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special articles

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Is research just an optional extra in clinical psychiatry? Invited commentary on . . . Research as part of the career of a psychiatrist entering clinical practice†

SUMMARY

A reassessment of the reasons for psychiatrists being reluctant to do research is made. It is suggested that a combination of inspiration and scepticism is required to both be a good researcher as well as a good clinician. These are seldom to be found in one individual but usually can be found if the trainee is prepared to scour. The benefits of success are many, and a long and productive life in clinical practice is likely with a positive attitude to research, not just to keep up with developments in an informed way but to prevent the ossifying process of clinical dogmatism from developing.

Dr Fogel points out two facts that are probably well known to psychiatrists but that are reinforced by his survey data. The first is that psychiatrists tend to be less academically inclined than doctors training in other clinical disciplines; the second is that research tends to be a low priority for most clinical psychiatrists. These data also suggest that if research was stressed more in the training of doctors that more people might come into the profession.

I am not convinced whether more research training is going to encourage more doctors to do psychiatry, but it is clear that it may attract a small number to concentrate on academic psychiatry as a career. What is, however, clear to me is that having an inspirational mentor is a strong reason for many going into psychiatry.

I was present at the eightieth birthday celebrations of Dr William Sargant, former head of psychiatry at St Thomas' Hospital, in 1986. My first psychiatric job was with Dr Sargant and he was one of the reasons why I went to St Thomas' Medical School from the University of Cambridge to do my clinical training. One of the tributes given to Dr Sargant on that occasion 23 years ago was a speech by Professor (subsequently Sir) David Goldberg in which he disclosed a conversation he had had with Professor Aubrey Lewis, the ultimate exemplar of detached scholarliness in academic psychiatry, when he first went to the Maudsley Hospital. When Aubrey Lewis found that David Goldberg had trained as a medical student at St Thomas' Hospital, he asked, amazed, 'Tell me something. How does Dr Sargant do it? How has he encouraged so many medical students to go into psychiatry?'.

I think I know the answer to this question. Dr Sargant was a charismatic enthusiast who was so far removed from Aubrey Lewis's icy clear-edged thinking they could have come from different planets. He pre-empted Barack Obama's famous three words 'yes we can' when asked if he could treat successfully what appeared then to be intractable mental disorders: 'Yes we can indeed. There is nothing we cannot treat, provided the patient is of good previous personality'. Nothing could be more exciting to medical students and if a few people were not of good previous personality, what matter. Here was a new discipline emerging from the torpor of therapeutic nihilism to one of hope and optimism and they could get in at the ground floor.

But this is only one half of this story. Dr Sargant was not a first-class researcher and he famously criticised Sir Austin Bradford Hill, the inventor of the randomised controlled trial, by claiming that good research could be carried out only 'at the bedside'. What I realised in working with Dr Sargant was that much of what he promulgated constituted hypothesis dressed up as fact. He believed that all drug treatments were better than psychological ones, with the possible exception of Pavlovian conditioning, and, like many pioneers in clinical practice, went far beyond his data and his pronouncements on drug treatment. But both Sargants and Lewises are needed in psychiatry. If we made the best possible combination of the sceptical Aubrey Lewis view of the world with the enthusiastic certainty of the Sargantian approach we would indeed be able to say, 'yes we did'.

Indeed, the Royal College of Psychiatrists has attempted this mix by making improvements to the MRCPsych examination, in which developments in critical appraisal have helped understanding of research, and in allowing specialist registrars two protected sessions for research as well as two others for special interest in their career pathways.

The trouble is that although psychiatrists by the time they become consultants are well trained in this combined approach, they tend to lose it once they become consultants. I am not saying they become lazy psychiatrists, or do not keep up to scratch with regard to continuous professional development, as these activities are given prominence and are mandatory requirements for all. But what is missing is the wide-eyed excitement of discovering new research questions that are important for clinical practice, the survivor of major trauma who has no stressful experience afterwards because he has been unconscious for the whole duration of the episode, the blind person who develops visual hallucinations despite never having seen, and the dying man who lives for many years beyond his predicted death because he is so determined to stay alive. These are the questions that need to be fed back to the researchers, now largely

†See special article, pp. 269–272, this issue.

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ensconced in institutions rather than in mental health settings, because if they do not get the right research questions they will never produce answers that are relevant to clinical practice.

Clinicians in psychiatry often underestimate their research skills and the potential of their contribution. One of the major changes in research in the last 20 years has been a shift from careful explanatory trials of treatments given under ideal conditions to pragmatic trials carried out in ordinary conditions of clinical practice. Large pragmatic trials are necessary to derive evidence for many of the treatments currently used in psychiatry and the growth of research networks such as the Mental Health Research Network in England and the UK Collaborative Research Network (UKCRN) have been set up to foster this interest and encourage clinicians to take part in these studies. Although I clearly express an interest here as a lead member of one of the hubs in the Mental Health Research Network, I have always been convinced that a clinician who takes some part in research activity, however minor, tends to be a better clinician than one who does not. This is because the answer of 'I don't know' should not be one perceived to indicate incompetence or inadequacy; it is an honest admission of the facts and demonstrates a need for research to answer that question. More simply, taking part in research makes you think better, and prevents the onset of dogmatic conviction that is one of the banes of older age.

So Dr Fogel is half right; good experience of research helps, but we need a human element too to attract the people we need into our discipline.

Declaration of interest

P.T. is the Lead of the North London Hub of the Mental Health Research Network in England, an organisation devoted to improving research in mental health services in the National Health Service.

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