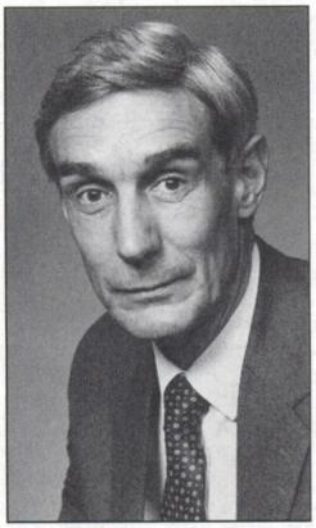
INTERVIEW

R. E. Kendell

In conversation with Alan Kerr



Dr Robert Evan Kendell was born in 1935. He was educated at Mill Hill School, the University of Cambridge and King's College Hospital Medical School. After obtaining the MRCP he worked at the Maudsley and Bethlem Royal Hospitals and the Institute of Psychiatry at the University of London. He became Professor of Psychiatry at the University of Edinburgh in 1974 and, from 1986–1990, was also Dean of the Faculty of Medicine.

In October 1991 he was appointed Chief Medical Officer at the Scottish Office.

He is the author of three books, editor of a well known textbook and has written over 150 papers.

He was awarded the Gaskell Gold Medal of the Royal College of Psychiatrists in 1967 and the Paul Hoch Medal of the American Psychopathological Association in 1988. In 1993 he became a Fellow of the Royal Society of Edinburgh and in 1992 he was appointed Commander of the British Empire for services to medical education.

Alan Kerr interviewed Dr Kendell in Edinburgh in September 1993.

We have traditionally interviewed people in retirement but this has now been extended to include people who have become active and distinguished in other fields.

I remember protesting at first.

Yes, why was that?

Well, because I thought that your invitation implied that you regarded me as over the hill.

It was a change in editorial policy. You were born in Yorkshire but your name has a Welsh feel about it.

Actually, Kendell, the majority of Kendells, live in South Yorkshire. My father's father was a Yorkshireman, my other three grandparents were Welsh so most of my family were Welsh. I think the name comes from the Westmoreland town of Kendal, but spelt in a rather odd way.

Is there a medical influence in the family?

One of my mother's brothers was a doctor but he was the only doctor that I know of in the family.

Was that a factor in determining your choice of career?

I have no idea. I remember being asked when I first went for an interview to Medical School why I wanted to be a doctor and being stumped by the question. It was something to do with reading books about nurses when I was about 10 I think.

Could you elaborate on that?

I remember reading a series of books about a mythical character called Sue Barton who was rather like Biggles or Dick Barton, but in this case a heroine who reappeared through a whole string of books. I made a remark at that interview in response to this question about why I wanted to be a doctor by mentioning something about reading books about nurses. I have no idea now whether that was true or whether I was just being flippant.

You went to school at Mill Hill boarding school?

Yes, I enjoyed it very much.

A fine reputation.

Well, I enjoyed playing a whole range of sports and, of course, had an unrivalled opportunity, living in a boarding school with rugby teams, cricket teams, swimming pool, shooting range and so forth. I loved it.

And what about the academic influences?

I think I was very well taught. I was very lucky, both in my housemaster and my form master

when I went into the medical sixth form. I think Mill Hill was unusual in having a medical sixth. I owe a lot to Donald Hall who taught me biology there. He is still alive actually. We exchange letters from time to time.

You obtained an open scholarship, to Peterhouse, the oldest College in Cambridge.

Yes, that's right, and the smallest.

You obtained a double first class honours in biochemistry. This was part of the pre-clinical course before going on to do the clinical part in medicine?

Yes, we had a choice, which I think still exists, between spending three years doing anatomy, physiology, biochemistry, pathology and such like or getting one's basic pre-medical qualifications out of the way in two years and spending the third year doing a Part II in a single subject of one's choice. I thought about taking psychology for Part II but finally plumped for biochemistry. It fascinated me. It was a time when radioactive isotopes were first freely available and they were an enormously powerful technical tool for exploring metabolic pathways. So, even as a student one had some sense of the excitement in a rapidly expanding science. Of course, although we didn't have much contact with them, there were some very distinguished people in the department, like Fred Sanger who eventually won two Nobel prizes and John Kendrew, another Nobel prizewinner who was also a fellow of my college. We were aware that this was a genuine centre of excellence even before Watson and Crick cracked the genetic code. It was an exciting place and an exciting time.

Was Max Perutz there?

Yes, he was, Perutz and Kendrew were the partnership who established the structure of the haemoglobin molecule by X-ray crystallography.

But you had always intended to go on and complete the medical degree and do clinical medicine?

Yes, I had. There was certainly a time, though, when I was intending just to qualify as a doctor and go back to biochemistry.

And you decided to go to King's College? Any particular reason for that?

I asked several doctors what they considered to be the second best medical school in the country. They all considered their own to be the best so that was really of no interest, but their second choice was useful information. But, more important, King's had a scholarship awarded purely on interview. In other words, you didn't have to do any work for it. So, I went in for this scholarship which was worth £300, £100 a year for three years, which was a great deal of money. A student grant in those days was £300 a year so it was a 33% surplus on that and I got it. One reason that I got it (I only learnt this a long time afterwards) was that the secretary of the Medical School who was on the interview committee was a pompous ass and he said to me, "Young man, tell me what was the last book you read" and I said, "*Peter Pan*". It was true. I had recently been going through an old book cupboard with some of my childhood books in and I had come across *Peter Pan* and read part of it. So I was able to answer questions about *Peter Pan*; and because I made him look silly and perhaps avoided talking myself about pompous things like reading Dostoyevsky that weighed in my favour and I got the scholarship.

The psychiatric teaching at King's? Was Denis Hill there at the time?

Yes, and I have no doubt at all that Denis Hill's influence took me into psychiatry. There was an introductory course which lasted about three months. I found it very boring. In fact I very nearly gave up medicine at that point and flirted with the idea of taking the Civil Service exam. The only teaching of any real interest to me during that three months was Denis Hill's lectures on psychological medicine. He was a superb lecturer. He used to pose interesting questions. He also had a gift of mimicry.

You said you might have gone into the Civil Service. It looks as if you eventually have.

Yes, I've thought about the irony of that.

After qualifying one of your house jobs was with Richard Asher. Had he published his work on myxoedema madness by that time?

Yes he had and he was a very well known, charismatic figure in London medicine at that time. He wrote beautifully on a whole range of topics and said very interesting things. He was actually a much better writer than a doctor. He was a highly intelligent man with an original way of looking at things.

His book Talking Sense *is marvellous advice for people trying to write. It used to irritate him when people asked him to write a paper because they thought it came easily to him. It didn't. He said it was extremely hard work.*

I remember him talking about that, yes. He often told me that a good paper is the result of endless polishing and rewriting.

Did he influence your approach to writing?

I don't think so, althought I definitely admired his writing. The person who did influence me was an anaesthetic registrar called Bill Deakin. I remember the first paper I wrote as a

houseman – about resuscitating a patient who had had a cardiac arrest in the casualty department. I wrote this paper for the BMJ and passed it to Bill Deakin for his comments. He crossed out every 'very' in the whole paper and put rings around all the adjectives and all the adverbs and said, "You can put back one 'very' and three adjectives and three adverbs and the rest must go. You can choose which". I was offended at the time but it was very good advice.

How do you approach writing chapters and books?

I usually put it off because I'm aware it's a big undertaking. When I've got to write something, that is the moment at which I will answer all unanswered letters or do all the other things which I haven't done in the preceding weeks as a means of postponing starting on the task. When I do start, I write in longhand, steadily through from start to finish and I go through it repeatedly; and, of course, the first paragraphs in the first chapter always get revised more often than the last ones. I think the most polished thing I ever wrote was the first chapter of my thesis, my monograph on depressive illness. I must have been through that about 30 to 40 times and every time I went through it, an odd word was changed. Things do slowly improve but it takes a lot of time.

And a lot of background reading. I remember the opening with classical references to Hippocrates and Areteus.

Well, yes, in an MD thesis you have to, even if it's the only time in your life. I spent a lot of time burrowing around in the files of the Royal Society of Medicine Library in London which is, of course, a very good historical library. I also tried at that time – I suppose it's something many people do – never to refer to a paper which I hadn't read right through myself. I have to confess that I have subsequently referred to papers which I haven't read at all, but at least at that stage I read everything I referred to.

You also had a house job at Queen's Square in Neurology. Who were you working with there?

John Marshall. His interest was in vascular diseases. Indeed, I did a little research on cerebrovascular disease when I was working for him. It was a very good year.

You moved to the Maudsley in 1962 where almost every academic psychiatrist had trained at that time.

Well, of course, I was working in London already and had trained literally across the road, at King's. So, it was the obvious place for me to turn to and I certainly have no regrets. Looking back on it, I had a superb education. It's really only now that many other branches of medicine are getting around to organising the kind of planned, rotational training for each individual with academic teaching going on simultaneously which had existed at the Maudsley, largely thanks to Aubrey Lewis, since the 1950s. We took it for granted.

You had exposure to every specialty within psychiatry.

Not every one, but a lot.

Could you tell me about those experiences?

Child psychiatry was a bit of a disaster. I was sent to the Brixton Child Guidance Clinic, which in those days was a punishment placement, because I had declined to go somewhere else. I learnt quite a lot about French cricket and ludo and about internecine warfare with social workers and between social workers but I didn't learn very much child psychiatry. But I learnt a lot about geriatric psychiatry from Felix Post and about psychotherapy from Heinz Wolff.

Did you work with Post on his classification work?

No, he had published it by that time but he was an excellent teacher.

And Heinz Wolff?

He was enormously enthusiastic, a very kind, optimistic man. It was his personality which was therapeutic. Sometimes his optimism flew in the face of reality but I learnt a lot from him. He wasn't hidebound by dogma and I think that was very important.

Did you work with Aubrey Lewis?

Aubrey didn't run a clinical service himself but I spent a year on the Professorial Unit and he chaired the admission and discharge conference every week and everybody went to his case conference every Thursday and his journal club every Saturday morning. So, we had a lot of contact with him in a variety of settings. He used to pose difficult questions which forced one to think.

There was a myth about Aubrey as a terrifying, tyrannical figure which, if it had ever been true, wasn't true by the time I got there. Maybe he had mellowed in old age, I don't know, but I remember one of my friends and contemporaries, Isaac Sakinofsky, who was a South African. He was always rather intimidated by Aubrey but when he was back in South Africa, a schizophrenic attempted to assassinate the Prime Minister, Verwoerd, and Sakinofsky was responsible for assessing the attempted assassin after the event. He was then cross-examined under

the arc lights by the State Police to justify his diagnosis of schizophrenia. This went on for several hours and he said, ruminating on this experience some time later, that he had always wondered what the purpose of Aubrey's admission and discharge conferences was, but in fact it was the perfect training for this interrogation.

How was he on a personal level?

He cared deeply about his students. I saw this very vividly once when I was a senior registrar and it was my job to produce cases for the DPM clinical. One of my contemporaries had failed the previous time, which didn't happen often, and was having to resit. Aubrey was obviously very worried about this and he must have said to me at least three times that it was very important that, let's call him Bloggs, didn't get too difficult a case in his clinical. Then, realising what he had said, he immediately followed this up by a statement to the effect that of course it was very important that I randomly allocated cases to candidates. He was obviously torn between these two feelings and I had the same conversation with him three times in as many days.

Was it he who suggested your work on the classification of depressive illnesses?

No. But I remember going to him, just to tell him what I was proposing to do and he encouraged me. He said it was important for me to realise that I wouldn't get an MD out of Cambridge University because they just didn't give MDs to psychiatrists and Eliot Slater (Editor at that time) would probably not be willing to publish my results in the *British Journal of Psychiatry* because he wouldn't like them. The first of those predictions was inaccurate but the second was not.

Who did suggest that the work be done, your classification study?

It was a topic which was preoccupying a lot of people and the idea of doing a discriminant function analysis as a means of resolving the argument had come to me from a lecture I had heard as a medical student. I remember hearing Edward Wayne, who was Regius Professor of Physic in Glasgow, talking about his research, trying to decide where to draw the boundary between thyrotoxicosis and normality. In effect what he was describing was a primitive form of discriminant function analysis. He got a bimodal distribution and it occurred to me years later that you ought to be able to do that with depressive illnesses.

You say that there was interest in that area at that time.

Well, Kiloh and Garside in Newcastle had just published a paper based on factor analysis, claiming to prove that neurotic and psychotic depressions, or what they called neurotic and endogenous depression, were separate illnesses. I thought that their statistical methods were invalid. You simply couldn't prove the issue either way with factor analysis but, remembering Wayne's work, I thought you could do it with a discriminant function, so I thought I'd set about doing that. And, of course, as young men do, I thought I could settle the argument once and for all. I was naive, of course.

You don't feel the issue has been resolved, do you?

No. I think there *has* been a consistent failure to demonstrate that there are two or more separate disease entities present, but that does not prove that there aren't; and part of the problem is that people haven't defined what they mean by a disease entity before they start. I would much rather have demonstrated a bimodal distribution than the unimodal distribution I obtained. I can remember plotting the scores out at home and slowly realising as I added more and more in that it was going to be unimodal and it was a great disappointment to me. Yet the study did demonstrate that the ratings of clinical symptoms that individual doctors made were clearly biased by their theoretical views. That pleased me enormously and I was really rather proud that I had been able to demonstrate this, rather elegantly I thought. That was one of the papers that Eliot Slater declined to publish.

Are there other figures that stand out in your mind as formative influences while at the Maudsley?

I learnt more in my first six months or my first year than in any subsequent time. We all do, I suppose, going to new subjects and a new environment. I remember being very frustrated and puzzled by the differences between psychiatry and neurology. In neurology, all the intellectual effort went into making a diagnosis and once you had done so, that was the end of it. Patient dismissed, back to GP. In psychiatry, diagnosis was almost irrelevant and an enormous amount of thought went into planning the management and discussing the prognosis of individual patients. That was quite a difficult adaptation but quite an interesting one, to see the change.

I worked for my first year for D.L. Davies, who was the Dean. I learnt a lot from him. He was a very quiet, shy man who was suspicious, indeed contemptuous, of theoretical systems, but he had both feet very firmly on the ground and to hear his comments at a case conference after the

comments of a string of psychotherapists was very illuminating. It seemed the voice of commonsense, based simply on long experience of how people actually behaved in particular predicaments. He was frightened of sex, though, and would go to enormous lengths to avoid sexual explanations of anything. Apart from that, he was very shrewd.

He was interested in alcohol problems which has been an interest of yours. Is there a link there?

Without any doubt, because a whole series of people who were his registrars – Neil Kessel, Griffith Edwards, myself and probably one or two others – all did their early research, and in some cases, life-long research, on alcohol and it was David Davies's influence. At that stage he was virtually the only person in Britain who was taking an interest in research on alcohol.

The role of diagnosis in psychiatry is also an area of long-standing interest to you.

Yes. It became a central issue for me mainly as a result of being a member of the US/UK Diagnostic Project Team for three to four years and discovering that those huge differences between the hospital admission rates for schizophrenia and manic depressive illness between New York and London which we had set out to investigate with all sorts of splendid social hypotheses in our minds were entirely due to differences in the psychiatrists. The patients themselves, when we studied them sufficiently closely and carefully in the two sets of hospitals, were virtually identical. That made a profound impression on me, as had my previous work on depression and seeing the way in which psychiatrists' ratings are biased by the views they start with.

How did those extraordinary differences between New York and London psychiatrists come about?

They were essentially transatlantic differences. They developed because from the 1930s until the 1960s there was relatively little interchange between different places. Transport was expensive and people didn't flit across the Atlantic in the way they started to do from the 1960s onwards, so there was a general cultural isolation. Diagnostic criteria were determined by individual charismatic figures. You learnt how to diagnose schizophrenia by observing which patients your boss attached the label to and doing the same. These charismatic teachers all had slightly different approaches, probably without being aware of them. It wasn't just psychiatry. There was a lot of puzzlement in the 1950s among chest physicians as to why it was that emphysema was so much commoner in America and chronic bronchitis so much commoner in Britain. Then they discovered that they were just using different words for the same patients.

Your research interests have spanned a wide variety of clinical areas – schizophrenia, depression, alcohol, hysteria, puerperal disorders, obsessional states, ME.

I am aware that I am a bit of a butterfly from a research point of view.

I didn't wish to imply that.

Well, no, that's my own feeling. I do flit from area to area and to some extent this has prevented me from mastering any single area. I do it because I think research, if done properly, is extraordinarily tedious and extraordinarily time-consuming. You therefore have to be really interested in the topic you are exploring to do it justice. I have moved from area to area because there was something there that interested me, or because I could see that there was an unexploited opportunity. That had some advantages but it also had some disadvantages. I suppose I spent at least a decade looking at diagnosis and diagnostic criteria from a range of different stances. But once I felt I had said all I could say, I turned to other things.

Your interest in alcohol problems seems to be a recurring theme.

Yes, that's true. Alcohol is a very interesting field, partly because of its enormous clinical importance. But the moment you start to do research into alcohol, you are into a whole range of different areas like economics and social history which is crucially important because everything has been done before. There are some very important lessons to be learnt from 18th and 19th century legislation.

There is an expressed aim to reduce the amount of drinking in Scotland by the year 2000.

The target is to reduce the number of men drinking more than 21 units and women drinking more than 14 units – of excessive drinkers defined in that way – by 20% by the year 2000. That was one of a series of targets which were set before I joined the Scottish Office. I am largely in favour of targets. It's a very good way of putting pressure on yourself, on your Ministers and on a whole range of other people and agencies.

You felt that taxation was the single most effective measure which could be taken to reduce a nation's drinking.

I think it has been demonstrated fairly conclusively in a number of different settings. The thing I added to that was to demonstrate that heavy drinkers reduced their consumption, not just the population as a whole, when alcohol became

more expensive. At that time, and to some extent still, the alcohol industry was arguing that it would only be the ordinary man in the street who would drink less if he had to pay more for his pint, whereas your real alcoholic would drink as much as ever and his family would suffer even more. Well, I was able to demonstrate that that was nonsense.

More recent research, carried out in the 80s, has been on ECT.

Yes. That was a series of studies I did with Chris Freeman and a psychologist, David Weeks, and they did most of the work. David Weeks gave a very detailed battery of psychological tests to something like 100 patients, before, immediately afterward and a long time after having a course of ECT in an attempt to tease out what the short term and the long term effects of ECT were.

We also advertised in the local evening paper for people who thought their memory had been permanently affected by ECT and tested them. Of course, we had no information on how they had been before ECT. But at least we were able to compare them with a population norm and we found that they were not performing as well as they ought to have been if they had been average people for their age and sex. It wasn't very strong evidence but it was better than nothing. Also the nature of their complaints was interesting. It was mostly that ECT had interfered, not with their capacity to remember new things now, but to recall memories from the distant past. There is evidence that bilateral ECT given more frequently than twice a week does, at least in some people, produce enduring defects of distant memory, but they are often highly personal memories which are not picked up with standard tests.

On the other hand, there has been a swing back towards bilateral ECT.

Oh yes, because it is much more effective.

On ICD-10 and DSM-IV, do you feel more hopeful that these classifications are going to be used by clinicians in their everyday work?

Well, DSM-III has had an enormous effect upon American psychiatrists, and world-wide. Certainly, successive revisions of a classification do influence the thinking and diagnostic behaviour of ordinary clinicians, but it is a slow process. I twice compared the diagnoses British psychiatrists were making a year before and a year after the introduction of a new revision of the ICD and there was almost no detectable effect, either in the change from ICD-6 to ICD-8 or the changeover from ICD-8 to ICD-9. But I hope that ICD-10, which will have operational criteria, will have more influence, although the classification has become much more complicated and detailed that I hoped it would be when the keel was first laid ten years ago.

You spent 1969–70 at Vermont as visiting professor.

Yes. It was a splendid year. I went under rather unusual circumstances. Most people go to America to do research. I had been doing full-time research for three years and was aware that there was going to be a lull in the work of the UK/US Diagnostic Project between one set of studies and another in which nothing much would happen. The opportunity came out of the blue to go to Vermont, not to do research, but to teach and to run a clinical service. So, I thought well, I'll go and do that and earn a lot of money as well. I enjoyed it very much.

You enjoyed teaching?

Yes. It was my first experience of teaching medical students. American students are very interesting. Many of them are incapable of writing a coherent paragraph on anything but they are serious, hard working and have a very impressive verbal fluency. Their culture is based on speech. Ours is much more based on written language – the exchange of letters and the exchange of minutes. It was very stimulating because if you gave them what they wanted, they'd say, "Gee Doc, that was great". If you disappointed them, they said, "We've heard that crap before", and of course it's very valuable to get immediate feedback.

It was also interesting running a ward in the completely different economic and administrative setting of an American hospital. The patients were identical to those I was familiar with in an English NHS hospital. It was a university hospital and I took over a ward in which at that time everybody was paying $55 a day – just for their bed, before they paid for anything else. It sounds a trivial sum now but it was a pretty prodigious sum in 1969. The first thing I did was decide that there was nothing I could do for these people that was worth $55 a day, so I discharged as many as possible. Within a fortnight I was on the mat before the hospital administrator because they were monitoring everybody's bed occupancy rates and mine had fallen. He said if you don't get those beds full again by the end of the month, we're withdrawing your contract.

So, I was immediately aware that I was in a different world, but it taught me a lot of important things. At the Maudsley we were accustomed to doing nothing for a week to see what effect simply being in the different environment of a hospital had on the patients' symptoms. So, no decisions about management were made in the first week. That was quite impossible in a setting in which people were paying $55 a day.

Decisions had to be made on the morning of admission.

Do you think there's something to be said for waiting a few days before starting treatment

Absolutely. But probably not enough to justify the cost. I was convinced by my American experience that it is possible to speed things up a great deal and that you don't often make bad mistakes as a result of doing so. You can get patients in, treated and out, much more quickly than I was used to. It means having ward rounds every morning, of course, not just twice a week, because you have to make decisions every day, including Saturdays.

And how did you readjust to life back at the Institute?

It was extraordinary. Although I'd been away in quite a different world for 18 months, I came back to the same job, to the same colleagues, and to living in the same house and after I'd been back for ten days, I could hardly believe I'd been away at all. I was back in the familiar rut. It was very easy. I spent most of the next six months writing the monograph comparing psychiatric diagnoses in London and New York.

You became professor of Psychiatry in Edinburgh in 1974. Was it a wrench, to leave the Institute?

Well it was a big step. I was very happy there. I was Denis Hill's first lieutenant and I got on very well with him. He gave me a lot of freedom, I had quite a lot of time for research, my own unit down at Bethlem, I was responsible for first year teaching for registrars. I would have stayed in that job happily for a long time. But it was a time when Chairs of Psychiatry were being created all over the place. In fact, somebody, probably David Goldberg, commented that the reason why we all became Professors was because they were the only jobs that were going at the time. It was clear that I would be under quite a lot of pressure to move elsewhere to a Chair and if I was going to move anywhere, Edinburgh was a very attractive place to move to.

You'd never worked in Scotland before?

No. When I went for my interview, somebody asked me what links I had with Scotland and in particular with Edinburgh and I said rather flippantly that, as far as I was concerned, Edinburgh was a place where you changed trains on the way to Wester Ross. I suppose that was almost a fatal remark, but that certainly was my experience of Edinburgh at that time.

It had a distinguished tradition of course.

Oh yes, It was the largest and the most prestigious department outside the Maudsley.

And how was it when you arrived in terms of resources, teaching, research, and so on?

In terms of resources, Edinburgh at that time was extraordinarily well off. The Department of Psychiatry – the Kennedy Tower – had opened two to three years previously. It was the creation of Alexander Kennedy who died before it opened. We had him to thank both for the Tower and the new professorial unit wards. The Department in those days had three established chairs, its own administrator, its own animal house, its own laboratories, and two MRC units. It was very well endowed compared with other undergraduate departments. Unfortunately, 1974 was the year in which university funding ceased rising. It was the end of the Robbins era and from then on it was a declining budget and retrenchment almost every year.

Your inaugural lecture was a bit controversial.

Yes, but it wasn't meant to be. My lecture was about the concept of disease. I was really trying to answer Szasz's argument that there is no such thing as mental illness. I started by arguing that you cannot have a meaningful discussion about any such assertion until you have defined what you mean by mental illness, and you can't define what you mean by mental illness until you've defined what you mean by illness or disease as a whole. My favourite definition was one put forward some years before by Guy Scadding and I observed *en passant* that one of the incidental implications of this definition was that it implied that homosexuality was a disease – because of the profound biological disadvantage involved in having a greatly diminished fertility. That led to uproar for two reasons which I was quite unaware of in advance. First, I didn't appreciate that my predecessor, Morris Carstairs, had been the patron saint of Scottish homosexuals. Even worse, I didn't know that the First World Congress of Homosexuals was due to take place in Edinburgh in about six weeks' time. So my casual aside was seen as highly provocative when it wasn't meant to be.

I think a major achievement has been the postgraduate textbook (Companion to Psychiatric Studies) *which was in existence before you arrived.*

It was started by Alistair Forrest. When the College membership exam was first being discussed, Alistair, who was a very energetic man and had an entrepreneurial streak in him, saw, before anybody else, that if you've got a new exam you're going to need a new textbook and he got this book out in time. It was very successful because it was produced at precisely the moment it was needed. Alistair then emigrated to a Chair in Canada and tragically soon afterwards

developed a brain tumour and died, so at that stage I was asked to take over.

There had been two editions.

Yes. Andrew Zealley and I took it over. We changed it a bit. I didn't like the idea of writing a textbook to get people through examinations. I wanted to try and produce a book which helped educate young psychiatrists rather than get them through some wretched exam. I'm glad I did it. The first edition I did with Andrew was our creation, we had the chance to put our stamp on it. It was exciting bringing that out. But 90% of it was written, and very well written, by our colleagues and we had an impressive range of talent to draw on. Inevitably, you don't get everything right the first time so in the next edition, which came out five years later, we were keen to put right the three or four things which we felt we hadn't got right the time before. But, beyond that stage, it's a labour committing yourself to revising a big text book every five years. It becomes a treadmill after a time. One of the things it taught me, though, is that, even in a seemingly slow moving discipline like psychiatry, a great many things change in five years and they are not just fashion.

The need to produce a new edition of this book every five years made me realise how rapidly psychiatry is now changing. There has been a huge change in service delivery with the rapid transition from institutional care to community care.

There has also been a conceptual paradigm change where psychotic illnesses are concerned. We are beginning to have some real understanding of the biological basis of these disorders and at a conceptual level there is a profound change in how psychiatric illnesses are visualised. I hope that the most important change in the fifth edition is the fact that we ceased using the term 'mental illness' on the grounds that there is no such thing.

That sounds like Szasz.

Yes, it does sound like Szasz, but with a quite different meaning. So-called mental illnesses are essentially no different from any other kind of illness. The distinction between mental and physical is meaningless, the distinction between organic and functional is meaningless and these terms ought to go.

Are you implying that the organic basis for psychosis is established?

Yes, I think we have good grounds for knowing that there must be a biological abnormality there. There is no fundamental difference between a neurological disorder like Parkinson's disease and a psychiatric disorder like schizophrenia. The similarities are much more impressive than the differences. The distinction between organic and functional is spurious and damaging.

Where does this leave the neuroses and the personality disorders?

It's going to be a fuzzy borderline. I think what will happen is that we will start by learning more about the biological basis of major disorders like schizophrenia and affective psychoses and probably move outwards from there towards what used to be called the neuroses.

After 12 years you became Dean at Edinburgh, as well as Professor of Psychiatry. How are Deans elected up here?

In Edinburgh they are elected by the Faculty on a yearly basis. I think it is a very good system. The Faculty elects its Dean and gives him very considerable power, but it could sack him each year.

Is there a maximum period?

No, the recent convention has been that the Dean spends three or four years in post but there were times in the past, in the 1940s and 1950s, when one man was Dean for 20 years.

Being a Professor of Psychiatry at the time, do you think your own Department suffered at all?

A Dean can't fight the battles of his own department. It would be fatal to try to do so and probably, therefore, his department suffers. One of my predecessors was Professor of Anatomy and his department suffered a lot while he was Dean. I was lucky in that I was the first Dean who was given somebody to replace him. I said, "I cannot take this job on unless you give my department a temporary senior lecturer while I am Dean" because I just couldn't go on running an acute admission ward while Dean. I kept on most of my teaching though.

Could you tell me a little about the experience of being Dean in Edinburgh (from 1986–1990)?

It was a very difficult time in that we were constantly on the defensive. The University was very short of money, quite a lot of influential people there were convinced that its financial problems could be solved if the Faculty of Medicine was cut down to size. They thought it was far too expensive. Quite a lot of my time was taken up by resisting that argument.

This occurs in other universities.

Oh yes. But the Health Board was also, for the first time, beginning to get seriously short of money and so it too was tempted to solve some of its problems by striking harder deals with the Medical School, withdrawing funding of things which it had previously funded. So there were

important battles to be fought on two fronts; and also very important attempts to help the health board get a new teaching hospital, so there was plenty going on. I got wholehearted support from my colleagues and, although it was hard work, it was a time I look back on with some pleasure and satisfaction.

What were the main achievements?

Well, nothing catastrophic happened. I kept the ship afloat at a time of many storms and didn't lose too many of the crew. I would also like to think that I helped the Medical School to achieve the '5' rating it recently obtained from the Higher Education Funding Council for the quality of its clinical research. The most enjoyable part of being Dean was, without any doubt, Graduation Day. You see these happy, smiling faces coming up, graduating, and it's a tremendous feeling and occasion. You think, "this is my product coming off the production line".

Two years ago you became Chief Medical Officer. What was the attraction of this position

Well, I'd been in the same job for $17\frac{1}{2}$ years and I could see that if I stayed in the same job till I retired, I would probably go on doing the same things as I had done in the past, rather less well and with rather less enthusiasm than I had earlier on. There were big changes taking place, both in universities and the health service, and I would inevitably have been in the position of trying to defend things which either I or my predecessors had created, and probably losing battles at the end of the day. Also, I didn't want to get into a situation where my lecturers would be muttering to each other, "When does the old bugger retire?" I felt it was important to get out before I was in that situation. I had the opportunity to do something completely different, which didn't involve uprooting my family, didn't involve wrecking my wife's job, which I had done once before – she's an anaesthetist – when I had uprooted her from London where she had just got herself a part-time consultant job to start all over again in Edinburgh. So, having the opportunity to do something completely different in my declining years without leaving the city was very attractive, so here I am.

And how has the reality been?

It is very interesting to see how government decision-making works. I have no regrets at all about moving. But it is frustrating because it is my role, both in theory and in practice, simply to advise. I am not responsible for anything. It is not my job to run the health service, simply to advise, in formal terms the Secretary of State and in practical terms the Management Executive and other civil servants in St Andrew's House. And, of course, they very often, for a variety of reasons, don't take the advice that I and my colleagues offer. And that's frustrating. But they take it often enough to make it worth going through the process.

There is a prodigious amount of paper work. It comes into my office in barrel loads every day. Also, quite a lot of tedious shuttling backwards and forwards to London. The days of swanning off to conferences abroad in the manner of a university professor have gone.

Any specific bits of advice you have given that have been accepted?

Yes, but I don't think at this stage I can tell you. But let me tell you one. In my first week here I got a minute from somebody whom I'd never met in a branch of the Scottish Office which I had never heard of, saying that plans were underway for a new Scottish Office building and could I advise on the recreational facilities that ought to be provided. There was a feeling that the Scottish Office ought to be setting an example as a good employer. There was nobody I could think of to whom I could pass this, so I had to deal with it. So I talked into a dictating machine for about $3\frac{1}{2}$ minutes. I said that the single most useful thing that they could do was to build a swimming pool because it provided exercise for people of all ages, it didn't wear out old joints and it would have genuine health benefits to staff of all ages, of both sexes, and would be widely used. I forgot all about it and then a year later I saw the plans for a splendid swimming pool.

In England the Health of the Nation *proposed various targets, including reduction in the numbers of suicides.*

We have a range of targets as well, indeed our's preceded England's. They came out in 1990. What is different is that ours, the Scottish targets, are more restrictive. We do not have, and this was a deliberate decision, a target for suicide reduction because we were not convinced that there were things which we could do which would lower our suicide rate. There are things which may happen which may lower the suicide rate. Catalytic converters on cars I hope will have a big effect over the next ten years. If unemployment comes down, that will have a real effect on suicide rates. But we didn't think that there was anything the Health Department could do. We didn't see ourselves as having control in any real sense.

A lot depends on what you think a target is for. By not setting a target for severe mental illness, we were undoubtedly allowing people to assume that we were not really interested in mental illness, whereas the Department of Health, by setting a suicide target, even if they actually can't

do very much about suicide, indeed even if suicide rates rise, are saying publicly that mental illness is important. So I am not sure that we made the right decision, but that was the reason for our decision.

Let's talk about your contribution to the College. You've been in the past very active in education and training areas.

The thing I was most deeply involved in was the Joint Committee on Higher Psychiatric Training. I was on it for six years and Chairman of the General Psychiatry Sub-Committee for three years, at a time when the Committee was going round all the senior registrar training programmes in the country for the first time. I hope that we did a lot of good, although that's for other people to decide. But certainly we were arriving as a novel group of people, making judgements about individual training programmes and, in some cases, saying you will only go on getting recognition from the Joint Committee if you make these changes.

I remember it clearly.

Yes, you were on the receiving end of one visitation I remember.

You were also on the College's Court of Electors for a time (1982–1985).

Yes. It was a very big group and I never felt that either the Court as a whole, or myself as one member of it, was taking important decisions in the way in which I did feel we were on the Joint Committee on Higher Psychiatric Training. I was learning a bit about how the College worked, rather than making an important contribution myself.

You continue to have a particular interest in psychiatric research and chaired a recent review of research at the Institute of Psychiatry.

Yes, and I was very glad to have the opportunity to do so. The Institute is going to remain crucial. It has been very successful in a wide range of fields. Much of the international reputation of British psychiatry depends on the people who work there and I think it is very important that it survives. I am delighted to see David Goldberg moving to take up the Chair there. It is splendid for him and I wish him every success.

I don't think British psychiatry can hope to be, in the future, as influential as it was in the 1960s. For two reasons. American psychiatry was at that time almost totally preoccupied with psychoanalysis. It was going down a blind alley and leaving a vacuum into which British psychiatry was able to move, to some extent. In relative terms we were also well funded in those days. We didn't realise it at the time but we were, compared with most other countries. We had at least two genuine academic centres. We had a tradition of social and community psychiatry which was very relevant. The creation of the National Health Service in 1948 gave us a framework which was infinitely better for psychiatry than in any other country and the 1959 Mental Health Act provided a more liberal framework, legally, for psychiatry to operate in. So I think we had some unique advantages in that generation which are unlikely to recur.

There are a lot of ways in which research is getting harder but these constraints apply in other countries too. Germany lost their case registers on the grounds of civil liberty. They were just closed down. It hasn't happened to us – yet. Although the amount of money that the Americans have for research is beyond our wildest dreams, there are still a lot of important constraints on what is possible for them. We have just got to exploit our niche in an international endeavour in which overall we are going to be an increasingly minor player. But we still have niches and talents that we can exploit.

About Distinction Awards. Do you feel it is as fair a system as it humanly can be or not?

Well, I only saw it at close enough quarters to have an informed view in South East Scotland. I was impressed by how hard everybody concerned does try to be fair. An enormous amount of time goes into it and people on the whole try hard to be fair to other disciplines than their own. One of the things I learnt is that a psychiatrist gets an award not just because the other psychiatrists say "he's a really good chap" but if the general physicians also say so. I think that is as it should be. I was also rather impressed by the way people did not get awards, simply because they were members of a College committee of something like that. People would argue that he spends far too much of his time at the College.

Did you feel that there was a risk that people working in peripheral hospitals or in small specialties would be missed out?

Oh there undoubtedly is such a risk, but at least there is an awareness that that is an important issue. Of course, if not many people know you, you are at a disadvantage.

I suspect that probably too much credit was given to academic achievements and not enough to being a really good, devoted doctor. Yet I was impressed by how hard people tried to be fair across a wide range of disciplines. But you're right, distinction awards are under threat.

You mentioned earlier that you'd only been to Edinburgh, prior to taking the Chair at the University, on your way to Wester Ross. Are you still walking, climbing, playing squash?

Yes, but I had to give up playing squash about three years ago. My knees ceased turning corners when the rest of me turned. But I still walk and climb. I spent my holiday this summer trekking in the Hindu Kush. It was quite hard work, but I felt much better for having had some fresh air and exercise. Sitting at a desk all day long doesn't suit me.

A piece of his mind

He is a kind man, a caring physician, who strove hard to help the children who had psychiatric problems; although the successes were hard won, the gratitude of the children and their parents more than made up for the long hours of work.

Not all of the patients could be cured, those with autism or severe behaviour disorders, and the children from inadequate families, but common sense and practical approaches would help to modify some of the daily problems.

Teachers and nurses, activity therapists, doctors and social workers worked together as a team, using their special skills to help these difficult children. Kindness and consistency, laughter and physical activity, learning and living together, were the most important parts of the treatment. These were the skills that he taught and used.

Now a cruel stroke of fate is robbing this man of his very self, as the relentless progression of Alzheimer's syndrome steals his mind. He loved to read the great authors, to listen to fine music, to plant trees to enrich the soil and save the environment.

This man who raised three children, and counted them as his best friends, who trained countless physicians and nurses and all the other team members, is now losing the very core of his being.

It is time for him to be the recipient of the love, care, patience, training and encouragement that he so liberally gave to others.

Just as for some of the children there was no cure, so there is no cure for him.

He knows what is happening and in his quiet and proud way, strives to live his life with dignity, keeping to himself the fears and difficulties for the most part. The frustration at taking long minutes to write a few words, always spelt correctly, although the letters and their making cannot be recalled without huge effort.

Reading books that he loves, only to find that the memory from one moment to the next is lost. Listening to music, a joy still to be savoured, bringing peace and calm to his muddied mind.

Just as the troubled children are lost in the task of living in this complex world, so this kind man is lost. But he knew where he was going until the cruel amyloid plaques invaded the brain, muddying the paths and twisting the thought process. To be a psychiatrist and make the diagnosis of Alzheimer's on oneself, would seem to be too much to bear.

The burden of the disease is shared by his whole family, and as the changes come, so they have to learn the great lesson of living each day to its fullest. Memories are always there, happy ones to be remembered and laughed over, the sad and the serious moments diluted by their very age, recalling long forgotten moments of happy times. Friends and colleagues assume new and greater importance, the friends from the past reaching out with letters and visits and acceptance of the turn of events. Colleagues, alas are often too busy looking after other patients to be able to spare the time for a much needed friendship at this difficult time.

Such are the tricks of fate dealt to one. It is a challenge to test the endurance and imagination of us all. Whether to sink under the load, or to find the hidden strengths with which to grow and flourish in the face of adversity. Just as the thousands of trees that he planted, grew in strength and beauty, weathering the drought and heat and icy cold of many years, maturing into a great and lovely forest.

BJPsych Bulletin

R. E. Kendell: In conversation with Alan Kerr

Psychiatric Bulletin 1994, 18:2-12.
Access the most recent version at DOI: 10.1192/pb.18.1.2

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Downloaded from http://pb.rcpsych.org/ on January 29, 2018
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