

DIARY OF EVENTS

Institute Meetings

Clinical Case Discussion Meetings: Second thursday in the Month from 10th November 1983 at Chandos Street, London. See Notice from Programme Secretary on page 4 for further details.

Leader Doctors Weekend 9th & 10th July 1983 at the Post House Hotel, Braunston Lane East, Leicester.

Residential Weekend Meeting
30th September – 2nd October 1983
Hugh Stewart Hall, Nottingham University, Nottingham.

Other Meetings

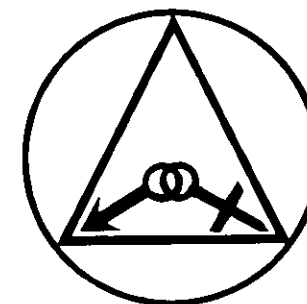
British Psycho-Analytical Society Saturday 11th June, 1983
9.30 – 4.30 at 63 New Cavendish Street, London W1M 7RD
"Some Forms of Self-Destruction: Their Development in Adolescence" Speakers to include: Drs Anton Obholzer, Robert Hale, Christopher Dare.

S.P.O.D. 2nd International Conference 19 – 22 July 1983
Owens Park, Manchester University "Learning, Loving and Living." Details: 33 Grantham Road, Chiswick, London.

7th International Congress on Psychosomatic Obstetrics & Gynaecology. 11 – 15 September 1983. Dublin, Ireland.

B.M.A. Clinical Congress 19 – 23 September 1983, Toronto. The final plenary session concerns psychosexual counselling and will be chaired by Dr Tony Keable-Elliott (B.M.A. Treasurer). Speakers will be Dr Wendy Greencross-Kates and Dr M. Rosenbluth.

Institute of Psychosexual Medicine



Newsletter No. 23
May 1983

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LIST OF OFFICERS

President	:	Dr Tom Main
Vice-presidents	:	Professor Norman Morris Dr James Carne Dr Robert Gosling
Chairman	:	Dr Roland Freedman
Secretary	:	Dr Katherine Draper
Treasurer	:	Dr Jessie Yorston
Director of Training	:	Dr Prudence Tunnadine
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Referral Secretary	:	Dr Margaret Gill
Administrative Assistant to the Secretary	:	Mrs Mary Walford
Administrative Assistant to the Hon. Treasurer (also Membership & Subscription Secretary)	:	Mr. Ronald Trowbridge 6 Dunsells Close, Ropley, Alresford, Hampshire SO24 0DN Tel: Ropley (096277) 2439

Members of the Council:

Dr J. Dewsbury	Dr Rosemarie Lincoln
Dr Katharine Draper	Dr Mary Rees
Dr Ronald Freedman	Dr John Rogers
Dr Judy Gilley	Dr Rena Sampson
Dr Jane Kilvington	Dr Robina Thexton
Dr Jessie Yorston	Dr Prudence Tunnadine

Co-opted Members:

Dr Joan Coombs, Dr Margaret Gill,
Dr Fay Hutchinson, Mrs Nancy Raphael.

All correspondence to Letsom House, 11 Chandos Street,
Cavendish Square, London W1M 9DE

INSTITUTE OF PSYCHOSEXUAL MEDICINE

Newsletter No. 23
May 1983

Dear Colleagues,

Another important step in the development of the Institute was taken with the establishment of a permanent headquarters in London. It is at Letsom House, 11 Chandos Square, at the premises of the Medical Society of London.

Our initial gathering there was for the AGM and we were impressed and delighted with the elegant charm and comfort of the rooms which we were able to use. There is a permanent office for the use of the Institute on the ground floor and the Secretary will be available on Thursday afternoons.

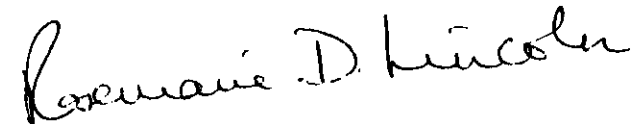
Meetings will be held there on the 2nd Thursday of each month. The purpose of which is to be an opportunity for members to meet socially for supper if they wish and then a formally led seminar will follow.

Echoes of the Brighton Conference are still heard and this newsletter contains a report from Professor H. Musaph. His impression of a sea of grey hair at the Brighton meeting was certainly confirmed at the AGM this year! The greyness of our hair explains the long discussions about subscriptions for retired members! We were also reminded that some people may not yet have contributed to the Margaret Blair Memorial Fund and may wish to do so now.

It is with some pride that we hear of requests for training from Singapore and Bahrain and that our Chairman, Dr Freedman, is having discussions with the Royal College of Psychiatry about a form of creditation for doctors who have completed seminar training.

This is the year when the work of the Institute is being published by three of its well known members; which is so thrilling and important because up until now, we have not been well known for written and published work. We do thank and congratulate all three of them.

Yours sincerely,



Rosemarie D. Lincoln
Hon. Editor

DR ANNE NEST MARY CRANE MB BCH DCH

It is with a great deal of sadness that friends in the Institute mourn the loss of such an active member as Dr Anne Nest Mary Crane. She died on the 18th September, 1982 after an extremely brave fight against a relentlessly spreading cancer.

Nest Llewelin was born in Carmarthen in 1917 and educated at Llandoverly Grammar School. In 1940 she graduated from the Welsh National School of Medicine in Cardiff and in 1943 married a fellow student, John Crane. She spent some time in General Practice and then in Community Health. Nest had a tremendous enthusiasm for her work and a constant need to expand her knowledge. Her interest in the Family Planning side of her work grew, and with characteristic enthusiasm she joined the first ever seminar group in psychosexual medicine in 1960, led by Dr Tom Main. I remember her application and dedication in boarding that weekly train from Carmarthen to London, a not inconsiderable journey. Her patients undoubtedly benefited from her constant caring and thirst for knowledge. Her enthusiasm resulted in her husband, John, also joining a seminar group.

Nest's interests were many and varied. She will be remembered for her work in soroptomism. She had been president of the Carmarthen branch and the divisional union of Wales. She had a great appreciation of art, in the form of paintings and of music. She loved to travel abroad, and always threw herself into learning the language of the country. Her last holiday before she was immobilised by her illness, was to Crete in the Autumn of 1981.

Friends in the Institute extend our deepest sympathy to Nest's family, her husband John, who is in general practice, and to her two daughters and her son, for the premature loss of an excellent doctor and devoted wife and mother.

Dr Gillian Vanhegan

NOTICES FROM OFFICERS

Notice from the Secretary

In the reports for the A.G.M. you will have read that we now have a permanent office in London. All correspondence should now be sent to:

The Institute of Psychosexual Medicine,
11 Chandos Street, Cavendish Square, London W1M 9DE

Mrs Mary Walford, Administrative Assistant to the Secretary, will be in the office every Thursday, from approximately 12 – 2 p.m. She will forward mail to the appropriate officers and can be 'phoned during this time (01-580-1043). There will be stocks of bibliographies (20p.) and leaflets (free) which she will send on request.

Notice from the Treasurer

In the Accounts at the A.G.M. the auditors did not separate the Newsletter costs from other items. According to Mr. Ron Trowbridge's accounts for 1982 it came to £888.54p.

Notice from the Director of Training

Advertisement

I have been asked by Dr. Eoin Cotter of the Ministry of Health in Bahrain whether anyone qualified in psychosexual medicine would consider a two year appointment there in relation to their family planning work in health centres. Any interested and qualified candidate should apply to him directly at

P.O. Box 42, Manama, Bahrain.

Meanwhile I have proposed to him that if no candidate is forthcoming we might be able to train his own staff for the future.

There is a vacancy for a Clinic Doctor for Psychosexual problems at the Margaret Pyke Centre. At present this is on Thursday mornings.

Please contact Mrs Sullivan at the Centre.

Notice from the Programme Secretary

Meetings for Clinical Case Discussion

Members who have completed their basic training seminars, and perhaps advanced seminars, but who are no longer in an ongoing seminar have often expressed an interest in having an opportunity to meet on a less regular basis, so that they can present their work to an informed group, and take part in discussion, led by a senior leader doctor.

In response to this need, a series of meetings has been planned for the Winter (1983 – 1984)

- Venue:** Letsom House, 11 Chandos Street, Cavendish Square, London W1M 9DE
- Dates:** Second Thursday in the month: 10th November, 1983
8th December, 1983
12th January, 1984
9th February, 1984
8th March, 1984.
- Time:** 6 – 7 p.m. Informal meeting and Refreshment.
7 – 9 p.m. Case discussion.
- Eligibility to attend:** Members or Associate Members of the Institute who have completed at least 2 years of Basic Seminar training.
- Cost:** £2 per session towards the hire of the room. As many members work all day, or have to travel to meetings, we are looking at the costs of providing a simple hot dish and fruit, or coffee and sandwiches before the meeting.
- Attendance:** If you wish to attend, please notify the secretary, Mrs Mary Walford, by letter to Letsom House, or on 01-580-1043 **only between 12 – 2 p.m. on Thursdays**, stating whether you want refreshments, so that arrangements can be made. We will need to know if you are attending the meeting the **week before** the meeting.
- Travel Expenses:** Members who travel more than 50 miles from their home may be able to get help for their travelling expenses from the Monkton Fund. To discover whether they are eligible for help they should write to the Administrator of the Fund: Mrs Nancy Raphael, 45A, Sloane Street, London SW1.

The council hopes that these meetings will fill a need and be well attended.

Publications – Dr Rena Sampson

Dr Katharine Draper has edited a book to be published by J. Libbey in June – “Practice of Psychosexual Medicine”. The Institute is to receive 12% of the royalties.

Dr Prudence Tunnadine’s book “Making of Love”, (J. Cape) is to be published in June. (See book review.)

Dr Roland Freedman has written a book entitled “Sexual Medicine”. The publisher is Churchill Livingstone.

Referral Secretary – Dr Margaret Gill

Total of letters answered this year	90	(37 from professionals)
for comparison 80/81	90	(7 from professionals)
81/82	54	(22 from professionals)

From the type of letters coming in it would seem that the work of the Institute is becoming increasingly better known and the requests for help are much more realistic than they were in 80/81.

From April 1982 there has been a list of Members and their clinics in the London Area available on request.

The Margaret Blair Fund

As Dr Roland Freedman announced in the November Newsletter, this fund is open for all who want to make some tangible tribute in memory of Dr Margaret Blair’s dedicated work in the development of the Institute, and of her immense value as friend and colleague to so many members.

The new development of a permanent home for the Institute in Letsom House is something which she worked towards and it seems appropriate that the fund in her memory might be used to purchase some special item for this.

Cheques, in favour of the Margaret Blair Fund, should be sent to:-
Mr. Ronald Trowbridge, 6 Dunsells Close, Ropley, Alresford, Hants.

REPORTS OF MEETINGS

ANNUAL GENERAL MEETING -- 18th MARCH 1983

by Dr Rosemarie Lincoln

The Training and Selection of Marriage Guidance Counsellors

The speakers were Mr. Nicholas Tyndall and Miss Joan Sullivan, Chief Officer and Head of Counselling respectively, of the Marriage Guidance Council. Mr. Tyndall described a typical counsellor as being aged about 35, female, married, having tertiary education. He thought of counsellors as ‘formal friends’ and spoke of the six parts of the counselling process.

- (1) To listen and not take sides – this was the talking and feeling part.
- (2) To help the client to understand the problem and develop insight.
- (3) The client should be able to identify the counsellor as a neutral person.
- (4) The counsellor should tease out the problem, getting to the roots of it.
- (5) To approach the problem in such a way as to ‘normalise’ it.
- (6) Sometimes guidance and advice were necessary from the counsellor.

Marital Sexual Therapy

Some counsellors were later trained in Behavioural Methods of dealing with sexual difficulties.

Clients

70% of clients are self-referred and it is a service used by all social classes, but more often by women than by men. 42% of interviews were with wives only, 33% were joint interviews and 20 % with men. A third of the clients were in their twenties. In a second marriage often the request comes early. The presenting problems were 55% personality traits, 20% sexual difficulties and 22% problems associated with infertility.

Follow-up

42% of clients thought that the counselling had helped, whereas 4/5ths of clients said the counsellor had done a good job.

Selection and Training

Miss Sullivan described in detail the training methods. Initial selection was at a local level followed by a day of selection at Rugby with two tutors and an outside assessor. 50% of candidates who presented themselves were selected. Qualities required from a counsellor are accurate empathy, possessive warmth, and creative openness. They must be able to allow other people to have a different view from their own. After a pre-training tutorial to assess the counsellor's existing skills the trainee begins working with clients under the supervision of a tutor. In addition there are case discussions with colleagues and a tutor alternate weeks and also six residential training weekends during the first two years. A counsellor must be prepared to do about 5 hours of counselling a week, usually having a case load of 6 or 7 people. Miss Sullivan made the point that the counsellor sets a model for her clients of being able to stand being in a muddle and getting out of it. Special study is made of the client/counsellor relationship. Discussion followed and members asked questions about the difficulties of combining the more directive marital sexual therapy with the usual unstructured counselling techniques in which all counsellors are trained.

2. CLINICAL MEETING (NOVEMBER 1982)

The third paper given at this meeting by Dr Joan Marshall will be included in the next newsletter.

An Introduction to Genito-Urinary Medicine

by Dr Sally Mitchison

As a family-planning doctor and Institute trainee I have recently been privileged to do a basic training course in G. U. Medicine leading onto occasional sessional work at the Special Clinic of St. Elsewhere's. I set out on this full of city sophistication but much to my surprise found myself quite shockable. Some men claimed a level of activity and variety that would be incompatible with a working life, and routine questions about alcohol intake the day before administering large doses of Flagyl, revealed a staggering lunchtime consumption. The Clinic buzzed with sexuality; we held many of our conversations in French, ostensibly because one technician was a native speaker but actually to enable us to pass racey comments on the clientele. Like all clinics of its kind, this one had several "old V.D. hands" – male technicians who had trained in the army during National Service. Their own sexual ambience was never clear and in the working atmosphere of titillation and innuendo was all the more intriguing.

Nonetheless, these old hands were not to be taken lightly. They had long memories and considerable experience and were a lot shrewder judges of character and more clairvoyant (will he come back for a second dose? will he bring his wife?) than I could hope to be in years. Our bossy and gossipy secretary had an uncanny ability to distinguish between thrush (which could wait till the morning) and gonorrhoea (which couldn't) over the phone, and also a phenomenal memory for faces – useful in identifying aliases of patients who felt too embarrassed to own up to a previous diagnosis of, say, gonorrhoea. I felt initially quite baffled by the ability of my more experienced colleagues to spot a patient's sexual inclination; how on earth did they know?. It's all very well with those who are Glad to be Gay, but some aren't and countless others are hemmed in by inhibitions soluble only in alcohol, and preferably in a foreign country. I stumbled over requests for "a full check" before I learnt that this meant a rectal examination and swabs. Women often referred delicately to "seeing" things – invariably vaginal blood or discharge. Not seeing something might indicate "falling" (for a baby). An astonishing number used no contraception but led active if irregular sex lives, suggesting in part a great underswell of desire to conceive.

There was also a fair amount of "just checking" – sometimes revealing anxiety about sexual performance or fulfillment, and sometimes an undisclosed extra-marital affair. To my regret, not everyone with an Obvious Sexual Problem wanted to talk about it but I did however see several men desperate for reassurance that a brief brush with gonorrhoea or recurrent NSU would neither affect their fertility nor be passed on to their children. Fears of "bad blood" seemed particularly strong in communities such as the Greek Cypriot one locally which retained strong moral views on chastity.

N.S.U. can be difficult to eradicate and there was a steady proportion of men who became impotent over a prolonged course of treatment. We probably contributed to their difficulties by telling them to hold off sex although logically this prohibition — if necessary in the first place — should have been extended to any form of sexual arousal which might aggravate their urethritis. We also said No Alcohol. "Isn't that just to prevent us from getting drunk and taking up with the wrong sort of company?" asked one young man, facing a second two-week prohibition. Indeed women are never told not to drink during treatment but the prohibition for men goes back into a distant past when the speciality was still known as Venereology; the reason for it seems similarly obscure. I think we probably underestimate the psychological trauma of forbidding sex and alcohol on top of the stigma of "that sort of disease". A sexually transmitted disease is clearly very stressful on new or unstable relationships. Men and women attended the Clinic through separate (but related) entrances, and frequently heated exchanges could be heard outside when two partners met up again, bringing their clinic diagnosis and determined to ascertain which of them had been responsible for it.

Most clinics are endlessly enthusiastic in following up patients. And the three-month return visit for all new patients is routine — this is to exclude syphilis. Clearly this makes sense if someone has contracted a serious infection, but for thrush or cystitis? Those most at risk tend to default while others filled with an unnatural dread, difficult for us as doctors to appreciate, often remain sexually inactive until fully cleared. Three months seems a long time. Then there is the business of contact-tracing. All clinics try to follow up contacts for syphilis and gonorrhoea, and their success is measured in the decreasing incidence of syphilis and relative rarity of gonorrhoea, compared to trichomonas, herpes or NSU, but some clinics take the business very seriously and chase around for community 'sources' for crabs and scabies. Is this worth the time or cost, I wonder? And patients don't much like having friends, lovers and "strays" (as they are scatalogically referred to in G.U. Medicine) chased up. Those on the game professionally usually come clean about this under questioning, but there are many gifted amateurs. How reliable are the names and addresses obtained from these? I found it all a very skilled and delicate business and I was very glad someone else was doing it and I merely had to ensure that certain patients encountered the Social Worker before leaving — the Clinic was carefully laid out with this in mind and it was hard to sneak off unobserved after treatment, but the regulars knew all the unauthorised exits.

I liked my work in the Clinic. The atmosphere was more relaxed and the pace usually considerably more leisurely than in Family Planning Clinics although there were predictable rushes such as those after bank holidays and Mondays are usually busy. Many clinics handle this by working an appointments-only system but in London all that meant was that the more desperate or urgent referred themselves elsewhere. It's not pleasant to sit even overnight on what you fear could be syphilis!

Mine has been a most enjoyable and educative introduction to G.U. Medicine. I hope I will continue to gain and grow through this fascinating area of work, sadly underestimated and neglected by hospital medicine as a whole.

Working in Genito-Urinary Medicine

Dr Penelope Oakley

Male patients seen in the light of Institute training.

I am a clinical assistant in genito-urinary medicine, but regard myself primarily as a family planning clinic doctor, who for some years has been used to dealing with female patients — a basically healthy and selected group. Girls and women who come to family planning clinics tend to be in stable sexual relationships with members of the opposite sex. On the whole they are able to think ahead and plan. They are often in relationships where it is the woman who takes responsibility for contraception.

After some years in Family Planning it dawned on me that the problem of V.D. was one which did not seem to crop up much in the clinics and this struck me as odd — as most other problems of a sexual nature do — so I set about gaining some experience in V.D. — initially by doing one female session, but later also a male one to see the other side of the story.

The reason why V.D. had not been much in evidence in the Family Planning Clinic was probably firstly because the organisms responsible by definition die quickly outside the body, so that unless culture facilities are good and microscopy available on the spot, often nothing of significance is found. The second reason is that the population involved is a slightly different one. Often patients in the Special Clinic are not in stable relationships, find it difficult to plan ahead and by the by are bad contraceptors — pregnancy is just another sexually transmitted condition!

On the male side one is dealing with men who are not just heterosexual but also homosexual and bisexual.

When I started a weekly male session I was very nervous. I wondered what the men would feel about a woman doctor. V.D. Departments are segregated into male and female sides — male nurses for the men, female nurses for the women. Doctors, as usual, are regarded as asexual and assigned to either side regardless.

Initially I worried about embarrassment and incompetence. It brought back the memory of first jumbling attempts at speculum insertion, with the defensive matter-of-factness, even brusqueness to hide the blushes. Again I found myself being very impersonal with these men. I worried how best to retract the foreskin, and if it should be replaced after examination; how to expose the urethral meatus and massage the urethra to express pus. The men helped a lot — they were more confident — so I had to abandon my pretences and allow myself to be taught. Gradually as my confidence grew, I was able to adopt a more matey approach, without feeling that this might be mis-interpreted. I was less concerned with my own embarrassment and how to hide it. The interview became less structured and I could be more aware of the patient as a person and what went on between us.

There has to be a certain amount of structure to the interviews in the sense that certain facts have to be obtained and certain procedures gone through to enable diagnosis and contact tracing. Treatment regimes must be adhered to if

disaster is not to overtake the patient and his consorts — however, I soon discovered that the first few minutes of contact were crucial to the outcome of the interaction. Once a relationship was established, it was OK to ask questions of a personal nature, without being perceived as prying or prurient, especially if the manner was easy and non-moralistic. The initial greeting I give tends to be welcoming and if I get a rebuff, I comment on it in some way and try to make it a real encounter if possible.

Some men are suspicious and emphasise the “doctor” bit as if to remind themselves that this is not a normal social encounter, others clearly cast me in the role of mother and become like little boys. Homosexuals can be matey — woman to woman, others are guarded and aloof. Some men start off by saying nothing much is wrong and then go on with all sorts of complaints.

The responses in fact are as varied as those of women in the family planning clinics. Some men, like the women, say at the end “I wouldn’t have your job” but I cannot remember any man wanting to see the “man doctor”. Perhaps they are less concerned than women with false modesty and feel they are more in control as men.

The physical examination surprisingly, is often a time of lessening of anxiety — especially the full general examination that all new patients get. Having blood pressure taken, lungs and heart examined abdomen palpated and reflexes elicited seems to be in the nature of a non-verbal reassurance. There is a rhythm and a routine about it. Men tend to relax under physical handling and tell you things. Then comes the crunch of the genital examination.

“Stand down and lets look at your genitals.”

Sometimes they do not seem to hear the first time, as if they do not believe I said what they think I said. Sometimes they do it with bravado. Sometimes they make remarks like “Oh it seems to have shrunk” or apologise for an erection.

Finally there is a rectal examination to check for evidence of prostatitis or other abnormality. This is an opportunity for men to express their anger at the indignity of coming to the clinic in an acceptable way, without getting at me personally. Sometimes they cannot show any anger and submit without protest. I have never known anyone refuse, but they often have the last word by saying “Doctor, tell me how much longer I am going to have to wait now?”

Usually in our society any difficulties experienced by a doctor and patient in examination are not voiced openly. Once, however, I had an Arabic patient who did this. He was able to tell me how he had slept with a prostitute and had got a yellow discharge without any embarrassment. I was a non-person, then I said “Drop your trousers and lets have a look.” He looked me straight in the eye like a Biblical patriarch. “Woman”, he said, “Aren’t you ashamed?” And of course I was, desperately! I was totally unable to point out that he should be ashamed at having gonorrhoea, and just muttered “I am a doctor.”

This in fact is always our defence in the face of pain, suffering or embarrassment. He was saying I am a man and you are a woman, and I countered with I am a doctor and you are a patient.

Luckily it is not normally necessary to spell this out and Institute work tries to help us break down the barriers we erect to protect ourselves, which stop us seeing real people with real feelings.

So in the V.D. Clinic I had to build up defences until I had enough confidence from having coped with hundreds of different men to be able to do without them some of the time. I began to realise that using the doctor/patient relationship was possible and not threatening.

I had discovered in my role as mother, that my love for my children did not depend on their behaviour, I loved **them**. In a similar way I found I could respect the patients in front of me regardless of their behaviour. In other words I was perhaps seeing them rather like children. It is difficult to treat your peers like this. In fact my greatest temptation is always to try to teach the patients, but the best moments seem to be when they tell me things and I show that I have heard. It seems that acknowledging their perceptions is helpful to them.

One of the other difficulties I had at the beginning was embarrassment about establishing whether a new patient was homosexual or heterosexual. This is necessary as homosexuals are more at risk from certain diseases, and have more orifices from which to take cultures and smears. In fact I need not have worried. Most homosexuals are nowadays quite open about it, and if in doubt one can always ask for the name of the consort. Only rarely does one have to ask “is it a man?” Some homosexuals are active — i.e. they do the penetrating, and take great pride in their maleness. Some are purely passive — sometimes they even complain of dyspareunia — I had one couple where the passive partner had pain on intercourse only with his regular partner, not with casual encounters. His boyfriend was jealous and hurt. I examined the passive partner in an attempt at a psycho-physical examination as with a female patient. — but found myself very much a non-person, and did not get very far — he was definitely not a woman.

Some men can be active or passive as the mood takes them, and these men can be extremely active sexually. Some are bi-sexual. Very few homosexuals seek help with their sexual orientation and do not usually complain of potency problems or prematurity — or perhaps any sexually disabled homosexuals just do not need to come to V. D. clinics so often.

Like Family Planning Clinics, V.D. Clinics are seen by men also as appropriate places to come and complain of sexual problems. Often they bring a discharge as a visiting card like the women, until they can gauge the manner of doctor they have to deal with. Initially I felt totally inadequate as a woman to be of use to them, and having tried my version of Masters and Johnson techniques with a bit of Kaplan thrown in, have attempted to deal with them in Institute ways, as with the women.

In fact one’s sex may be helpful — showing a man how he is behaving with this woman. However it is often easier for men to assume they are in awe of the doctor in front of them rather than the woman, so it is better if when I see them I am not also wearing my V.D. doctors hat and treating them for NSU.

Many men are not amenable to Balint techniques, because they insist that the problem is organic, and if they are not given pills, then it is a waste of time to talk, so it is good if some sort of rapport can be established very quickly and something shown to them that convinces them that it might be useful to talk even if no magic pills are on offer.

So there are many similarities between the family planning clinic and the special clinic as well as a few differences. In both situations the patients usually walk in unreferral and without an appointment. There is a large overlap in the populations – both tend to be young and sexually active. There are rather more people in the family planning clinic who are in a stable relationship and rather more in the V.D. Clinic who are not.

In the Family Planning Clinic the patient comes for advice, in the Special Clinic for diagnosis and treatment, so what the doctor decides is more important, but the setup is similar – a doctor, a patient and back-up staff. The doctors in the Special Clinic have more opportunity to discuss together and ask each other advice than in the Family Planning Clinic.

From the patients point of view they are more likely to be frightened, suspicious and angry and may be faced with a doctor who indulges in white lies and duplicity to maintain confidentiality between partners and protect the innocent – so tends to treat them more like children than adults – different from the Family Planning Clinic.

But with all this there is a real need to allow patients to voice their anxieties and have their questions answered honestly, and the nature of the disease explained.

Some men are quite capable of giving up sex altogether if they think they have an incurable form of V.D. – out of all proportion to the seriousness of the condition, so that a little initial explanation, accompanied by an opportunity to explain their fears and doubts is common everyday stuff in the Clinic – preventative psychotherapy to limit the chances of V.D. neuroses. Where Institute Training helps is that it stops one relying on reassurance alone and sometimes leaves one open to let them express their fears and fantasies which is much more helpful for them, and certainly saves time in the long run.

A SINGAPORE TRAINING VENTURE

by Dr P. Tunnadine

It was a challenging surprise to be asked via Prof. Norman Morris to go at short notice to Singapore to “put on a course like that run by the Institute at Brighton”, requested and sponsored by the O and G chapter of their Academy of Medicine.

It was of course both impossible and irresistible! About 50 attended for four and a half days; gynaecologists, some of considerable distinction, G.P.’s and family planners, psychiatrists and a few clinical psychologists, social workers and others. The cultural mix was as rich as that exciting city and neighbouring Malaysia can offer. I opened each of the two hour work sessions with a short talk on our experience of each topic, and then led discussion of their work. Apart from the concentrated pressure of such a “crash” course it was just like home. Their problems were just like ours when we began. Non-consummation is rife; religious and cultural and generation-gap reasons offered. “Ah, but you see Chinese girls – or Muslim girls – are all brought up to be different . . .” when here I would have heard “Ah, but you see all Irish Catholic girls . . .”.

They, like we did, have to fight for training in this field, the fear being that encouraging sexuality leads to licentiousness and the breakdown of moral values. Some had tried their best with Masters and Johnson, arranging two hour sessions with two co-therapists per couple and beginning to recognise its limitations. Like us they crave certainty in a field in which uncertainty is threatening for doctors, and pathognomic in patients! By the end they were beginning to buzz, and to reveal the usual parting dissatisfactions. “But what do you do with cases of . . .?” and “What books can we read?” Well, we have a few now, don’t we?!

In the last session a professor of gynaecology – one of three present – was bravely reporting his own work. He and his co-therapist had spent half an hour taking a careful history from an awkward vaginismus “little girl” of thirty without getting round to the sex life. Tunnadine “wondered why?”. “Oh it’s very important to go gently and get their trust. I always do”. A general discussion about what all the others “always do” made me feel I had fallen upon stony ground. But then his final case. This provocative lass complaining of discharge and lack of orgasm got no long history taken. Up on the couch, swab, sharp lecture, prescription, out!! And my glimmer of reward at last. Three leapt in – not just two outstanding G.P.’s, one male, one female, whose brief contact with Michael Balint had shone through from the first day. No, three leapt in. “Hey, you didn’t go gently to get the trust of this one!”

Dr Main has always insisted you can’t do much in crash courses, and yet again, dammit, his lifetime experience is vindicated. But it was fun – and they did suggest we hold our next International Conference there. They did ask me to act as their medical advisor if they can get their own Association started for regular case discussion. And George Pinker and I, who have exchanged patients across the street for years, met at last face to face as honoured guests of the RCOG dinner at Raffles Hotel!

Elsewhere you will find an advertisement for Bahrain. If we cannot find a leader to fill it, we will try to find a way to train their own people, I or another going perhaps monthly and Dr Main by telephone seminar between visits. Or nothing may come of it. But it is clear that we are becoming known and sought as trainers far afield, even though we may seem to remain prophets without honour in our own Regents Park. It will be exciting to see how far we can adapt our training methods to respond to such requests.

THE FIRST INTERNATIONAL CONFERENCE OF THE INSTITUTE OF PSYCHOSEXUAL MEDICINE

Professor Dr H. Musaph, Utrecht

This conference was held at Brighton on the English South-East coast on July 7th – 10th 1982. The Institute to which only medical men and women doctors can belong arose from the Family Planning Association of Gt. Britain. The birth control movement was founded by Mary Stopes, the English Aletta Jacobs, and the FPA followed on the birth control movement and has founded clinics for contraception and sexuality all over Gt. Britain mainly manned by female doctors assisted by female social workers. The doctors are being supported by gynaecologists and psychiatrists. In the sixties the famous psychiatrist, Dr Michael Balint, was called in, applying his method of dynamic group training to clinic doctors who had asked for his help with patients with sexual problems. The treatment of the problems by use of the doctor/patient relationship is the centrepiece in this approach. After the death of Dr Balint the leadership was taken over by the present President, Dr Tom Main, a psychiatrist and analyst, formerly superintendent of the Cassel Hospital in London.

This previous history makes the composition of the audience understandable. There were 188 participants, about 80% being females between 45 and 65 years of age. Sitting in the back of the hall one had a curious view; almost everyone had shortcut grey hair or hair turning grey. In personal conversation with these doctors there emerged what an enormous experience these women had had in dealing with the most difficult social situations of patients in which people from 13 to 50 years could be. It seemed that they often did their job with idealism and patience and at a ridiculously low fee! Most of them were well informed of the current psychiatric conceptions of which psycho-dynamic, social-psychological and cultural insights are the nucleus. Thus I quickly had the feeling of recognition of being amongst congenial colleagues. In the group sessions in which I took part, it struck me in particular how short the acquaintance period was that led to an intensive personal exchange because we had the same pattern of thinking and the same technical jargon. Phenomenologists would have talked of a 'real' meeting.

Every morning there were two lectures with discussions. Thursday morning Dr Roland Freedman, a G.P. from Newcastle-upon-Tyne, gave a survey on sexual problems in General Practice. He pointed out the non-sexual complaints of the patients which may mask the underlying sexual difficulties. He mentioned relationship problems in marriage manifesting themselves somatically in tension headache, low-backpain, pain in the lower stomach and eating disturbances without organic abnormality. However, he did not forget to mention the physical illnesses that first show themselves in sexual dysfunction in man and woman. Afterwards Dr Hutchinson gave an impressive survey on the problems of 14 - 17 year olds belonging to the poorest socially economic sections of the population where unwanted pregnancy was mostly the reason for the consultation. Such an unwanted pregnancy is a signal of great psychosocial stress. Abortion itself is like 'washing the floors with the taps running', one cannot let go of these people after the abortion, after the therapeutical. Furthermore she

told that a child of 14 – 15 years old refused to have an abortion as was demanded by her mother. The child was hoping for a child so that she finally would have a little creature of her own to love her. She also touched on the alarming problem of incestuous relationships in these inadequate families.

In the afternoon Dr Bramley from Sheffield talked about the problems of the couple with non-consummation. Her ideas are similar to ours which are based on experience gained in the Polyclinic of Sexuality of the Academic Hospital at Utrecht. Dr Rosemarie Lincoln from Norwich and Dr Robina Thexton from London discussed non-ejaculation which they treated with short psychotherapy 'on analytical lines'. The experience of this problem is the same in the Netherlands.

Dr Proctor from Newcastle gave an account of couples with non-consummation who had reported themselves to a clinic. It is interesting to mention that of 50% of the couples contacted by follow-up replied – the same percentage we had of our survey in Utrecht. The cure percentage lies internationally on a somewhat fixed level, that is to say, between 70 and 80% no matter what therapeutic strategy is being used. She was of the opinion also that the doctor-patient relationship is the most important and decisive feature.

Dr MacDonald Burns, Urologist from The Royal Free Hospital in London, gave a survey on pain in the genitals of men who he had encountered in a clinic for sexual communicable diseases. On Friday morning Dr Alexandra Tobert from Nottingham gave a survey on family problems that can manifest themselves sexually and physically after childbirth and she especially discussed the secondary frigidity of women.

Dr Jessie Yorston from Romsey gave a survey on causes of impotence. What seemed interesting to me was her experience in physical examination; the fear which many men show when their genital is being examined by a doctor can be dealt with by discussion and can be used to trace the psychogenic roots of the impotence. (Perhaps this should read – Permission to be angry with women is a constructive therapeutic strategy).

The afternoon was spent on more specified scientific research. I had the privilege of giving a lecture about post-examination follow-up on couples with non-consummation two years after their discharge following successful intercourse. Our finding that the significance of the methods of Masters and Johnson, especially consisting of the sanction of sexual relationships, identification and decrease of feelings of guilt appealed strongly to the participants of the conference.

In the evening there was a banquet and our work in The Netherlands was praised as I hope not only from politeness! Saturday morning Dr Prudence Tunnadine from London, Director of Training of the Institute, gave a speech which left me with a deep impression. What struck me was the courage to pierce through fashionable conceptions about sexual behaviour. In this way she told of many women who on strict social indications had experienced therapeutic abortion and who had later complained of different complaints about sexual function. Their complaints were mostly based on the feeling of having been deserted and the lack of psychological help. Having had a very refreshing experience we had to leave the conference the last word of Dr Main because of a railway strike and having to be in London in time.

ARTICLE

The Ethics of Telling the Patient

by Dr Lawrence Goldie

The question whether or not to tell a patient the truth usually arises in connection with cancer. One would expect it to arise with other diseases but it does not do so. There does not appear to be the same debate about telling patients they have disseminated sclerosis, or coronary disease as there is with cancer. The issue, therefore, is not simply a matter of telling the truth it is a matter of telling the truth in one circumstance and not in another. Thus what the word 'cancer' signifies to the patient is supposed to influence the doctor in his decision to lie about the diagnosis. In fact I believe the decision is more influenced by the doctor's own feelings about cancer than by the patient's. Virtually all patients attending for diagnostic, exploratory, or other procedures, in the early stages of any malignancy, have in mind the possibility of cancer. The doctor's decision, therefore, is not whether to tell the patient the truth, or to deny it, but whether to play out a charade, with the patient, of normal life and prospects, in the presence of incontrovertible symptoms and signs of the growing cancer. The charade may include other players; a surgeon may tell a spouse not to use the word cancer to the patient and urge a pretence that it is something else by using words like, 'lump', 'ulcer', 'abscess', 'blockage', with an added diminutive as in the phrase 'it's just a little growth'. This may mean, for example, a patient knows that his wife knows, but they do not speak of it to each other! The doctor's decision to initiate this restriction on free speech, and the truth, disrupts any normal intercourse, so that couples instead of growing together, wither in each other's arms.

In many diseases the doctor, not necessarily concerned with the truth for its own sake, may press home 'the truth' in order to induce patients to submit to unpleasant procedures that they would (it is presumed) wish to avoid. Less commonly and with less effect it is used to induce a patient to change from a destructive way of life. For example, an attempt may be made to activate an obese, physically inert individual into constructive adaptations after a heart attack, by telling him he is in grave danger if he does not change. With cancer, however, a point is commonly reached when it is believed that nothing more can be done by the patient or the physician, to alter the course of the disease. This is also the case with, for example, multiple sclerosis, where there is no alteration in life-style that we know of which can materially alter the progression of the disease. However, the patient is generally told the truth, though the manner of dying is more likely to be painful and difficult than it is with most forms of cancer. What a patient is told about the diagnosis and outlook may be determined by the fantasies about the illness and reactions to it in both physician and patient, rather than by the nature of the illness itself. Physicians may know the actuarial realities of a disease, and its outcome, and they may use these to avoid describing the various real-life scenarios that characterise life with a particular disease. The statistical prognosis may be used to justify optimism, and a particular form of treatment. This is the most pernicious form of lying because the

statistical 'odds' do not tell people what they really want to know: their personal prognosis. At best this ploy encourages a short-lived gambler's euphoria.

The medical attendants have fantasies about the consequences of telling the truth, and this often determines their behaviour in the presence of patients. The most common 'philosophy' for action is to avoid mentioning the worst for as long as possible. The 'worst' often being an eventuality, if the patient and his or her resources are unknown to the doctor, conjured up in fantasy. For example, Lyn came from another hospital, where she had attended but had refused to continue. She was a young woman of 22, who had been studying physiotherapy before she got married. After her first baby was born she diagnosed that she had cancer of the clitoris. She told the surgeon this before biopsy and operation. When she arrived on the ward, prior to operation, she so dismayed the ward sister by telling her the diagnosis, that the sister asked immediately for an inquiry to find out who was responsible for her knowing the diagnosis. At a later date the patient saw another doctor for radiotherapy, and he infuriated her by trying to persuade her that she was mistaken in thinking that she had cancer, and by putting on an act that she thought was an insult to her intelligence and character. She was so hurt and mortified that she refused to re-attend the hospital. Once during a discussion with the author she said that 'patients' should be told the truth . . . she then had to stop short and she paused as she absorbed the truth, the truth about herself, she actually had cancer. She was a patient. Transiently she said that she had felt that she was discussing something that happened to other people. She went on to describe how her father had died when she was 12 years old of cancer of the lung. Her mother was told not to let her husband know. Her mother was still distressed and guilty at having obeyed this injunction. She still wondered what her husband had thought and needed. The patient felt that the conspiracy of silence had prevented them from sharing his most intimate thoughts and she still wondered if her father had wanted to say something special to her before he died. Lyn was intelligent and sensitive and I was asked to see her because it was thought that, knowing her condition, she would become depressed. She discussed her life without reproach. She was sad without being persecuted or resentful. She could manage her pain, her discomfort, and her relative isolation, without anyone, but she seemed to value the discussions. Though it was a privilege to talk to her, few had the courage to do so and significantly nurses, all her contemporaries, rarely chatted with her, presumably because they were frightened of the challenge she presented, knowing her diagnosis and too readily seeing themselves in her place.

A patient may be given bad news in many different ways — none can make it good! Patients may be told without having to ask questions or they may be told the truth in response to a question. Should people be told that their remaining life is very limited, and the way it will end, even if they do not ask? Alternatively should they be told in order to give them the opportunity to discuss their life and its future? The patient may need to make various arrangements and preparations for his or her demise. Is it then ethical or fair to decide, without the patient's knowledge, what he should or should not know about his own life? Is it right to assess a personality, and its potential, without knowledge of its strengths and weaknesses, after a brief contact arranged for an entirely different purpose? The position is rather similar to knowing that an individual is

going to have to perform a task requiring considerable fortitude and endurance. The individual is kept in ignorance of the true nature of the task on the grounds that it is best not to anticipate an unpleasant experience, so that the individual is shocked and unprepared for what then transpires.

The truth can be told in many ways and there are many variations in the circumstances of the telling. Should people be told the frightening diagnosis bluntly and plainly in five spare minutes in a busy out-patients clinic? With no time to give comfort and help them cope with the aftermath or for further questions? Or is it better to tell the patient in conditions of privacy, where time has been allocated and protected in advance (by ordering an embargo on calls and interruptions, for a specified time)? Doctors in general do not know how to pace themselves, and to generate excitement and an appearance of Herculean labours coped with heroically they appear nonchalant and are eventually careless of other people's time. For instance, some out-patient departments are full because a doctor, careless of public dignity, has made 50 appointments at one time. This also has the effect of embarrassing patients into silence and leaving no time for questions.

The truth may be told quite plainly, the diagnosis being given baldly without preliminaries, or questions. On the other hand a patient may use a pause or diffidence in the doctor and ask 'Have I got cancer?', or 'Am I going to die?'. The response to these questions may be mature consideration and simply, 'Yes', or 'No'; or 'It would appear to be so', or 'What do you think?'. Despite the doctor's fantasies about what he would feel in the circumstances, there can be a presentation of the truth by simple statements, refusing to deny what the patient already knows, and with gentleness, compassion and sensitivity, following the patient's lead as he tries to live with the doubts raised by the disease. One patient for example, not suspecting that anything serious was amiss, went to hospital for 'blood tests'. Subsequently, because of the nature of the results, an appointment was made for him with a physician. Without preamble the consultant presented him with the news that he had a very serious form of leukaemia! The patient collapsed and was incontinent of urine and faeces. One might surmise that had the patient been told by his general practitioner what was being considered and had he had an opportunity to discuss the various eventualities he might not have been so defenceless.

I was taken by surprise when Mrs. S was pushed into the consulting room in a wheelchair. I had not read her case notes or the referral letter. Her husband, who had pushed the chair, disappeared as he closed the door behind her. She was slumped, crumpling in her wheelchair, haggard, grey, and emaciated: a woman in her early forties, obviously a shadow of her former self, whimpering with despair. Her first words were, as if surprised and incredulous 'I am not getting any better?' I said, 'It does appear so'. She said 'I am going to die then?' and I said 'Yes . . .' She said 'Soon?' I said 'Yes, but I do not know when . . .' She said 'I want to be here for my grandson's second birthday'. I asked when that would be. She said 'At Christmas time'. That was approximately five months away. I said that I did not know whether that would happen. This interview took an hour. During it she visibly altered, she straightened up in her wheelchair, and her demeanour changed. She stopped whimpering, and the conversation

after these initial exchanges, took quite a different direction. She reviewed her past, and the ways in which she had been fortunate. She had had two sons who had just missed being old enough to have been in World War II. The transformation was remarkable, true hope and optimism replaced despair. She was asked why she had in the past seen several psychiatrists. She said that in her younger days she had become depressed at one time, and her general practitioner had referred her to a psychiatrist. As a result she saw eight psychiatrists, but none of them had spoken to her for more than ten minutes at a time, and the treatment had consisted mainly of the prescription of various tranquillisers and anti-depressant drugs.

Subsequently, whilst her physical condition deteriorated, the patient developed and her relationships with other people burgeoned. She succeeded in repairing damaged relationships and resolved a family feud. She had a steady stream of visitors, and was forthright in urging them not to use euphemisms, but to speak plainly about her illness. She told them that she knew what it was, and she knew that shortly she would die. It was interesting to note that one night-nurse so enjoyed the patient's company that she often visited her in off-duty time. When medical professionals speculate on whether patients should be told the truth or not, they rarely have this type of experience to draw upon. Their judgement is then based upon fantasy, usually generated by putting themselves 'in the patient's shoes', presuming that they know the patient's mind.

In another instance the psychotherapist was asked to see a patient because she was due to have a severely mutilating operation in three days' time. The psychotherapist arranged for the operation to be postponed, to give the patient time fully to appreciate and discuss the consequences of the operation. She had carcinoma of the tongue. To remove it would involve the sacrifice of all or part of the tongue, and part of the jaw. Subsequently there would be several plastic procedures to remedy, partially, defects in the skin and bone of the jaw. The patient discussed the operation with the surgeon and separately, with the psycho-therapist. It was thought that the operation would make the terminal stages of the disease more bearable: the surgical justification for the operation was not to prevent the lesion from extending or spreading. What the patient was told appeared to be the truth, and she made her decision. But she was not told the whole truth. The patient was told that surgery was an attempt to get rid of the disease and that there was no certainty that it would do so. The whole truth was in fact that whether the patient had the operation or not she was almost certain to die from an extension of the cancer. The various options and eventualities, and the price to be paid in deformity and suffering, for the dubious benefits of the operation were not discussed. The sister, an expert in nursing such patients, had no doubts that she herself would not have had the operation. But because the patient was not told the whole truth her lips were sealed, and she supported a course of action she did not believe was constructive. One can only speculate as to what she would have told the patient before operation.

Medical training advocates that the scientific method should be applied in clinical medicine, the aim being to provide conditions that enable observations

by one person to be repeated by different observers at another time and place. The doctor looks for signs and symptoms of a disease seen elsewhere at other times by others, so that what has been observed in an experiment to alter the course of the disease can be repeated. Unfortunately this has encouraged clinicians, who are generally inept and gauche when it comes to observing and studying psychological phenomena, to ignore the whole person, to dispense 'psychology' in a few favourite aphorisms, and then to concentrate exclusively on the physical. Generalisations about disease, and particularly about physical signs and symptoms, can be useful according to this 'scientific' approach, whereas generalisations about personality, character, and emotions are generally misleading, though seductive. But psychological phenomena, though they are far more complicated, can be usefully observed and categorised, though this requires different gifts and different methods from those a doctor could be expected to have. The first real attempt to do this observing and categorising was made using the psychoanalytic method. This method has since led to an approach which may be designated 'the psychotherapeutic approach'.

The object of enquiry here is the mind, and its contents, and physical methods of investigation are inappropriate. Furthermore, the investigators are both the patient and the psychotherapist, partners in the endeavour to obtain a true appreciation of what is in the mind. In studying human beings the scientific method attempts to eliminate the influence of the 'subjective factor'. Psychoanalysis and psychotherapy make the subject — the person — the observer of feelings, the object of study. The process is difficult, requiring talent, skill, experience and technique, the patient being both an observer and also an unwitting source of distortions of the truth. A patient may seem to be giving an account of his feelings, yet, wishing to deny their significance, he may play some down and exaggerate others. Obviously the 'observer' will be changed, and the powers of observation reduced by anything which suppresses the brain. Drugs, toxins or alterations of body chemistry which cloud consciousness, or produce disinhibition will alter the ability to perceive and the capacity to distinguish between 'inside' and 'outside' in the mind. The skill of the physical scientist is evident in the way in which he asks his questions. Questions are formulated so that an attempt at answering them can be made and the very attempt results in new information being acquired. The main reason for using this method is because it works but the motive can be anything from the wish simply to discover the truth (pure research) for its own sake, to wanting to make money by finding products that can be sold profitably or to wanting to make more efficient instruments for destroying life (invention and applied research). Psychoanalysis may be likened to pure research (as opposed to applied research, equivalent to symptomatic treatment) and is an attempt to know the truth about what goes on in the mind. Psychotherapy, however, uses the psychoanalytic technique in searching for the truths which will help people to reduce unnecessary suffering and survive it when it is inevitable. The therapist with conviction based on experience believes that this is the best way of helping individuals cope with unease, or disease. From this point of view it would be

unethical to help the patient or anyone else to obscure, fudge, or distort the truth. In practice it is both honest, and reassuring to patients, for them to be told that this is the ethic and aim of the procedure, the psychotherapeutic endeavour. Obviously one would not begin to seek out and display the truth without undertaking to remain with patients whilst they digest and assimilate it: to do otherwise would be like performing a skilful surgical operation and then leaving the skin unsutured, the wound uncovered, and the patient deteriorating. For the purposes of treating the disease the scientist/doctor must know the truth about the physical processes in order to treat and to have the ability to predict to some extent the course of events. Is it ethical to do so without letting the patient know what is believed to be going on in his body, what risks he is taking, and the future that is being planned for him? It would be like having an expert in to examine the water system in a house without being told what the expert finds, what he intends to do about it, and above all the cost. It would be intolerable, yet this is sometimes the position of the patient in relation to the medical expert. He is deprived of the privilege of knowing, in terms that he can understand, what the expert thinks and prognosticates. The expert then decides his fate without knowing the patient's character and strength — the doctor may think that he knows, having put himself in the patient's shoes, but that is the best way of not knowing what another feels! Psychotherapy, if it succeeds in making the truth available, gives patients the freedom, if they want to use it, to act and to take responsibility for their future.

Most doctors, if asked about their hospital work, would give quite a sensitive account of the dramas played out in the hospital and in their work. For the most part they would feel that they know how they appear to patients, and would probably have very definite ideas about how they should and do behave towards patients. As Balfour Mount has shown, this is erroneous (1). But they have not considered themselves as victims of the covert destructive limiting forces in a hospital. These forces, in the form of social and group pressures — can severely restrict freedom of thought and action. They arise especially when groups of people feel exposed and vulnerable. Living with doubt and uncertainty leads to denial. In war-time this was seen in the humour of the air-raid shelters; the apparent nonchalance of airmen — death-dealing and facing death. (Part of this process was the brilliant and officially encouraged RAF magazine Tee Emm. Full of ironic and at times macabre humour with the bawdiest of origins, it contributed dozens of colourful phrases and idioms to every-day English). Wards for patients with muscular dystrophy — virtually all boys, with none surviving beyond the age of 18 (exceptions reach 20 — 22 years of age) sometimes have the atmosphere of an air-crew mess. Patients are calm and cheerful, with the weekly news of someone who has not survived the weekend producing a wry comment and barely a ripple in the organised surface of routine and bonhomie. For less constructive purposes the same denial operates in the staff of other institutions. In psychiatric hospitals in the Soviet Union which incarcerate dissidents and political opponents of the regime, the staff exonerate themselves from blame by denial. They deny that anything destructive is happening by attributing destructiveness to the victim, or they justify their participation on

the grounds that they as individuals are powerless to alter the system by influencing colleagues or superiors or disobeying orders. The arguments and rationalisations have a familiar ring because they are ubiquitous defences against truth and depression. The hospital, where life and death issues condense and concentrate, produces similar reactions in the staff.

In the presence of pain, imminent death and mourning there can be amongst staff a cheerful appearance of dealing with the commonplace as if they have no responsibility for what is happening. Nurses cannot help what doctors do, or fail to do. Doctors cannot act without a superior's permission and superiors feel that they cannot change the system, claiming to be victims of the administration, the political system or inept colleagues. Solzhenitsyn in 'The First Circle' describes the tremendous effort needed by 'victims' of the system to retain their integrity and independence of thought. The forces that coerce and seduce staff are in proportion to the presence of unrelieved stress. Hospital personnel react in a quasi-military style: uniforms, ranks and deferential treatment of staff high in the hierarchical system are how they are ruled. General hospitals manifest such denial and specialist hospitals which produce an overwhelming concentration of feared conditions have even more hidden but rigid ways of preventing the emergence of doubt, fear and independence — like the 'specialist' in 'The First Circle' prison of Solzhenitsyn's account.

The hospital produces imperceptible measures to encourage compliance in the patient and the minimum of awkward self-appraisal in the staff. This can be very tortuous. For example, it may become undeniably evident that the large number of patients who have cancer of the breast need something extra by way of consideration of their feelings. The staff, medical and nursing, acknowledge the need, create a post — with a new title, and fill it with a member of the staff. The staff member is no better equipped for the work than anyone was before the new slot was created and he or she continues to do what nurses and medical staff should be doing anyway in their traditional roles. The important function of the manoeuvre is to deny that there is a special need which none of them are satisfying. This need should be met by a specially trained person, appropriately orientated by vocation and training, being brought in to attend to those areas of care and concern which are being neglected. As far as the new appointment is concerned the fear is of the unknown; medical staff fear an approach of which they have no knowledge — they react as if issues are going to be raised and forces unleashed which they cannot control. Hence new appointments are given to controlling figures who can be understood and identified with. In the cancer hospital the 'military' state of mind is evident in the jargon which is in fact used in describing 'aggressive' treatment regimes against 'invasive' or aggressive disease. The word 'cancer' is avoided by referring to 'the disease'.

A young man had a recurrence of a cerebral tumour and became morose and depressed. It was feared he would commit suicide, though he had never expressed this intention. This presumption (or fantasy) was not based upon actual knowledge of what the patient had in mind. It seemed so obvious and certain, that no one asked what he thought and he was never left alone. With

ingenious frankness he opened our conversation by saying that he had just been to Paris and when he went with a prostitute found that he was impotent. He could not masturbate either and this dismayed him. He was also very upset because he had interrupted his career to come to this country to have the operation to remove the tumour. By now his fellow medical students would be well ahead of him. Thus the staff by putting themselves in his shoes had misconceived his thoughts and intentions — worse still, their certainty that they knew what he was thinking meant that no-one inquired! Subsequently the patient left the hospital and as an out-patient became engaged in psychotherapy with interviews four to five times weekly. His mood changed, he took up swimming and squash again. After six months he re-applied for a university place and was accepted. This young man, with a serious physical condition, is not so concerned by it as he is with what are for him much more important problems. On the ward he became a victim, literally a prisoner of the staff's delusions. He was not given the opportunity to say what he thought. The psychiatrist was asked to see him merely in order to effect his transfer to a mental hospital. In other words the patient stood accused without knowing why.

These 'Kafka-esque' situations arise because the 'carers' have fantasies about cancer and death and in enacting them may make the unwitting patient suffer. This is a very common situation and patients react to these implicit accusations and delusions about themselves in a variety of different ways. The patients may respond by trying themselves to make 'sense' of incomprehensible behaviour and messages. Some patients are often described as 'paranoid' when in fact they are suspicious with good reason. The most common situation is where patients are bewildered. No one has discussed with them the nature of their disease and yet they are subjected to various investigations. The most common reason given for failing to discuss the disease and possibilities with the patient is because the investigations are not completed. In fact the truncated conversations on ward rounds and the vagueness of replies to their questions (to avoid being committed) leave patients bewildered and suspicious. Even when the news is bad, patients often express relief because the truth removes doubt and gives them a rational explanation for the investigations and for the concern of their doctors. Apart from the painful feeling of being excluded, patients are, by these devices, prevented from considering and influencing their own future. People who are seriously ill for the first time may be worrying about their home, particularly if they live alone. They may wish to plan for the benefit of relatives if the treatment is going to be prolonged. Social workers, if available, may not be able to discuss alternative arrangements because the medical or surgical teams have not committed themselves to a diagnosis and prognosis. The length of time they will be in hospital, the degree of incapacity they can expect and the probable length of life is unknown, undiscussed and imprisoning. This is unethical interference with patient's lives. Their freedom of choice is by these means taken away from them. Thus patients in these circumstances are inadvertently made into prisoners, with others deciding their fate.

The last case illustrates rather painfully some of the consequences of doctors and nursing staff acting upon what are nothing more than fantasies — uninspired guesses, about what other people think and feel. It is equivalent to prescribing for patients without examination. Mr. P. decided, when his cancer of the oesophagus was discovered, to forego any treatment for it. A year later he was referred to the psychotherapist because he was thought to be 'depressed'. When interviewed it turned out that he was depressed because his vision was blurred and he could not co-ordinate sufficiently to write. And this, it turned out, was due to the side-effects of three drugs which were 'anti-depressants' and 'tranquillisers' and three drugs which were for the relief of pain. He had been given these drugs because it was presumed that he would be in pain, yet he said he had never complained of pain. The tranquillisers were given because it was thought he would be anxious as death was close. He said that he was not afraid of dying but he was concerned about the possibility of dying through choking, with no relief available. In effect he had been given drugs without having a condition which required them, and his ability to think and act as he wished, constructively, had been taken away from him. He had not been told what the drugs were for and they had in effect imprisoned him in a nightmare. All these drugs were stopped and he went home. There, he went over the household affairs with his wife, teaching her how to do many of the odd jobs that he would have done, as he anticipated that on her own she would not call in an electrician, for example. He taught her how to change a fuse and to understand the ring main. Several months later he phoned in saying that he 'had had enough'. He was admitted and his oesophagus was virtually closed off. He could just swallow a teaspoon of fluid. He was still a well nourished robust-looking man, and it was as if having completed his task there was nothing more to do, and on his third day after admission he died — peacefully.

Sometimes the hospital, or part of it, can become like a totalitarian state, with a limitation on the subject's freedom to think and act independently. Perhaps as a legacy from the days of the poor law institution, when medicine was a charity and patients were expected to be deferential and effusively grateful, so sometimes today patients may be treated as if they were privileged to be in hospital at all and receiving treatment. In fact it is the healthy doctor or nurse who are the privileged parties as they are by chance healthy, and free to be of service to those less fortunate. One feels that what was once urged in retail shops by progressive and enterprising shopkeepers ought also to apply in a hospital: 'The customer is always right!' So too the patient is always right, including the patient who complains and the patient who complains too much: indeed the latter may be a patient just because he complains 'too much'.

Meeting a 'patient' is a very special event, a transaction to be handled with great care. The 'patient' in most instances cannot escape the meeting. As the nurse or doctor one is empowered and able perhaps to impose oneself, awkward and inept, on another. Patients have the power to refuse others entry into their world — but because they hope something good will come of the meeting and to avoid hurting another's feelings they hide their misgivings. Staff may thus be

misled, and being preserved from self-knowledge by the sheltering title, and position, stalk the wards unaware of the tolerance they are being shown. Often they are manifestly eccentric, assuming as they pontificate, that they are superior to the row upon row of horizontal ordinary folk, casualties precipitated into vulnerability. The caring professionals, the healthy ones, are in great danger, for their characters become shallow and fossilised if they fail to realise their humble position — and their privilege.

Reference

- (1) Mount B M. Death and dying — attitudes in a teaching hospital. *Urology* 1974. Dec; Vol 4. No 6.

CORRESPONDENCE

In response to the letters published in Newsletter Number 22 from Mr Elliot Philipp and Dr Anne Smith, the following have been received:-

From Mr Elliot Philipp:

Dear Dr Lincoln,

I have had a terrific response to feelers I put out about the reaction amongst women when a Pap smear is taken from the cervix.

My difficulty at the moment is to design a proper pro forma or questionnaire to send out to gynaecologists and others who take smears so that they can carry the research still further. I will concentrate on this shortly and take further advice from some of the dozen doctors who have been kind enough to be in correspondence with me. I have replied individually to every one of these doctors but for various reasons, chief of which is the difficulty in designing a proper pro forma, I have not advanced the research.

There has been almost, but not quite universal agreement with my findings that some women react when the cervix is touched and others do not.

What has been difficult, however, is to design a research scheme that will prove the anatomical hypothesis behind this discovery (not really a discovery at all) and to coordinate the findings with a clinical situation of lack of or presence of orgasm stimulated by deep penetration. One of the difficulties is to eliminate the sensation from the clitoris and vulva. This seems to be a big stumbling block although one or two lady gynaecologists with whom I spoke, however, have told me that they can differentiate the two types of orgasm in themselves without too much difficulty and have long wondered whether Masters and Johnson got it right when they said that there was no such thing as a vaginal (cervical) orgasm.

Yours sincerely,

Elliot Philipp

From Dr Robina Thexton to Dr Anne Smith:

Dear Dr Smith,

I was interested in your case studies in the Newsletter and surprisingly, the very next man I saw at his second visit reminded me that he had had left sided pain! What does it mean? He is right handed. He did have an injury to his left knee which is now arthritic, but I think that is coincidental. I enclose a copy of my letter to his doctor and will watch out for further cases.

Yours sincerely,

Robina Thexton

Dr Thexton's letter to the G.P. reads:

"Thank you for your letter about this pleasant 43 year old who complained of impotence. At last he came to the top of the waiting list and I have seen him for the second time tonight. His difficulty during intercourse came on about 2 years ago and his wife was expressing frustration. She changed her attitude a lot when he actually kept the appointment and 'did something about it'.

He is a pleasant man with normal genitals, no sugar in his urine and no drugs. He had been having an ache in his left groin while in bed and a pain going upwards from his left testicle to his groin when he had an erection. Since his first visit he has achieved successful intercourse once and had no further pain. He now finds that he wakes in the night with an erection and interestingly turns over and goes to sleep rather than use it — this is in keeping with his usual attitude of not starting anything in case it doesn't work. He plans to change this attitude further as he has begun to do already. I shall see him again.

His wife is 42 years old and has never been pregnant. They have a 17 year old adopted son. I discussed with him that they might get a pregnancy as they use no birth control and he seemed happy about that.

Thank you for . . . etc."

Dr Thexton adds, at the time of going to press, "This man came two more times. The improvement was not maintained, but he and his wife accepted the lack of intercourse more happily because he felt he had made an attempt to get help and she was satisfied. He still occasionally gets pain in the left testicle when he wakes in the morning."

BOOK REVIEW

"The Making of Love" by Dr Prudence Tunnadine and published by J. Cape

It is with affection and pride that I review "The Making of Love" by Dr Prudence Tunnadine.

From its pages speak 23 years of shared experiences painful and joyous, through which our colleagues and our patients have learned and changed a little, or quite a lot! The book is written with such skill that it is very difficult to put it down. It is only 200 pages, but each is packed with observation and understanding of human emotion and the conflicts that such emotion may engender with intellectual and logical truth. The series of word portraits of people who have had some difficulties in the "making of love" keeps our interest throughout and although the author tells us that it was written primarily for non-medical readers, the language and content is such that it can be understood by any interested human being, miraculously it is also appropriate reading for doctors with a special interest in psychosexual medicine and also general practitioners or doctors in allied fields.

We, as her colleagues, are grateful to 'Pru' for writing about our work and her enormous contribution to it in such a refreshingly lively and straight-forward way, and with no jargon.

I have to declare my well-known bias, but I think that this book will be a winner. It is not available in the bookshops until June, 1983.

Dr R. D. Lincoln

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