In Conversation with Edward Hare: Part I

Brian Barraclough interviewed Edward Hare at his home on 11 April 1984.

BMB Did you come from a medical family?

EHH No, I didn't. That's a disadvantage for a doctor, I believe. It means you lack the familiarity with medical ways of thinking which is inbred in children from doctors' families. But it may mean you come to medicine with less prejudice and more ready to be objective about what it can do.

BMB And your father?

EHH He was a clergyman. In many ways, of course, a clergyman's work is not very different from a psychiatrist's. But he died when I was 13 and I greatly missed his guiding hand.

BMB What determined your choice of medicine?

EHH Probably my mother's wish that one of her children should be a doctor. My mother lived into her nineties and had a great influence on my life. I'd wanted to be a scientist, but at Cambridge I failed to get the double first which was needed for a research job in the Biochemistry Department there. So I went to the counsellor on careers and accepted his advice to become a medical student.

BMB What happened after that?

EHH My clinical training was at University College Hospital, London, where I was fortunate in having eminent teachers—Sir Thomas Lewis, Sir Harold Himsworth, Sir Max Rosenheim and the neurologist Sir Francis Walshe. Walshe was—and has remained—my image of the ideal physician. He was kind, suave and witty, and had many caustic things to say about psychoanalysis—but that didn't stop me wanting to become a psychiatrist.

BMB It must have been unusual then, to decide on psychiatry before you graduated in medicine?

EHH As an undergraduate I'd read some Freud. But I'd also attended a course of lectures on abnormal psychology given at Cambridge by the Canadian, John MacCurdy. He wasn't a Freudian, but I think it was the excellence of his lectures and his sound common sense which really attracted me to psychiatry.

BMB What happened after you graduated?

EHH It seemed proper to get a good background in general medicine, so I did a number of hospital jobs—medicine, surgery, obstetrics, ophthalmology—and some locums in general practice. I would have studied for the MRCP but was advised this wasn't necessary for someone who only wanted to be a mental hospital doctor. So I spent my spare time reading literature—*Don Quixote, Paradise Lost, Don Juan, The Decline and Fall.* Looking back, I think this was more help to me than the Membership would have been, as it taught me to write English and appreciate good prose. I loved Gibbon's irony, and have often felt his comment on the virtues of the clergy could be equally applied to doctors.

BMB What was your first experience of psychiatry?

EHH As a houseman at the Cardiff City Mental Hospital (now Whitchurch Hospital): the hospital, where John Hennelly was superintendent, was well-known for the research done in its biochemistry department, but the department was closed at the time I came. When my six months was up, I had difficulty finding another job. I'd been unfit for war service (from deafness), and priority was understandably being given to doctors discharged from the armed forces. But eventually I found a job at Brentwood Mental Hospital, Essex, where I experienced the mild rule of Geoffrey Nightingale, the stimulating conversation of Thomas Power and the bitter winter of 1946. My next junior post was at the Berkshire County Mental Hospital (now the Fairmile). I went there because married accommodation—in short supply then—was available in nearby Wallingford, from where I cycled to work each day. The hospital was set in lovely quiet country between the Thames and the Berkshire Downs. I had no ambitions and would have been content to spend my working life in such a place. But the problem was housing. Our landlady fell ill and we had to move. Again it was a matter of finding a hospital with married quarters. The search led me to Springfield Hospital, Tooting.

BMB What do you think about medical superintendents, having worked under so many?

EHH They ranged from good to bad, as one might expect—from King Log to King Stork. I enjoyed my time with the good ones and was uncomfortable with the bad ones—though how far it was they who were bad or me who was awkward, I don't know.

BMB In what respects were they bad?

EHH It was the fault of the system really. The requirement was for an administrator rather than a clinician. They had too much power and were authoritarian—some were benevolent despots, some were tyrants. Once appointed, often at an early age, a superintendent was there for life. He might do good work in his first years, but later would commonly be more concerned with avoiding trouble than with new ideas.

BMB Was there training for medical superintendents other than learning on the job?

EHH I don't think so, although they used to get together a good deal. The Medico-Psychological Association was founded as a society for medical superintendents.

BMB Was there training for junior staff?

EHH None at all. They picked it up as best they could. I came into that category. I never had any formal training in psychiatry.

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BMB How did you do it then?

EHH I didn't do it. My concern was to get the Diploma in Psychological Medicine—you got £50 a year extra on your pay for that. I studied the textbooks, but the first time I sat the exam I was failed in the clinical by Aubrey Lewis.

BMB What was life like for a junior doctor in a mental hospital in the 1940s?

EHH You were given some 'chronic' wards to look after, usually the male wards as they were thought to be easier. Your job was to prescribe sedatives and make the periodic physical and mental examinations on patients, as required by the Board of Control. You did this, conscientiously or otherwise, and noted the findings in the case-record. The note was commonly limited to the words, 'no change'. On visiting days you saw those relatives who were content to see a junior doctor; and you replied to relatives' letters—though the replies were vetted and signed by the superintendent. As I recall, there were no clinical meetings, no journal clubs, no medical libraries worth the name. But there were perks, even for juniors. The food was good—free milk, cream, vegetables—and post-war rationing went unnoticed. It was a quiet, pleasant, dull life, still very much in the old asylum tradition.

BMB What happened after Springfield?

EHH I never wanted to work in London—too noisy and dirty—so I looked for another country hospital. My colleague Desmond Pond (we'd been students together at UCH) told me of the research going on at Barrow Hospital, Bristol. Barrow was then a country cousin of the old Bristol City Mental Hospital (Fishponds Hospital). It had been built in the countryside just before the war, with plenty of space, set among green fields and woods—and the lodge-keeper's cottage was vacant. So I applied for a post there.

BMB As a senior registrar?

EHH Yes, at first. Later I was promoted to SHMO. The pay was meagre, the status not very grand, but it was a secure job. Security of tenure was important to me, as I didn't always get on with my superintendents.

BMB How long did you stay?

EHH About three years. Barrow was a progressive hospital. There was a research department, a good medical library and the occasional clinical conference.

BMB Was that the result of a progessive medical superintendent?

EHH Yes. He was Robert Hemphill, later to become a professor in South Africa. A bit of a tartar in some ways, but he had an enterprising mind, was a good administrator, and encouraged research. I was able to do my MD thesis there.

BMB What was your thesis?

EHH The subject I put forward to my Regius Professor was 'What do patients think about their stay in a mental hospital?' But he suggested a broader subject, 'The ecology of mental disease', choosing that title perhaps because a professor of ecology had just been appointed at Cambridge. I think his use of the word 'ecology' was a bad one. It should have been 'epidemiology'. Ecology deals with the relation between an organism and its environment and can't properly be applied to diseases. All one had to do for a Cambridge MD was to review the literature and write up some case histories. But I found it a terrible struggle and almost despaired. My wife had to shut me up in the study and not let me out till I'd finished.

I was awarded an MD, and then it occurred to me to submit part of my thesis for one of the £10 prizes offered by the RMPA. Some months later I was surprised to receive page proofs of this, as an article for the Journal. I'd never thought of submitting it for publication, but was very pleased. That started me off. As Byron says:

> 'Tis pleasant sure to see one's name in print;
> A book's a book although there's nothing in't.

BMB That was your first substantial study?

EHH Yes. It led me to be interested in epidemiology and also in the writings of 19th-century psychiatrists such as D. H. Tuke.

BMB And after your MD?

EHH My chief concern was to get a consultant post and be better paid. I tried for several, without success. Then in the hope of improving my chances I studied hard and sat for the Gaskell medal—in 1953. The number of entrants was small in those years and the papers not noticeably more difficult than the DPM, so the chances for anyone who'd worked hard were quite good. I was awarded the prize, jointly with the late Dick Pratt. Then after one or two more attempts I got a consultant post, at Warlingham Park Hospital. The superintendent there, Percy Rees, had become renowned for his enlightened policies. He aimed to make his hospital a pleasant place for long-stay patients to live out their lives, and he used to tell them the fence round the ground wasn't to keep them in but to keep other people out. His first act as superintendent was to open the main gates, and they were kept open thereafter. He ordered—what was thought very risky—that the wards for 'suicidal' patients should be unlocked and the patients sent out on working parties in the grounds. He was a kind, benevolent Welshman who encouraged his staff and made his consultants feel the importance of their rank.

BMB How long did you stay at Warlingham?

EHH Rees retired soon after I came and Stephen MacKeith took over. I was settling down to a quiet life when one day I was amazed to get a letter from Professor Lewis asking me to see him at the Maudsley. When I got there he said at once he

wanted me to apply for a vacant consultant job. I protested I felt quite unequipped, but he said he'd liked the papers I'd published and he didn't think there was anyone he'd put up for a job at the Maudsley who had failed to get it. Encouraged by this, I duly applied and was appointed. I believe I was the first member of the staff not to have been trained there.

BMB And that was when?

EHH 1957. Lewis certainly took a gamble.

BMB Would you like to say something about Aubrey Lewis?

EHH I admired him immensely. His scholarly and rigorous approach was what was needed then; his influence on British psychiatry—on world psychiatry—was profound. People said he was too sceptical but I didn't think so. Because hard facts are so few in psychiatry, there's a constant flow of vague, hopeful hypotheses, and these need to be met with proper scepticism or they'd soon swamp the place. As he used to say, scepticism is only the wish to look more closely.

BMB So you feel he was an influence for the good?

EHH Oh, undoubtedly. Looking back, I think he may have been wrong in wanting to exclude undergraduate teaching and in stopping consultants having part-time appointments at other teaching hospitals. I used to wish we'd had medical students at the Maudsley. They're not committed to a specialty and often have fresh and original ideas. Postgraduates may be more knowledgeable but—as in much of medicine—their originality tends to be stifled by the need to pass higher exams.

BMB How did you find the change when Sir Aubrey retired and Sir Denis Hill became professor?

EHH I think Sir Denis felt that part of his task was to redress the balance from Lewis' sceptical and biological approach. No doubt that was a fair way of seeing it. But to my mind the balance was swung too far. Hill championed the psychotherapists and wanted to create a school of psychotherapy at the Maudsley. He once said to me—I could hardly believe my ears—that he thought psychoanalysis the most important part of psychiatry. But he was sound on clinical matters and had quite outstanding gifts as a committee man.

BMB At the Maudsley you were in the same post throughout?

EHH I was there 25 years, full-time NHS, and retired at 65.

BMB It's unusual for an NHS consultant to be as productive as you have been in writing.

EHH The stimulus came from Aubrey Lewis who told me, when I was appointed, that I should be able to devote half my time to research. I kept that in mind, and after a few years started to take a research day each week. Some of my colleagues were a little surprised by this, I think; but in later years, when my clinical commitments were less, I used to take two days.

BMB Could we now turn from your career to your clinical experience? What, to your mind, have been the most notable changes in clinical phenomena, comparing today's cases with those you saw at first?

EHH My strong impression is that patients are not as ill as they used to be. In the 1940s there were many patients with advanced degrees of what was called 'dementia'. And there were patients with severe chronic catatonia—I remember one who slept with his head raised off the pillow and had done that for 20 years, the nurses said. I don't think such cases are common now. Schizophrenia and manic-depression seem to run a milder course.

BMB Milder? In what ways?

EHH Both in symptoms and prognosis. I can remember cases of 'acute delirious mania'. I saw many patients admitted with acute schizophrenia who didn't improve and became so 'demented' within two or three months that their discharge was impossible. It may of course be just a matter of what cases you happen to see, but I don't think that sort of deterioration occurs much now. The change to milder cases is commonly put down to better treatment, but I think there's good evidence that's not the only reason.

BMB What evidence?

EHH Professor Ødegård,[1] for instance, showed the prognosis of schizophrenia improved steadily in Norway during 1920 to 1960—so it was happening before coma insulin or ECT or the phenothiazines came in. He also found the incidence of schizophrenia, in terms of first admissions, was decreasing. Manfred Bleuler[2] says the prognosis of schizophrenia in Switzerland improved during the 1940s and he didn't think it was due to drug treatment. Others have found much the same.

BMB What can be the explanation?

EHH I think many diseases—perhaps all—vary a good deal in their signs and prognosis over the years, for reasons which aren't clear. There may be changes in the virulence of infectious agents or in host resistance. In medicine, treatments tend to change as much from fashion as from improvements in efficacy. And it shouldn't be forgotten that if a disease is getting milder from 'natural' causes, the efficacy of treatment will appear to increase.

BMB Do you think the symptoms and signs of illness which are taught in the books correspond to the symptoms and signs that we see now? Some texts are based on observations made on patients a long time ago.

EHH If the manifestations of a disease are changing, then any textbook description will become out of date. I think psychiatric illnesses are apt to change quicker than other kinds because their manifestations are more dependent on social factors. I also suspect that

the manifestations of any psychiatric illness vary from place to place. If these things are so, then it's hard to provide a description which is valid for long or valid for different countries. The danger of textbooks, as I see it, is that they easily lead a student to see his cases in terms of what the books say he ought to see. If the description doesn't match what he sees, then he may procrusteanize his judgement or lose confidence in himself. But he should remember that it's his teachers who may be out of date.

BMB What do you think of the Present State Examination?

EHH I never had much experience in the use of structured questionnaires. They are entirely proper for a particular research, of course, but I had reservations about their use in clinical work. A structured questionnaire may introduce an inappropriate rigidity into a clinical interview, and it may contain leading questions which prompt a perhaps bemused patient towards certain answers. I could rarely bring myself, for example, to ask about the 'first rank symptoms' of schizophrenia: they seemed to me altogether too curious. Instead, I came to think a patient's answers to questions were of minor importance—he might not have understood the question in the way it was intended or he might have chosen to answer in a way which suited him. The best clinical guide is not the way a patient answers questions but the way he behaves—as you observe him or as told you by a fond relative.

BMB Let us turn to the *British Journal of Psychiatry*. When did you become editor?

EHH In 1973, when Eliot Slater decided to retire after a ten-year stint.

BMB You were elected?

EHH Yes. It was the first time an election for editor had been held under the College rules.

BMB What do you think of electing an editor?

EHH At the time I thought it wrong. I thought an editor should be appointed by Council, because most members with a right to vote probably wouldn't know much about the candidates.

BMB But the editor is also an Officer of the College, so that might be one reason why election was decided on. And perhaps another reason was that some previous editors were thought to have stayed too long.

EHH I think the ten-year period now laid down by the College is about right.

BMB How many years did you serve?

EHH About four and a half, and then didn't seek re-election. I found myself over-worked. The editorship of a monthly journal is a hard job for a man with a full-time clinical commitment—and for a time I was also chairman of the Medical Committee at the Maudsley.

BMB Do you think it right the NHS should subsidize the College in paying for the editor's time?

EHH There seemed no other way then. College finances would have made it impossible to appoint a paid editor.

BMB What kind of shape did you find the *Journal* in when you became editor?

EHH A ship sailing steadily along. Under Slater the *Journal* had improved both in scientific quality and in prestige. It changed from six issues to a monthly production at a time when I think Slater had retired from clinical work. But the honorary editor of a monthly, who still has clinical duties, will be under much pressure unless he can devolve the work-load. You yourself were kind enough to relieve me of some of the strain.

BMB You were the first editor who paid serious attention to the business side of the *Journal*.

EHH At the Council meeting I attended after my appointment, someone suggested the new editor should look into the *Journal* finances. As I've always liked dealing with figures I was quite ready to do that. The accounts of our advertising manager were routinely sent to the editor, and I studied these. But it was only after some months that I found our printers sent accounts to the Treasurer's department which were not shown to the editor. I asked to see these, and immediately recognized that the cost of printing advertisements was greater than our receipts from the advertisers—in other words, that the *Journal* was paying to carry its advertisements. Looking back over the past records, I found the *Journal* had been losing some £2,000 a year on advertising over a ten-year period. Our advertising manager knew nothing of our printing costs and had been increasing the advertising rates on a routine basis. We appointed a new agency whose manager proved altogether more efficient.

BMB That wasn't the only financial aspect you looked at?

EHH No; it led me to look more generally at the *Journal* finances. I found that about half the recent losses were due to advertisements and the rest was partly because printing costs had risen steeply—faster than inflation—and partly because the increases in the *Journal* subscription rate hadn't kept pace with inflation. I saw, too, there were various ways of economizing—for example, by reducing the weight of the *Journal* paper (lighter paper costs less to buy, less to print on and less for postage). But all this was only half the battle.

Over many years—indeed, since the 1860s—the annual reports of our Association contain a debit sum under the heading 'the cost of the *Journal*'. When I first suggested to the Journal Committee that the *Journal* might make a profit for the College, the idea was not well received. Longstanding members thought it sounded too business-like for a learned society and feared a profit might attract the attention of the tax-man. Just then, however, the

College was in some financial straits, and it was agreed the *Journal* accounts might reasonably show a surplus rather than a deficit. In the event, and in the circumstances of the time, the *Journal* became a useful source of revenue. This seems entirely proper to me. The *Journal* acquired its prestige and readership as the result of generations of hard work by its honorary editorial teams. The College, which owns and administers the *Journal*, should profit from this historical asset.

BMB Did you enjoy your time as editor?

EHH I wish I could say yes, but I was so busy all the time. Perhaps it was my fault for being over-conscientious.

BMB Should the arrangement of an unpaid honorary editor be continued?

EHH Perhaps; but if so, the editor should have had previous experience of journal or book production. I came with no such experience, and though this perhaps meant I came with a fresh mind, I made some mistakes from ignorance. Dr Crammer, my successor, had had quite a lot of experience and I expect this was a help to him. Our present editor has also had previous experience.

BMB Another approach might be for the *Journal* to be produced by a publishing firm.

EHH True. When I was editor, we were approached by a well-known firm to take over publication. I looked into the finances of such a deal, and although life would have been easier for the editor, it clearly wouldn't have been to the financial advantage of the College—at least not at that time, when we'd begun making a profit. But there's always something to be said for handing over publication to people who have special experience.

BMB How do you think the *Journal* compares with other journals in the field?

EHH I've often heard it said our *Journal* was one of the most respected of its kind—but that may be only self-praise or propaganda. Yet our *Journal* has certainly had a long and honourable history—age hasn't withered it—and I'd say we're preserving our honour satisfactorily.

BMB Have you read the very early issues of the *Journal*?

EHH I'm familiar with them. There were some extraordinarily able British psychiatrists in the 19th century who wrote excellent articles and fine textbooks—and of a literary standard which I'm not sure we've been able to match.

BMB And their subject matter?

EHH Not very different from today's, in essence. The early issues of a hundred years ago are full of sound stuff by the standards then. Nowadays there's more statistics, control and technical equipment, but I don't think there's been any real change in quality.

(The references will appear with Part II of this interview which will be published next month.)

Medical Evidence in the Court of Protection

MRS A. B. MACFARLANE, Master of the Court of Protection

Part I

The Court of Protection, in carrying out its task of managing and administering the property and affairs of those who are incapable of managing for themselves, normally works by appointing a receiver to stand in the patient's shoes. The application for appointment of a receiver may be made through a firm of solicitors or by personal application to the Court. In either case, it needs to be supported by medical evidence, which is usually given on Form CP3. The Court is always conscious that its jurisdiction only extends to people who are incapable of managing their affairs by reason of mental disorder, so medical evidence there must be. (In rare cases, in an emergency, the Court is empowered to act even before receiving formal medical evidence, provided it has reason to believe that the person in question is suffering from mental disorder, but this power is exercised sparingly and only when its use is essential for the patient's protection.) It is an extreme step to deprive a person of his financial liberty and it must be reserved for cases where it is really necessary.

How does the medical certificate help the Court to decide a person's mental competence? First, it requires the doctor to give his name and address and his medical qualifications. (I need hardly say that the doctor may equally well be a woman, and the patient is even more likely to be a woman, but only the masculine pronoun is used in this article, for the sake of simplicity.)

Secondly, he is required to give details of the appointment he holds (if the patient is under his care by reason of being in, or attending at, a hospital or mental nursing home), or if the patient is at home or staying with relatives or friends, the doctor must state where the patient is living, that he is the patient's medical attendant and how long he has acted in that capacity.

Thirdly, the doctor must give the date on which he last examined the patient and must state, unreservedly, that in his opinion the patient is incapable by reason of mental disorder of managing and administering his property and affairs. The definition of mental disorder set out in section 1(2) of the Mental Health Act 1983 is one with which doctors will be familiar. However, one point needs particular emphasis: section 1(3) provides that nothing in the preceding sub-section shall be construed as implying that a person may be dealt with under the Act as suffering from mental disorder, or from any form of mental disorder

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