anatomy. I got first place in subsequent exams and the various scholarships that went with them, qualifying in the summer of 1946 with a First Class Honours Degree.

I started in August on my Internship in the Richmond Hospital, now closed, and worked in Surgery with the late A. A. McConnell and later with the late Professor Leonard Abrahamson in Medicine. Toward the end of my intern year I attended interviews with Dr Norman Moore when called in to examine patients for Professor Abrahamson. He asked me to come and join him in St Patrick's Hospital but I said I was interested in medicine and not really in psychiatry. He reassured me that my responsibilities would involve the physical care of patients in St Patrick's. The arrangement was that I would study for my Membership in Medicine. During this time I obtained my Membership. My salary when I joined St Patrick's was £50 a year. When I got my Membership Part I, it went to £500 and when I got Part II, it went up to £1000 which was an enormous increase in the late '40s.

In St Patrick's I met Dr M. O'Drury, Dr Maurice Pillsworth and Dr Vincent Dolphin. They are now regrettably all dead. With Norman Moore as Chairman, they ran very good case conferences every Monday, Wednesday and Friday. I attended as many as possible but without taking an active part in them. Con Drury from Exeter was also there. He was something of a philosopher. I was very friendly with him and although he was a most intelligent man, his main interest was cowboy films.

Within a short time I adjusted to my new environment in a psychiatric hospital. It was not as traumatic as it initially seemed. The doors were, however, locked on the wards. Professor Norman Moore encouraged me to do my DPM while I was studying for my Membership as the subjects in the Part I were much the same except for psychology which I found dreadfully hard to tackle. However, I managed to scrape a pass in it; Part II was easy enough. Norman Moore maintained that The Maudsley was the only place to go.

Norman Moore himself – what was he like?

He was an authoritarian man. He ran St Patrick's more like you'd run a boarding school. He was known as "the Boss". He ran every part of it paternalistically, but generally speaking he was easy to work with. You started early – at 7.30 a.m. Myself and Dr Joe Meehan used to start the list for ECT at about 8.15 a.m. We reviewed the night and day reports with Norman Moore at about 9.00 a.m. This involved going through the previous day report and night reports. Then to the grand round – on Monday the female side and on Tuesday on the male side.

Every afternoon Dr Moore saw patients in his consulting rooms from which he sent a constant flow of patients. In the first year there were only 300 or 400 admissions; this was easy to cope with, but it soon became a torrent. There was little time for reading. You could just about read a journal while falling asleep. But, being off-duty meant that when 5 p.m. came you were free. At 5.05 p.m. I was off down James's Street on my bike.

Norman was very articulate, intelligent, and influential. The case conferences were good. At least one of them a month would be taken up coping with administrative problems in the hospital rather than patients and we learned how the hospital ran. It was a great help in the sense that I learned about the funding of hospitals, which was useful when I went to Waterford and was responsible for everything down to the sheep that were savaged by the dogs.

St Patrick's Hospital also had a farm with 300 acres. I learnt something about farming, even helped to operate on a cow one night in an effort to remove a cyst.

We had a large influx of patients with all sorts of unusual problems to deal with in the case conferences. If you were in charge of the patient you were expected to take a reasonable history and do a mental state and summary. Then the patient was interviewed. There was a very good standard of teaching in those days in Dublin. This helped me to cope when I went to The Maudsley. It was an awesome place compared to St Patrick's. St Patrick's was hard-working and intense enough, but it wasn't frightening. Norman Moore wasn't a frightening person, he was an authoritarian person and you understood where you stood and did your duty.

St Patrick's, in its own way, is different to anywhere else in Irish psychiatry – why is that?

They always try to be ahead of the field. They would be innovative and take on everything new. At one stage we were giving intravenous acetylcholine for various neuroses and also giving inhalations of carbon dioxide. It didn't catch on for any length of time (about 9 months to a year). But we had given up insulin coma before they gave it up elsewhere. Once they discovered another less dangerous way of treating schizophrenic patients, they took that on board very fast and were quick to use the neuroleptics and the antidepressants.

Norman Moore still remains a very good friend and I meet him now every year or so at an occasional meeting. He still does a small amount of practice – attending St Edmondsbury occasionally or going to his rooms once a week.

Norman Moore and John Dunne seem to have been the two big figures of Irish psychiatry back then.

I think John Dunne probably in some way was envious of or resented Norman Moore's arrival on the scene in the sense that Norman Moore automatically took away the Trinity College students for teaching purposes. When I was doing psychiatry, teaching consisted of about 10 lectures in Grangegorman Hospital at some stage between April and June. You attended there at about 4.30 p.m. and met all your colleagues from the three medical schools. We went into an enormous ward unit and sat around a dais. John Dunne stood on the podium and presented the cases. Even in my ignorance I was often very embarrassed for the patient. I remember one patient who was quite theatrical being made to demonstrate that with the stethoscope he could listen to Tokyo. It was comic stage stuff rather than teaching. You got your attendance sheets signed, paid your fees, and the exam was a formality.

Before Norman Moore how did St Patrick's operate? Did they have a comparable Norman Moore before Norman?

No, there was a man called, I think, Thompson who reigned three years. Before him was a Dr R. Leaper. I never knew either. Dr Leaper was in charge of St Patrick's from 1906 to about 1942. He was credited for having changed the cells to rooms. He took out the straw and he put in beds and mattresses. He built a cinema and recreation centre for patients and was instrumental in purchasing St Edmondsbury as a convalescent hospital. St Edmondsbury was never a locked facility. I remember Norman Moore telling me that the first item on the agenda of the Board of St Patrick's when he arrived was the sale of St Edmondsbury, which he managed to stop.

Norman was keen on fishing and shooting and St Edmondsbury was a lovely place with over 300 acres. He used to go shooting and fishing with us, in our single days.

The hospital had an old Austin 1929 car with a luggage grid in the back which you could stand on. I was usually the lad without the gun and I was selected to drive the car at night with the headlights on, while Maurice Pillsworth and Denis Doorley stood on the luggage carrier shooting rabbits. It was a different life at that period.

In 1952 I went to The Maudsley on leave of absence. I was attached to the non-Professorial Unit with Dr Felix Post. Also on the team were two other SHOs, one I remember was Dr Doreen Sherwood Jones whose consultant was Dr Harris.

Felix Post was one of the most pleasant consultants to work for. He wasn't at that stage fully involved in geriatrics but was a general psychiatrist. I remember I had brought over my Ford Prefect on a tourist visa. He brought a new Ford Prefect which I had to tutor him on driving and how to avoid stalling in traffic. One day, looking at his car engine, I remarked it's a beautiful engine, I'd love to swap it with the old one in my car. They were similar cars and only later Eric Carr, who shared a flat with me, came to me and said that Felix Post was so worried that I might be able to do it and he would never know.

My impression of The Maudsley was that it was certainly a very strange hospital. Everybody was in absolute fear of Aubrey Lewis who appeared to terrify all the registrars and social workers and was even held in awe by the junior consultants. In my short stay I was subjected to the usual Thursday morning conference with the non-PU registrars. I had to do one Monday morning conference and one journal club on a Saturday. I found him quite friendly. His only comment at the conference in front of an audience of over a 100, when I made a statement that this patient's choice of beverage was Guinness, he said that it was presumably Thames rather than Liffey water, to which I replied that unfortunately it was only Thames water he could get.

I returned in 1953 to St Patrick's where I was given the title then of staff psychiatrist and consultant to the Meath Hospital out-patient department.

In 1956 I married Sheila O'Donovan, also a doctor. We have five children, four are doctors. The last daughter did her finals in June 1991. Our eldest girl is a psychologist and married to a psychologist and she's working at the Walsgrave Hospital in Coventry as a clinical psychologist.

On my return to St Patrick's, Dr Denis Doorley was joined on the staff by Dr Joe Meehan and the late Dr A. J. Kilpatrick. Dr Con Drury was in St Edmondsbury. Shortly after Dr Tom Bewley joined us for two years with his sister Dr Mary Bewley, who married Dr Eddie Martin, Neurologist.

I left in October 1961 to go South to Waterford as the Resident Medical Superintendent of St Otteran's Hospital. It was an enormous change but I always had ambitions to run a hospital myself.

Tell me about the change?

My new colleagues were excellent! Dr Paddy Meehan, who had been acting medical superintendent, Dr Tom Toohy and Dr Jerry Fleming. They were somewhat older than I but very friendly. One day when we were doing a clinic in West Waterford at Lismore I was informed by Dr Paddy Meehan that

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we'd now have to go up and buy some wood for the fish boxes. This was part of our duty – buying wood for the patients' rehabilitation factory. I was not only in charge of a hospital of just under 600 beds but had an 800 acre farm with a piggery, cattle, grain, etc and one of my duties every morning was to sign the chits for the bread and for the milk, for the pigs and for whatever else might be needed that day.

Fortunately, the chief clerk and secretary for the hospital saw my point when I said I couldn't be counting loaves of bread – that it would be senseless and a waste of time and he agreed and it stopped. Sheila O'Driscoll was a superb matron and her standard of nursing was excellent.

How did St Otteran's compare to Grangegorman at the time?

In parts it was grim, but it was a small dolls-house of a hospital and easy to maintain. As I was working in a local health authority you could contact the county manager and the city manager very easily.

The one big achievement came when the opportunity arose to start a psychiatric unit in a general hospital, Ardkeen. It was possible in Waterford only because the district general hospital had been a sanatorium with numerous units. These were changed into medical, surgical and obstetric units, and also a gynaecological unit, orthopaedic unit and eye unit. There were spare chest units half empty, and with the co-operation of the RMS of Ardkeen Hospital, Dr Fintan Corrigan, and my own medical and nursing staff we developed a psychiatric unit which opened in 1965. It was the first psychiatric unit developed in a general hospital in Southern Ireland.

Were you sure at the time that it was going to work?

Yes. At the time Waterford Health Authority and the Department of Health funded me to attend two fortnight long residential courses to King Edward VII College for hospital administrators just off the Edgeware Road which were extremely interesting. On both occasions they waived the fees.

But it did take a long time to get the project off the ground. We had certain difficulties with our general hospital medical colleagues but on the whole they saw the logic of the concept. At the start it was amusing – some of our own psychiatric nurses told us that general nurses were taking a different route to the dining room to avoid passing the psychiatric unit. But that ceased within a year, mainly as we were treating relatives of many of them on an out-patient basis, and they realised that we weren't ogres.

Within the space of a year and a half we had integrated fully with the general hospital. We had reopened the rehabilitation, occupational therapy setup which had closed with the decline in the number of TB patients. I was there six and a half years when a Chair of Psychiatry at the Royal College of Surgeons was advertised. It was conditional on having a consultant appointment for the Eastern Health Region, which I felt I probably would get. At the interview the external assessor was Sir Martin Roth. I knew him vaguely from attending medical meetings but I found it a trying and difficult interview. I remember returning home 104 miles to Waterford that evening to tell Sheila that I was not going up for any further interviews such as that again.

We departed on holiday to Kerry the next day only to find that we were being sought by the College by wire and telegraph. I had several phone calls to ring back to Dublin to tell me that I had the Chair. I returned to Dublin in February 1968 to take over the post of Clinical Director of Psychiatric Services of the Eastern Health Board.

Do you think there's any scope for an Irish College?

This has been mooted many times. It would be very expensive to have an Irish College. We have tried to look at the situation, and point out that the Royal College of Psychiatrists headquarters just happens to be in London. We are the Irish Branch of the Royal College of Psychiatrists. Actually psychiatry, rugby and hockey are the only truly joint ventures between North and South. We have never had any problem. In fact, I took over as Chairman of the Irish Division from John Fennelly, and was succeeded by Gordon McCallam of Belfast. At least one meeting in the year is held in Belfast.

At one stage the Irish Division felt if our Chairman had been from the North, it wouldn't be appropriate for him to negotiate with our Department of Health for conditions for either patients or staff in the South. So we decided, on the advice of Professor Ken Rawnsley who said there were some similar problems in Wales, to change our hats and just call ourselves the Irish Psychiatric Association when arguing in the Department of Health over conditions or such things. But in essence we were the same body of men as the Irish Division of the Royal College.

Dermot Walshe was always keen to have an Irish College of Psychiatry but that requires a lot of funding and I don't think it is practical. Norman Moore in his day was very anxious that the Postgraduate Training Committee would be a faculty of Royal College of Physicians of Ireland.

I was elected to the Irish Executive of the Royal College in the middle '70s and was one of the first Irish examiners in the Membership. In the winter of 1981 I was very pleased to be elected the Vice-President of the Royal College of Psychiatrists. From 1981–82 I was a junior Vice-President and from 1982–83 the senior Vice-President.

The last committee of the Royal College I served on was the Court of Electors. I served for five years and it gave me a link to the Royal College for over ten years. The man who succeeded me as Vice-President was Joseph Jancar. At one stage I was senior Vice-President, Joseph Jancar was junior Vice-President and Tom Bewley was the Dean, all three using an Irish passport.

About this time I became involved with the American Psychiatric Association and managed to persuade the APA to have a mini meeting in Dublin after their main meeting in Toronto. This was about 1982. I remember Sir Desmond Pond asking if we would consider having it in the Isle of Man as a neutral venue. But I had already contacted all the relevant bodies in Ireland to get funding to entertain the Americans. The Royal College did join us in Dublin and we had 300 to 400 delegates here for a three day meeting at the end of May 1982. As a result I was elected an honorary correspondence fellow of the APA.

The Royal College of Surgeons has an unusual role in the Irish medical scene, doesn't it?

There are several Royal Colleges in Ireland. They have individual Charters which they cherish greatly. The RCSI was granted its Charter by George III in 1784.

Before the act of Union?

Yes, and the Royal College of Physicians was Chartered a 100 years before that. The two colleges work as a Conjoint Board. The Royal College of Surgeons is an under-graduate school, as it once was in England and in Scotland. They have recently created a Chair in General Practice. When I was first appointed in 1968 it had a small medical faculty and you could get things done quickly. But of course it has expanded enormously and meetings now last much longer. Everybody is seeking teaching space in the curriculum.

The College itself has been generous in the sense that one man could not possibly cater for the needs of under-graduates, cover all that has to be covered in psychiatry, so they have funded four senior lecturers. They also permit the co-option of our senior registrars as tutors in psychiatry and also fund lecturers to give specialised talks to students.

In Ireland compared to the UK, there's been quite a good mix of private and public services for years now. Over in the UK we're slowly moving towards this idea of Trust hospitals and becoming quite concerned as to what's going to happen to psychiatric services etc. Do you think there's anything that the Irish experience can offer us as a pointer to the future?

Yes. The system here works very well. It is, however, complex. There is a mix of state-owned hospitals, state-run institutions, privately run hospitals in the sense of run by religious orders, or indeed run by lay boards such as St Patrick's Hospital and Stewart's Institute for the Mental Handicap. Also the voluntary hospitals, which are semi-private – they are voluntary in the sense that they were self-funded, but of course now the state has to underwrite these costs, but they are independent and they can appoint their own consultants.

All usually work together very well. As regards to the senior registrars, there is a point that is exercising the minds of the present members of the Psychiatric Training Committee. Currently if a trainee on the Eastern Health Board Training Programme starts in one of its hospitals, he or she stays there. It is rather difficult for them to move, say, from St Brendan's to St Patrick's or St Vincent's and then on to St John of God. It can be done, but only by retiring from the Health Board and applying and obtaining a post in the other facility.

The Health Board probably offers the most extensive training in the sense that they have available not just big psychiatric training centres and general hospital units such as we have in Blanchardstown Hospital; but they also have facilities for child psychiatry, forensic psychiatry and mental handicap services.

You were lucky being in St Patrick's when the modern psychotropic drugs came out first – at the time was there a feeling of a revolution of some sort?

Yes. I remember Norman Moore was one of the first to use these new 'wonder' drugs. The only therapy was ECT for the psychotic depressed patients and insulin coma for the schizophrenic patients. I ran the insulin unit for nine months. We had 18 to 20 patients every morning for insulin coma and also an enormous number of patients for ECT every day of the week; of course, it was straight ECT. I was there when Scoline first came on stream.

The first neuroleptic to arrive was chlorpromazine, Largactil, and shortly after that serapazil came on the market. Unfortunately we had many patients who became very depressed while medicated with serpazil.

At the time there was a constant stream of drug representatives with 16 mm films depicting the beneficial effects of these drugs on monkey behaviour – they stopped clawing and biting you. About the same time marsilid appeared on the market as an anti-depressant. The tricylics, imipramine/Tofranil, came on stream a year or two later. Later again, amitriptyline (Tryptizol) and subsequently a plethora of similar drugs appeared. The first benzodiazepines arrived shortly afterwards.

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I left St Patrick's to take up the post of RMS at St Otteran's Hospital, Waterford in October 1961. I remember a patient being referred on to me who had been attending St Patrick's Hospital and were prescribed "Roche something", a yellow round pill which was a narcotic and anxiolytic. I rang Norman Moore to ask what this drug was. It was Valium but it wasn't widely available then. At the time it seemed a wonderful drug to cope with stress, and of course, it was over-used.

Did insulin coma work?

I think it helped schizophrenic patients because they were treated as a specialised group of patients, 15 to 25 at a time, on a 50/50 ratio, male/female.

What really was happening was that these were a group of fairly acute schizophrenic patients who were young and were kept activated. There were special rehabilitation and resocialisation programmes for them. Activation alone was probably as good as any insulin course. When insulin was discontinued, tranquillisers were substituted to minimise the more acute symptoms, make them more amenable to psychotherapy etc.

Regarding neuroleptics, my first dramatic experience was with an out-patient in County Waterford, a young boy who was prescribed a small dose of chlorpromazine – he had paranoid symptoms and while he was on the drug he was symptom free but when he omitted to take it he would relapse within weeks. This was very dramatic, so much so that I became convinced that it wasn't just purely damping down the psychotic symptoms, until they naturally abated of their accord. This, to my mind, provided proof of an anti-psychotic effect.

The depot neuroleptics appeared in the late 1960s. There are a plethora of these available now. In those days nobody knew how they worked. It was clear that they were effective and in some patients dramatically so.

At the time you were prescribing neuroleptics, what kind of doses were you actually prescribing – you see what seems to me to have happened is that what was actually prescribed would now be called low dose regimes and then somewhere in the mid to late 70s the megadose regimes came in, which were no more efficacious so that we are on the way back now to the kind of regimes that were first described.

I think that's probably perfectly true. Also I think one was prescribing low dose regimes of several drugs rather than sticking to one drug in a higher dosage. There's no doubt polypharmacy was practised. My colleagues in Waterford had commenced out-patient clinics in Dugarvan, 30 miles west of the city, and then Lismore another 16 miles west again.

Quite considerable amounts of the drugs were dispensed in little paper envelopes. They'd have the name of the drug and the amount prescribed with the date. If the question of an overdose arose, the local GP only had to look at the drug envelope to see when they last attended for the drugs and how many were prescribed.

Do you think the pills made a big change? There are two views on this, as you know: that these pills transformed psychiatry, and the other view that pills just coincidentally came in at the same time as a lot of other radical changes were happening?

I think that drugs helped; I'm quite certain that it wasn't just that patients were coincidentally getting better for other reasons. Certainly there were other improvements – the patients' conditions were improving, the public were getting interested in patient care. I suppose you could say that medication made these other changes possible. The drugs certainly did abate or subdue many of the unwelcome symptoms of disturbed patients. They make it more possible to communicate with them and develop rapport. Use of the neuroleptic drugs could have a very dramatic therapeutic effect even in quite small doses.

Many of us have the experience of patients, well-controlled on depot neuroleptics, indeed so well controlled that they decided to stretch the intervals between their injections. Remaining well they eventually decided – "I can do without" and in a matter of three or four months they are back in hospital having relapsed.

St Patrick's, I guess, compared to places like Grangegorman even though they had locked wards, would have been a much less horrific place than Grangegorman.

Of course, it did not have to cope with the great numbers of elderly mentally handicapped patients, which you have in public mental hospitals. Hospitals like St Patrick's and St John of God's do cater mainly for social class I–III. Such people because of greater facilities available to them at home would be better motivated and have a better chance of recovery. Having said that, they did admit and treat acutely psychotic patients to St Patrick's.

Grangegorman (St Brendan's) on the other hand, was always considered the end of line. When St Patrick's or St John of God's couldn't cope patients were sent to St Brendan's. Actually St Ita's used to be the very end of the line for the public patients. When you have to cater for the severely mentally handicapped patients you cannot keep the wards in pristine condition.

In England, 'private' as regards medicine is a somewhat dirty word; it's not the same here – can you explain it?

I used to have the opinion that it was a socialist view that brought this about but I don't believe so now. Many times at the Court of Elector meetings, some members expressed a contemptuous attitude to the private sector. I remember protesting at one meeting that if it wasn't for the private hospitals, their President, Dr Thomas Bewley, and myself would not have been trained in psychiatry. In Ireland there is a different attitude to the private sector. St Patrick's Hospital was founded in 1745 for the poor of Dublin – Jonathan Swift's will specified this and the hospital always provided accommodation for people from the deprived areas of the City. It runs out-patient clinics for the surrounding sector subsidised by the hospital.

I guess the fact that places like St John of God are being run by religious orders and aren't profit-making makes some difference?

In fact, St John of God's have funded wonderful improvements in the hospital, as have St Patrick's – elegant foyers, offices and accommodation that certainly in no way resemble the old style hospital. It's difficult to find such money for a public mental hospital – politicians and the public in general scrutinise where our tax money is spent. It's a pity that more emphasis isn't spent on upgrading the public mental hospitals. St Patrick's Hospital and St John of God's Hospital are a credit to Ireland. Indeed, the Royal College of Psychiatrists hold the membership exams there.

That's okay for the actual service within the hospital, for nurse training and other things – but what about trying to run a service in the community. Tom Fahy would say you can't do it.

You mean the private hospitals do not run a community service. This is extremely difficult. The service in the community really has to be funded by the State. There can be no profit in it and to keep themselves going they have to be solvent. There could be no capitation fee to cover the number of patients they treat. For example, the number of psychiatric patients seen in the out-patient department in Blanchardstown General Hospital on a Friday morning is usually about 50. Granted there are four psychiatrists there and four can readily manage that number. But those 50 do not have to pay anything. They will also get their prescription drugs free.

It needs a health authority to give this back-up, as well as to provide hostels, day centres, workshops etc, all required for rehabilitation.

Community services need state funding if they are going to succeed. The state has provided some funding but unfortunately community services are not cheap. Many consultant psychiatrists suspected that the motive for closing hospitals was to save money. Most administrators now realise that community care facilities are not a cheap option.

Can you tell me something about your role in the Mental Health Association?

I am a founder of the Mental Health Association of Ireland and currently hold the post of Honorary Secretary of the MHAI. It was founded 25 years ago. It is a limited liability company. Its aims, at that stage, were to set up rehabilitation facilities for psychiatric patients and educate the public. Basically the aims are still the same with the emphasis of course on the latter. It is a big organisation now with more than 50 local branches throughout the country. Our Chief Executive Officer, Mary O'Mahony, is a very live wire, although the Board tends to be getting old now and most of us have reached retiring age.

MIND in England has gone a different road. We did not follow their lead. They became political and were often used as a stepping ground for higher things in politics. The Mental Health Association of Ireland has not. One of the reasons for my staying on the Board has been to ensure it keeps its original aims, to try and increase knowledge and stimulate the public interest in psychiatry. Of course there are still prejudices, there's still a stigma. You do not counter centuries of prejudice over a matter of a few decades.

You've been a clinical director on the Eastern Health Board. With the move in the UK towards Trust hospitals and clinical directorates, has the example of Irish clinical directorates any lessons to offer the British?

A Clinical Director here in theory meant that one could look after one's own clinical material, be responsible for that and allow lay people to manage administration. But a number of my colleagues as clinical directors have become so involved in administrative work that they can spend little time in clinical work. I continue to run my own out-patient clinics, day centres and workshops and I continue to see patients on the wards. But it's more and more difficult because administration problems are lumped upon you and you pick up too many committees.

At one stage in my career, I developed an interest in rehabilitation so I was appointed to the National Rehabilitation Board, to the Central Remedial Clinic and to the Rehabilitation Institute. In addition I found myself a member of the National Drugs Advisory Board. Added to that there were the Royal

College of Surgeons and the Royal College of Psychiatrists committees. When I was senior Vice-President of the Royal College of Psychiatrists I was run off my feet.

What else do you think we need to do in the next ten years in Irish psychiatry?

Here in Ireland further development of the training programme is a first priority. There are not less than 20 to 25 vacant consultant posts being filled by locums throughout the country. Creating more senior registrar posts and, of course, getting them funded would help solve this. Psychiatry has become a much more acceptable speciality. The standard of medical personnel intake nowadays is very good, many aspirants having double membership.

This is a problem. Only the academic lecturers and Professors have higher medical degrees. Many people in psychiatry think that is an old fashioned view. I think it shows a very good broad education, not just in the psychiatric field but in general medicine also.

What is needed now is an expansion of the service by increasing the number of consultant posts in mental handicap and in child psychiatry. At the moment with cut-backs, psychotherapy is almost off any menu. We have, however, managed to get the Health Board and Department of Health to accept that future senior registrar posts in psychiatry should be so structured that candidates get some experience in psychotherapy.

What do you think the English have to learn from us? It has obviously helped us to be in the Royal College but does it help them in anyway to have us as part of the College?

I'm not sure. We are very alike in our views regarding psychiatry. The Irish are probably less intense in their approach. I wonder if that is a good thing to recommend to the UK. The majority of our colleagues in England have similar interests and hobbies. I think that England have much better organised research facilities but our clinical and rehabilitation facilities are better organised.

Have we better clinical facilities?

Yes, I think so. I have experience of clinical work in England, and work in the community. I do not think the facilities in the community are as well organised. Workshops, day hospitals, day centres and hostel places are very well provided throughout Ireland.

Our nursing staff are better trained in Ireland. I also think that the concept of psychiatric nurses in the community is more advanced in Ireland. We have some excellent community services developed by these nursing staff. In England there is a dichotomy between community and hospital. The only separation that exists here is between the community physicians and community directors, i.e. the medical personnel in charge of community physical health as distinct from mental health. They developed from the old style Medical Officer of Health and are only remotely linked to the hospital service.