## FUTURE INSTITUTE OF PSYCHOSEXUAL MEDICINE EVENTS

### WINTER MEETINGS 1986-87

A meeting has been arranged at Chandos Street on Wednesday November 26 at 5.30 p.m. The subject will be "Clinical Encounters with Homosexuality". Members and associates are welcome to attend. Supper will be available if prior notice is given by letter or telephone to the IPM Secretary by November 19. Price £10-00.

**February 18 1987**
A meeting could be arranged on this date at 5.30 p.m. if there is sufficient demand, possibly an ad hoc seminar. Those interested please telephone the programme secretary on 0727 53156.

**March 20 1987**
The annual general meeting of the IPM at Chandos Street. The speaker is to be announced later.

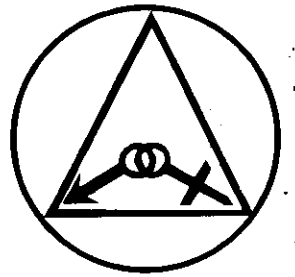
**September 25/26/27 1987**
The annual Scientific Meeting 1987 at Selwyn College, Cambridge

**23/24/25 September 1988**
Provisional dates for annual Scientific Meeting.

# Institute of Psychosexual Medicine

*CONTENTS*


EDITORIAL ..... page 1
ARTICLES
**The Lady of Shallot**
Dr. Merryl Roberts ..... 3
**The Workshop on research & communication**
Dr. Marshall Marinker ..... 7
**The discussion** ..... 16
LETTERS TO THE EDITOR
Dr. Jean Pasmore ..... 21
Dr. Elphis Christopher ..... 21
NOTICES ..... 24
NEW ASSOCIATES & SUBSCRIBERS 26
REGIONAL TRAINING COORDINATORS ..... 28
TRAINING SEMINARS ..... Inside Back Cover
I.P.M. PROGRAMME ..... Back Cover


**NEWSLETTER No. 30** **NOVEMBER 1986**

## LIST OF OFFICERS

| | |
|---|---|
| *President* | Dr. Tom Main |
| *Vice Presidents* | Professor Norman Morris<br>Dr. James Carne |
| *Chairman* | Dr. Ruth Skrine<br>Castanea House<br>Sham Castle Lane, Bath BA2 6JN |
| *Secretary* | Dr. Judy Gilley<br>42 Avondale Avenue, London N12 |
| *Treasurer* | Dr. Jessie Yorston<br>'Luibeg', Gardeners Lane<br>Romsey, Hampshire SO5, 0BB |
| *Director of Training* | Dr. Prudence Tunnadine<br>Flat 7, Wimpole House<br>29 Wimpole Street<br>London W1M 7AD |
| *Programme Secretary* | Dr. Jane Kilvington<br>122 Marshalwick Lane, St. Albans<br>Hertfordshire AL1 4XD |
| *Panel Secretary* | Dr. Margaret Gill<br>10 Peters Wood Hill, Ware<br>Hertfordshire SG12 9NR |
| *Publications Secretary* | Dr. Heather Montford<br>Cardinal House, The Green<br>Hampton Court, Surrey KT8 9BW |
| *Referral Secretary* | Dr. Sheila Filshie<br>2 Pembroke Drive, Mapperley Park<br>Nottingham |
| *Administrative Assistant to the Secretary* | Mrs. Judith Green<br>The Institute of Psychosexual Medicine<br>11 Chandos Street, Cavendish Square<br>London W1M 9DE |
| *Administrative Assistant to the Treasurer, also Membership & Subscription Secretary* | Mr. Ronald Trowbridge<br>6 Dunsells Close, Ropley, Alresford<br>Hampshire SO24 0DN<br>Tel. No.: Ropley (096277) 2439 |
| *Newsletter Editor* | Dr. Joan Coombs<br>13 Holly Park, Huby, nr. Leeds<br>N. Yorkshire LS17 0BT |

**COUNCIL**

Consists of the President and 12 members, viz.: Dr. Prudence Tunnadine, Dr. Judy Gilley, Dr. Jessie Yorston, Dr. Joan Coombs, Dr. Sheila Filshie, Dr. Margaret Gill, Dr. Jenny Lisle, Lady Morag Bramley, Dr. Heather Montford, Dr. Ruth Skrine, Dr. Ann Smith, Dr. Katherine Draper.

Mrs. Nancy Raphael is an Honorary Permanent Co-option to the Council.

Dr. Jane Kilvington is an ex-Officio Member of Council in her capacity as Programme Secretary.

N.A.F.P.D. observer on Council, Dr. Ann Morgan.

Mrs. Judith Green will be at 11 Chandos Street on Thursdays from 10.00 a.m. until 2.00 p.m.: Telephone 01-580 0631.

# INSTITUTE OF PSYCHOSEXUAL MEDICINE

*NEWSLETTER No. 30, NOVEMBER 1986*

## *EDITORIAL*

A long time ago I went to a party at the Pump Room in Bath. It was part of the Bath Festival programme. My husband and I travelled from Yorkshire to attend and bought bathing costumes in Manchester because we had forgotten and left ours at home. We arrived late and it was raining and by Birmingham it had become an impossible mad idea.

It was an extraordinary scene, people in evening dress, people in swimwear, potted palms and a group of string musicians beside the pools. Both pools were suffused in pink light and the bathers seemed naked in the steam. Not Bacchanalia though, more like Alice in Wonderland in the Pool of Tears. People bobbed by in the water, too buoyant to sink, and chatted and passed by warm and friendly.

The men changed amongst the hypocausts, their clothes piled on the stones. The ladies changed in tile-lined cellars deep underground, hot and cloudy with talcum powder. Beau Nash the Master of Ceremonies welcomed us to dinner and then we danced, evening clothes and wet hair.

This September the 12th Annual Scientific Meeting of the Institute of Psychosexual Medicine; back in Bath but a different Pool of Tears and a different Beau Nash.

Over 100 members of the Institute attended the conference and there were also guests from the local medical profession invited by the chairman Dr. Ruth Skrine. Dr. Jane Kilvington our programme secretary had put in a lot of work preparing the conference and everyone's thanks went to her and to Mr. George Rivas and his team for their efforts.

Dinner in the Pump Room was delightful and was the gift from Wyeth to the members.

During the weekend papers were given on varying themes, but in particular I was glad to hear Dr. Forsythe explaining the importance of writing up the kind of work we do. It stimulated lively discussion, how to capture the evanescent cascade of consciousness. This theme was an echo of Dr. Marshall Marinker's paper. He talked of "Narrative research" and Dr. Gilley talked of how writing about the consultation is like writing a play. Certainly Dr. Merryl Roberts' piece reads like a script for a play.

Capturing these moments on paper is time-consuming as well as daunting. The narrative can take as long as the consultation. In other areas of medicine, research is financed. Many of our members are not salaried but work on a sessional basis. Even so, many of them are prepared to invest their own time to further the work of the IPM.

It is appropriate to pay tribute at this point to the many hours of voluntary work which have been put in over the years by so many people. For example our Director of Training Dr. Prudence Tunnadine who has worked for so long without respite. It is invidious to mention one without

all the others but our thanks go to them all.

The Council of the IPM met whilst in Bath in September and recommended that the proceedings of the afternoon spent with Dr. Marshall Marinker should be reported in the Newsletter. I received a verbatim typescript some 50 pages long and have spent many hours trying to condense it. Members will be interested that I was not able to edit or condense the paper at all. Dr. Marinker's use of language is so precise and eloquent that every sentence means something that has to be included — impossible to prune his burgeoning thinking.

The discussion was different and I severely pruned it. All the while I was conscious of how editing can distort according to our perception. We edit what we hear, we edit what we say, we edit what we think. I hope that my perceptions have not distorted the gist of the discussion.

According to the Concise Oxford Dictionary to train is to bring to a desired state or standard of efficiency by instruction and practice. Discipline is defined as the trained condition. Our aims are to strive for better understanding of human beings and to regain the sensitivity that we might have lost in medical school. Dr. Main describes the discipline as the "experience to get in touch with, immerse oneself in, be sensitive to somebody else and then pull out and think about it". The task is immense. Each patient is unique. Each doctor is unique. Settings vary and the rôle of the doctor varies from general practitioner to specialist. Each doctor/patient relationship is unique. We all use different pathways, differing steps and varying paces. The aim is not to become copies of each other but to hone our own particular skills for the benefit of our patients. The discipline is that of sensitivity and thought.

We are all sensitive to the confidentiality of our consultations. They are characterised by their intimacy. Within this community of psychosexual doctors many of us still hesitate to share our researches because of the secrets that are given to us in trust and confidence.

Not only the secrets of our patients do we guard but also those about ourselves. Those doctors in Bath who presented accounts of their doctor/patient dealings did not experience the cosy rosy nakedness of Beau Nash's swimming party but a different exposure of themselves under the scrutiny of their peers.

Dr. Main suggested that findings made from the field of psychosexual medicine should be communicated to the IPM community in this Newsletter.

As long as names and places and identifiable features are disguised, few patients would object to such studies which are aimed to help others through greater understanding. As Dr. Marinker said, "None of us would be ashamed to aspire to Bronowski's guidelines in the kind of world we want".

Creativity

The habit of truth

And the sense of human dignity.

*Joan Coombs*



*The Lady of Shallot.* – At the Scientific Meeting held in September at the University of Bath Dr. Elizabeth Forsythe gave a paper on "Writing articles for medical journals". Dr. Forsythe is editor of the British Journal of Family Planning. She would like more items on psychosexual subjects in the Journal. During her exposition she gave an example of an exceptional description of grief. It was by Dr. Merryl Roberts when she presented a paper at last year's Scientific Meeting. With her permission I am reprinting it here as an illustration of the sort of writing that Dr. Forsythe is interested in. — ED.

## BUDDY HOLLY, THE SMILE AND THE LADY OF SHALLOT

A lot of us are connected in some way with training young doctors. I am a family planning instructing doctor and, on the whole, I enjoy it — with the notable exception of the first few IUCD sessions. I know I identify too much with the patients; I say to myself, if you were coming, in fear and trembling, to have a foreign body inserted into your uterus, who would you prefer — experienced old you, or inexperienced and over-anxious trainee? The inevitable answer produces a state of guilty anxiety in me; not logical, I'm sure, but it's there nevertheless — and it does tend to concentrate the mind marvellously. I know *exactly* what I intend to teach my trainees, make sure their technical grounding is good, that their inserting technique is skilled and that they are aware that around every fecund uterus is a real live woman. And that's all. It's enough, for heaven's sake.

Let me tell you about one trainee. Having recently done a gynaecology HO he clearly considered time spent in the Family Planning Clinic a waste of time. He was here because he had to be, and I felt that I and the patients were strangely two dimensional — the only real thing was the piece of paper he needed. He was very knowledgeable and keen on statistics — 'What is the exact percentage of . . ?' he would inquire, a gambit which made me feel very inadequate as I combine ignorance with a gut distrust of statistics. He was very tall and thin, his hair stood up on end and he wore large glasses. He reminded me of Buddy Holly and, in an effort to break the rapidly thickening ice, I said, 'Do you know, you look exactly like Buddy Holly?', whereupon he bent a cold eye down upon me and said, 'Who?'

Anyway, time passed and it was Buddy's last session. I had reached the fly-on-the-wall stage, only getting up when asked, and not at all for the last hour. I reflected how misleading first impressions can be; Buddy had turned out well, not only technically good, but sympathetic to patients as well. Our nurse, a soft, calm lady in her 50s came in. 'Last patient', she said, 'and thank heavens she hasn't got a problem, she just wants her coil out'. It had been a busy clinic. As I began to fill in the final details on Buddy's form I heard the door open and the nurse's voice, higher and harsher than usual. 'Come in, Mrs. Bloggs', she said with a completely alien, forced jollity. 'Last, but not least, better late than never . . .' Intrigued, I looked up. Mrs. Bloggs hesitated in the doorway before trotting into the room. No, 'trotting' is wrong, she moved like the figure seen on mediaeval clocks, body held rigid, only the feet moving. She was a primary school teacher in her late 40s, and had that rather menacing 'mother-knows-best' aura, neat

and tidy from her carefully waved hair to her sensibly shod feet. And stapled across her face, fixed from ear to ear, a terrible, ghastly smile, a gash, frightening in its determined intensity. Reaching the patient's chair she adjusted its position, folded her coat neatly over the back, hung her bag on the side, moved it again and then sat, on the edge, feet together, hands in lap, and turned that awful smile on Buddy. Buddy was clearly uncomfortable, but he was left no time to think as Mrs. Bloggs went straight on the offensive. 'You *must* be tired', she cried patronisingly. 'Never mind, I am your last patient and I won't bother you — I only want my coil out'. Poor Buddy, reduced to a rising five who had spilled his paint pot, he shifted uneasily and took refuge behind an avuncular, wise old GP. His voice came out higher and louder; if he had *had* half-moon specs he would have twinkled over them, a sort of Dr. Cameron of the Family Planning Clinic. 'Well, well', he tried to boom. 'Have you been having problems?' Alas, Mrs. Bloggs disposed of Dr. Cameron easily. 'No, no', she admonished. 'Nor do I need any further advice. It's just that my divorce has come through'. Buddy threw in the sponge, while still clinging to the tattered remnants of Dr. Cameron. 'Right, fine', he said. 'Off you go to the couch, and I'll do that for you'.

As Mrs. Bloggs stood up and turned round, that smile had me up and following her to the couch. The nurse, busy sorting out the trolley, gave me a surprised look, and then silently backed away. Buddy looked uncertain and, as I drew the curtain, I motioned for him to join us. Mrs. Bloggs took off her clothes, leaving them in a neatly folded pile on the chair, and sat on the couch, turning the smile on me. I had a moment of panic: what could I possibly say? Hesitatingly I said, 'It seems to me, that coming to have this coil out is a difficult . . . painful . . . distressing, emotional experience for you'. 'Well', I thought, 'that was pretty inadequate'. Her smile wavered and we looked at one another; then she shook her head angrily — 'I hated having the wretched thing in', she said, 'I've had nothing but trouble with it, but now, when there's no reason to put up with it . . . Oh, I don't know . . .' Tears filled her eyes and the smile had gone. Moved, I reached out and took her hands and she wept, with words tumbling out of her; her 'happy' marriage; then husband going off sex, blamed it on the sheath, so, under pressure she felt, she had a coil in, but it made no difference, and she discovered he had met someone else. Her anger, her feelings of hurt rejection, her feeling of impotence poured out. I said, 'It's as though having this coil out is accepting that it's happened. You're hurt, and more than any piece of paper a judge gives you, this is the closing of that door'. She wept and gradually the atmosphere became calmer. I said, 'Well, shall we take the coil out?' She nodded and lay back and my lovely Buddy, he took out that coil with respect, and when he had done we three had a momentary silence, a little mourning, a grieve. Then she let go of my hands (which by then felt as though they had been stuck in a mangle), wiped her face and said, 'Right'. It was a dismissal and we accepted it. Very quickly she emerged, red, swollen face, tousled hair, tights wrinkled, but with a real, if watery, smile. She grabbed her things and said, 'Thanks', and as she reached the door, 'I'll be back'. The nurse, Buddy and I discussed what had happened and Buddy stretched out his long arms behind him and said, 'I have really enjoyed these sessions — and I have learnt a lot'. Pleased, I riposted, 'You have the Merryl



Roberts' stamp of approval — go forth into the world and insert coils'. 'Coils?' he said, puzzled. 'Oh, coils — no, I meant, well, do you remember that stunning girl in our very first session? — you didn't actually put a coil in her'. I remembered, but I was surprised he had . . .

The clinic had been as hectic as usual; our attempts to cut down numbers in training sessions are never successful. The girl was referred from another doctor in the same clinic to have a coil inserted and before she came in I only had time to open her notes and glance at the treatment card. Turning to Buddy I said, 'Look at this, this girl has only been coming for eighteen months and she has been on every pill we have. If you see this your alarm bells should be ringing "I spy a problem" . . .' and she came in. She *was* stunning, oval face surrounded by a halo of curly hair — she looked just like a pre-Raphaelite painting. She even had the mournful, rather fatalistic expression. As I looked at her, the dim recesses of my memory banks produced a couplet — 'The curse has come upon me, cried the Lady of Shallot'. I had a little (internal) giggle at my tendency to dramatise, but found my reaction interesting, nevertheless. I opened her notes and there was a long list of complaints; well you know the sort, everything from aching legs to headache, but mainly vaginal discharge, vaginal soreness, dyspareunia, time and again. With a finger running down the page I drew Buddy's attention to this, as I said to the Lady of Shallot — 'You've had an unpleasant time with your vagina over the past eighteen months'. She looked at me rather warily. 'Yes', she said, 'the other, *nice* doctor, she said it's common on the pill, it's due to hormonal change'. 'Mm', I said. 'Discharge, soreness, pain — must have affected your sex life'. 'Yes', she said, even more warily, 'the other, *nice* doctor said that is also very common on the pill, that's why she recommended a coil. I am getting married in two months' time'. 'Mm', I said, sliding my finger over to the other page to guide Buddy's eyes. 'So, since you had the termination, your vagina has been pretty nasty and you've gone off sex'. By now she looked neither mournful, nor fatalistic, more like a rabbit facing a stoat really. She said, 'I *never* think of that'. As she spoke her eyes filled with tears. - 'Hell', she said, 'I vowed I wouldn't cry any more — do you know, when I woke up from the anaesthetic I was crying? Can you imagine, crying when I woke up from the anaesthetic?' She was crying now and I whizzed my chair across to her and took her hands. Her parents and her boyfriend's mother had insisted that a termination of pregnancy was the best thing . . . her uncertainty . . . how angry she had been and still was at her boyfriend's refusal to back her up — 'All he would say was, "It's up to you, love" . . . so, in the end I gave in and I said OK, if that's the way you want it, but oh, how I regret it, regret it . . .' Out poured the anger, guilt, grief, washing over Buddy and me. I wondered who was clinging on to whose hands for support, but she became calmer and dropped her gaze to the floor. Remembering the curse I waited and in a small voice she said, 'And I've read what awful damage it can do . . . I may not be able to have children . . .' 'Well', I said, 'Let's have a look', and eagerly she trotted to the couch. I turned to a stunned Buddy, he opened his mouth and I put my finger over mine and beckoned him with me to the couch. She was already on the bed, waiting anxiously. As I examined her she raised her head, apprehensively watching my face. When I had finished, I said, 'Well, I think the whole dreadful experience left a scar, but' (I reached

across and tapped her forehead) — 'in there, in your emotions. Down her is absolutely normal'. She looked at me for a second, then dropped her head back on the pillow. I waited. She said, 'You don't think it was the pill, do you?' 'Do you?' I said. She thought. 'No', she said. 'Do you mind if I don't have a coil in — I think I'd better talk things over with my boyfriend'. 'It's been a long eighteen months', I said. 'If you feel you need to talk more, come and see me in the Wednesday morning clinic, we've more time'. 'I will, if I need to', she said. When she had gone, I only had a short time to chat about her to Buddy, but I did tell him about the Institute and the psychosexual clinic.

I am not suggesting that Buddy left me and plunged into seminars — I'm sure he didn't. Who knows if he will be interested enough to do so in the future? For certain he left knowing about the Institute, a little about the sort of techniques we use, and something of the powerful emotions lurking in us all — even patients. A steady stream of trainees, of all kinds, passes through our hands. Far from intending to pass on our Institute ideas, we are probably not even aware that we are. But we do, and perhaps, as with Buddy, because it is unintentional, it makes a deep impression. Buddy came to learn about coils and was not at all impressed that he did so — his enthusiasm was for what he did *not* expect to learn. I think we should not underestimate ourselves.

*Dr. Merryl Roberts*
Member of the Institute of Psychosexual Medicine



## The workshop in research and communication led by Dr. Marshall Marinker, 16th May 1986

*The workshop was held at the headquarters of the Institute of Psychosexual Medicine*

**Dr. Tom Main** introduced Dr. Marshall Marinker and described him as a distinguished general practitioner whose interest in the theory and philosophy of general practice led to his appointment as Professor of General Practice at the University of Leicester. Now Dr. Marinker is directing a series of experiments and researches into training methods in general practice and is funded not by the National Health Service but by a private foundation. The foundation is run in BMA House and every now and then he is on contract to the National Health Service to run courses.

Dr. Marinker is a deep thinker and a philosopher of general practice and his writings, which come from an original pen, are stimulating and admirable. Dr. Main recalled that on behalf of the Balint Society, Dr. Marinker did a survey of training methods up and down the country in general practice. One of the things he did was to look into the training methods of what has now become the Institute of Psychosexual Medicine.

In particular there was concern about, 'What do we do about leaders? Must they all be psychoanalysts?' Dr. Marinker was interested in this other way of training leaders and recommended it to the College of General Practitioners. His interest in psychosexual medicine has included sessional work fifteeen years ago for the Family Planning Association in Islington.

*Dr. Marinker's address is now reported as near verbatim as possible. This was the unanimous wish of the Council of IPM at their recent council meeting at Bath during September. They felt that the content and language of the paper should be recorded in its entirety.*

- - - - - - -

**Dr. Marshall Marinker** I thought I would talk about a subject that is teasing and intriguing me: the problem of how one does qualitative research in the sort of fields that you are all interested in.

Of course all the time I will be referring to my own world of general practice, but I think *that* world is very close to the one that you are working in. Happily the boundaries are poorly defined. The more poorly defined your boundaries are, the more exciting your work is because all the most exciting things in the world happen on boundaries.

Really what I want to begin with is a notion that I have played around with for some time. That is the notion of what constitutes a subject. 'What is psychosexual medicine? What is general practice?' When I thought about psychosexual medicine I realised that one could be talking about the things that Masters and Johnson talked about. Alternatively one could be talking about the kind of thing that Tom Main talks about and they are not the same thing. They come from different assumptions, different worlds and yet they appear to be addressing the same sort of issues. The example that I always use is that both French and English are literatures that are taught in universities and yet they are very different subjects. My guess is that they are

different subjects because of the context and because of the material. If you look in an English dictionary and a French dictionary you will find that the French dictionary is about an inch thick and that the English dictionary is about two inches thick. There is an essential difference between the two languages. The precision, the beauty, the truth of the English language is hidden in the dense meaning of its many words. English is a romantic language whereas the beauty of French lies in its construction and in its form.

This difference I think expands into the kind of thoughts that you can have in the two languages and the kind of ideas and philosophies and beauty that you can express.

I was always fascinated by the criticism thrown at Heine* because he was seen not to be a real German but a French romantic poet writing in the wrong language. I have always felt that the general practitioner is a French romantic poet writing in the wrong language and we are still struggling to find ours as maybe you are struggling to find yours.

So I believe what a subject needs to have is a unique content which we can describe. I think from that there probably comes a preferred method not only of working but of teaching. There comes a methodology which is uniquely developed to explain this content. There comes a language to describe itself and a territory to limit its boundaries.

It is really the third of those *characteristics of a subject* that I want to explore with you this afternoon. It is the notion of the methodology uniquely developed to explain its own content. In the end I think that a subject is its research, its way of thinking, its theory and its philosophy.

Some researches seem to grow from the tools which are developed to extricate it. An example of that in medicine might be radiotherapy machines. Without them there would be no such subject nor any such concept nor any such way of looking at cells and molecules and how they are changed. Other subjects, other researches grow from social need or a social rôle. Geriatric medicine in general practice, and I would guess also psychosexual medicine, are in that category.

We have a major problem in general practice which I would guess is echoed in your field and that is that it is very hard not to be captured by the major, the dominant, the most successful scientific methodologies of the day. In medicine those are epidemiology and numerate research — the power of statistics. The power of measurement is enormous and I will be coming back to that time and again.

Unfortunately in general practice the dominant epidemiology results in research which asks only the most banal questions and seeks only the most predictable answers. One of the most distinguished researchers in general practice that I know has said: "I have never asked a research question of which I didn't already know the answer before I began, but by God the methodology is exquisite".

I want to suggest that it would be more productive, more adventurous and

*Heinrich Heine, 1797-1856. German poet, satirist and journalist of Jewish origin. France was his 'adopted' country and he lived in Paris from the age of 34 until his death. — ED



better if we attempted to answer the important questions however imperfectly. Our methodologies will be less than exquisite because they are not numerate. I want to suggest that it is sometimes important to be brave rather than prudent when tackling the kind of research issues that I believe you are all concerned with.

In the end there might be more that unites scientists and researchers than divides us. I will be talking a little about contrasts between the perceptions of the arts and the sciences but I hope I will end by saying that the differences are superficial and that which binds them together is what is really important. What worries me about so much of current research is that numerate research drives us to a premature sense of concreteness. We begin to have the illusion of knowing things and what we know may not be very important.

Let me give you two examples of bits of research and they are not examples which I would equally value. The first I value far less than the second because the first one is a piece of research that I was involved with. It was during my time at Leicester and my department had a very strong epidemiological biostatistical wing to it. Needless to say it was a wing which I fathered but never quite understood. I felt I needed in some way to have some kind of corrective research going on. I had a bunch of very bright and very creative general practitioners who felt alienated from much of the statistical research that was going on. They found that what was being researched bore almost no relationshiup to what was being done as a doctor or taught as a teacher. The values were quite different.

We decided that we would form a research group which would be unique. We would begin by not knowing what it was that we wanted to research. We would try for as long as possible not to become too prematurely concrete.

We began by looking at various aspects of our day-to-day work which were totally mysterious to us like abdominal pain in children. This is a subject about which quite a lot is written but no-one knows anything about. It will not astonish you to find that in the end we thought it would be quite interesting to look at women whose menstrual problems led them to have hysterectomies.

Now if you can for a moment step outside what you know and feel about your experiences, I guess you will be very close to where we landed up. Try to examine how doctors currently trained with current preoccupations would begin to look at that kind of research.

They would say, well, if you are going to look at menstrual irregularities, you would want to look at some of the demographic data: the age, the marital status, number of children. You would want to look at social data: what kind of social class and social experience this patient has. You might want to look at the patient's sexual life as well: you might want to see whether the patient is sexually happy or unhappy. You might want to look at her haemoglobin level or the size of her uterus.

The more you look at these hard concrete marvellous things, the more you realise that they are in fact very plastic, very, very soft. You very very soon come to the understanding that a bulky uterus is a normal uterus about to be removed by a gynaecologist.

We were terribly anxious not to begin to direct our research in the way

that all other research is directed towards the measurement of variables like the times the patient comes, drugs and so on. These variables are chosen before the measurement begins and are only best guesses and, quite frankly, they are pretty lousy guesses. The variables which should be measured should be those which seem important after an examination of what is actually going on.

All sorts of things which we could not have predicted suddenly began to impress themselves upon us. We were desperately unhappy to find that our patients were not by and large dreadfully sexually unhappy as they were supposed to be according to research. We felt very let down by psychodynamic tests in not finding that.

We found that there were two sorts of reactions to hysterectomies. There were those patients who were very happy that they had had their uteruses removed and there were those who were desperately unhappy and mourned for them. To make matters slightly more complicated, it was the ones that had normal uteruses that were happy. The ones that had evidently very diseased uteruses snatched from them were unhappy. That was not something that one could have guessed before one started to look. The patients who had lost normal uteruses were deeply suspicious of what was going on and kept asking questions: "I wonder what it looked like. I wish I could have seen the X-ray". They had a lot of anxieties about what their bodies were like and what was really going on inside them. The other patients never seemed to ask these questions.

There is a lovely side bit to this story. In a bit of ecumenical zeal I decided to share these perceptions with an epidemiologist. He had lots of data about patients who had had surgery. We thought we had a hypothesis. It was that if there were a group of women who were fairly anxious to get rid of a normal organ, maybe they would like to get rid of others like their gall bladders and their appendices. The Director of the Oxford Record Linkage Scheme wrote: "What an interesting idea! I have done a first preliminary run-through on the computer. There is actually a trend in the direction that you predict, not yet at the level of statistical significance" — i.e. it didn't actually have the kind of Holy Grail but it nudged in that direction. Later I received another letter about a month later: "I've got terrible news for you. I have been through the data and pathology exists in the gall bladders and appendices; so it can't be right".

There was this notion of power even among the brightest of people captured by beliefs of the day that the presence of pathological findings under the microscope somehow invalidates the correlation. This is just a lovely example of how easy it is to be captured by the enormous force of academic respectability and the beliefs of the day.

I cannot resist telling you the most interesting finding of all. We discovered that three groups of doctors — psychiatrists, general practitioners and gynaecologists — all treated these so-called normal hysterectomies as medical emergencies. The general practitioners who were doing the research and who knew what was going on continued to treat these patients in exactly the same way even while they were doing the research. There was something enormously powerful going on in the doctor/patient relationship which we could not understand and we ourselves were part of it.



That is my poor example. My good example was a book by Leonard Friedman called "Virgin Wives" which was published in 1962. I remember reading that book as a young general practitioner. I was so excited by the methodology; it was unbelievable to me that that approach to the human condition could actually constitute human research into medicine. What impressed me were the comments that Michael Balint made in his foreword to the work when he said there were three contexts to this research which predicted it. One was what he called the classical gynaecological examination. He made the still fascinating statement that there was no male equivalent of that. Secondly he commented on the psychological examination of what he calls women's emotions and fantasies that could go on at the same time. The third comment he made was that all the researchers were women doctors although the work was written up by a man. The combination of those three set the context for the research. I found that very exciting then and I still do.

My problem is that the research which is at the centre of what this Institute is about still has to deliver the most important goods. They are still to come; we have not yet been strong enough to explore the possibilities of that research.

What interests me is that other people outside of medicine are beginning to ask the same kind of questions that we are asking. They are beginning to make progress in this direction. I have in mind people from particular schools of sociology, the work of Gotham on stigma and on institutions. People in education are beginning to ask very pertinent questions about how to do qualitative research, what I call *narrative research* — research that stems from a story.

Recently I was invited to give a paper at a conference in the States. The theme was Communicativeness, which was a funny kind of American mixture of communications and ethics and relationships. There is now a whole school of thought that believes that we need to explore the power of narrative in life. They have actually got the notion of *homo narrens*, story-telling man, and that comes very close to the kind of medicine that I have always regarded as being at the centre of my life and my interests.

Four or five years ago I came across an article by a man called E.W. Eismann. He was writing in a journal called 'Educational Research'. He was contrasting what he called the artistic and the scientific approach to research in education. He was talking about the American equivalent of our primary education. He had ten interesting headings which I think might give us some signposts of where we might be going.

His first heading is what he calls the *forms of representation* and I would call *languages*.

Let me tell you a story about my hysterectomy study. We had looked at a number of audio tapes of consultations. We believed that audio tapes would reveal the truth. They do not. They reveal more truth than video tapes, but best of all is not to have either of them. Dr. A is a woman doctor who had spent consultation after consultation trying to break through a kind of rigid formality that the patient seemed to want in relation to the patient's feelings. The patient was suffering from very heavy periods which were inevitably leading to the longed-for hysterectomy. The doctor struggled valiantly but

failed and hysterectomy happened. In the subsequent consultation, still not being able to get close to the patient, the patient complained about what she described as "a pain in my cut", "pain on passing urine" and "the dreadful state of the lavatories in the hospital" and "did the surgeon really have to take it all away?" and then, "I feel so relieved, Doctor". Then she gave the doctor a bottle of perfume and the perfume was called *RAPPORT*.

Now that is the language of the kind of research that I think we are touching on. Bronowski puts it beautifully when he said that 'Science communicates itself in a single valued language'. Science cannot use the terms of language; it has to use symbols, symbols that mean one thing and one thing only. E means energy. It does not mean speed of light; E means energy.

Art uses a language which is multi-valued; every word means so many different things. John Donne says of a tear that when it falls, "tears of much joy they are, emblems of more, not any more than joy" and he was remembering that Ann Moore was his mistress at the time when he wrote that poem.

This is the language in which my patients talk to me all the time. The problem is that I don't always hear it properly.

Next Eismann talks of the *criteria for appraisal*. How do we judge the quality of work? Of course in the kind of research that we are talking about the language of statistics is not terribly important, but also in medical research the language of anatomy and physiology is predominant. When an idea is presented in molecular or physiological terms we actually give it a value which stems not from what is said but from the sanctity of the languages, the language of the body, the language of opening up the inner surfaces. That language actually has a value quite independent of whether what is being talked about is nonsense or sense. The kind of language that you want to use when you talk about narrative and feelings does not have that kind of imprimature.

Next he talks about the *difference in the point of focus*. For the scientist the point of focus is clearly what is to be observed. There is no question that in looking at nephritis the least that we are looking at is the kidney or a bit of the kidney or a bit of a bit of the kidney. There is no doubt that what we are looking at is the patient!

In the kind of research that we are talking about it is possible that it is not only the person we are looking at. Most threatening of all we are looking at the doctor as well. The debate is as to whether we are looking at the doctor or whether we are alternatively looking at *the doctor/patient relationship as an instrument for looking at the patient*.

Next there is the question of *the nature of generalisation*. How do we generalise from our research to the world outside? For those who are doing normal traditional research that is not too difficult. That is based on the adoption of proper sampling techniques, of proper controls. The rules for that are terribly important to follow to the letter, because if you are going to do that kind of research you have got to do it properly, otherwise it is totally invalidated. What about a research that is based on the unique individual situation of the unique person. When Arthur Miller writes a play called "Death of a Salesman", is he just telling us the unique story of one saleman,



or is he saying something about the human condition of all salesmen? Or is he saying something about the human condition because all of us are salesmen? It is that kind of generalisation which we need to address to see how we can actually make it.

Yesterday I was in a research group which is being led by Enid Balint. We are looking at surprises that occur in consultations. A woman doctor, Dr. A, was describing a 30-year-old woman patient; her second marriage, two small children, living in a large family. The relationships always seem to be between the children and the grandmother. The mother always seems to be absent, so she becomes another, she becomes something else. You couldn't understand it. The consultation ended in a vaginal examination and there was something about this 30-year-old woman feeling herself to be grubby and dirty. In particular her vagina was dirty. She had had vulval warts years ago and those Dr. A had treated and the woman had had an awful lot of shame and distaste about it. As the story went on I was overwhelmed by the sense that this woman was a Cinderella and that her story resonated with the story of Cinderella. Cinderella is one of the great archetypes, and all the things that go with that story. Maybe there is something there in how we generalise and we generalise because what we touch on are really quite important truths about the human condition that suddenly come to us in different narratives. That seems to me to be another fascinating area for further discovery and elucidation.

Eismann's next point is that *form* is terribly important in one kind of research but not in another. In normal research you always talk in the third person. The most you can do is to talk in the first person plural. You never say "I". The fact that you might be the centre of things and actually have to own up to being a variable in the research is unthinkable in "good research". Having used the third person you can then begin by giving the background. You then state your hypothesis and the methodology most suited to the testing of those hypotheses. Now Medawar and Popper, the great 20th century philosophers, are the first to tell us that that is a lie. It is a "con". The hypotheses are only finally written when all the results are in. What is presented as a tidy, rational, sensible logic from A to Z is a lie. What has happened is that something very interesting has been found. How it actually got found or what went on and how creative the mistakes were is hidden. This is edited out for all time. If you want to know what really led to the discovery of DNA read Watson's "The Double Helix" where all the humanity of that work is shown including who really discovered it.

I think that Eismann is wrong in saying that our work should not have form. Art to me is at its best when at its most disciplined and rigorous. For me the greatest poetry is still the Sonnets and the greatest music is still that of Bach and Mozart. Rigour and discipline seem to me to be an indissoluble part of good thinking, but what must not be ruled out is the creativity that goes with that rigour and discipline. I believe that in this kind of research we are still searching for the right kind of form. Certainly when I look back on some of the reports of researches that I have been engaged in in the past, I wish that more of the processes of that research had been made clear because that is what we learn from.

The next two points that Eismann makes are regarding the rôle of

*prediction* and *explication* in research of things. I would add to that also *description*. He says that as research moves from being descriptive and predictive to actually explaining, it moves from the technical and scientific to the artistic. We have an enormous appetite for explication. We want to understand. It may be that the only way we achieve this kind of research is by accepting that there will be imaginative leaps, large ones, between what we know and what we speculate. That does not seem to me to obviate the value of the research because the whole of the human endeavour depends on that. The notion that everything depends on knowing, and knowing in a way which is at the very least at every point falsifiable, seems to me to shrink the human experience so that all we will ever do is what we currently believe to be safe.

What is fascinating is that if you really want to look for allies in psychosexual research, don't look in the Department of Surgery or in a modern Department of Psychiatry. Look in the Department of Subatomic Physics. There they know exactly what they are talking about and they use the same kind of imagination.

Next he talks about *sources of data* and all one needs to say is that we are talking about, on the one hand measured behaviours and measured quantities, and on the other hand sensed feelings. The notion that a measuring instrument to look at phenomena is always reliable, but the equipment we have for sensing feelings is unreliable, needs to be reconsidered.

I give you an example of how crazy the world has become. We now have standards for good clinical practice: like, what you should really do with a patient who has a coronary thrombosis or backache. How are these standards being devised in medicine? They are being devised by what are called *prodigals*, branching logic algorithms. Each step of the algorithm divides into a yes and a no. Well, why do we do it that way? Because that is the way in which computers think. Computers think in a particularly stupid way because that is the way in which electronics work. So what we do, as man, is that we adapt a very stupid but fast way of thinking and then we say that this is the way we are going to think in the future. We omit the fact that actually we have biological computers of our own which we have inherited. People are actually now wanting to teach people to think like computers think because that is the way we invented computers to think! So much of what appears to be logic and reason is really a matter of what I can only describe as narrowly held religious belief and dogma.

That comes on to his ninth point, which is about the *basis of knowing*. I believe that the basis of knowing is rooted in what you are prepared to believe in.

What are the ultimate aims? Eismann says they are different in art and science and I am not sure he is right. He says that science is about the discovery of mechanisms and truth and that art is about the creation of meaning, coherence, images of the world with which we can deal. I think science is about that too. A scientific theory is no more than that. It is an image of the world. It is something that we can handle in order to understand what is going on. It is a tool, no more.

Let me tell you about a consultation which was randomly picked. I said to a friend of mine, tell me about your second consultation of Tuesday morning. She is a young woman doctor in a single-handed practice in a working-class district of Glasgow, a well-trained clinician. She telephoned to tell me of this guy of 56: "He is a diabetic and he has hypertension and he is on five different tablets for his various diseases. He is a metal worker, an engineer and he has been out of work for about a year. He has diabetic retinopathy and honestly I don't think he is ever going to see properly again despite laser treatment. He came for his diabetes and his hypertension and for a repeat prescription to be off work. Really I know very little about him. He is not married and he lives with his mother. The company he worked for is shortly to go out of business in a year or so and the chances of getting back to work he knows are pretty awful".



I had this enormous sense as she was telling me the story of the contrast between him and this young woman doctor, very alive, a very zappy lady with a very rich kind of professional, social and personal life.

She said that was all that happened. "Oddly enough, I found myself saying to him, 'you know what I would really like to do: not give you a prescription for any of these drugs. I would like to give you a prescription for two weeks on a paradise island'. And he said, 'I wouldn't risk it, doctor, unless you came with me'..."

Now my question is: How do you value that consultation? What was it about? What is a good or a bad consultation? What went on? How could you research it?

One of the thoughts I had is that even people like us are captured by the idea that every consultation is about solving the problem, maybe a problem about feelings, but still a problem-solving exercise.

I think that a lot of my consultations have not been problem-solving but have been a different kind of experience, like a piece of theatre, or a celebration, or an expiation; something different.

That leads me to the notion that there may actually be an aesthetics of the consultation which we have not even begun to look at. We may go a long way if we start to value consultations not as though they are all crossword puzzles, but as though some of them are poems.

---

# THE DISCUSSION

*The discussion that followed Dr. Marshall Marinker's paper has been edited so that it could be included in the Newsletter*

**Dr. Main** Dr. Marinker said he turned in the long run to the physicists for an exemplar. What did that mean?

**Dr. Marinker** I am not a subatomic physicist, but I do regularly read every week the New Scientist, which is a fascinating journal. My understanding is that when physicists get to the stage of calculating what is going on with subatomic particles, they have to leave the rational world in which they were trained. They have to invent mythical worlds with marvellous particles like quarks. They give them the most beautiful of names. The pictures that they build of reality, the images that they give us, are a long way from any kind of proof which may or may not come later. What they are saying is that we cannot wait for the tools which will prove or disprove these pictures; we have to go on building the pictures. In a sense there is a kind of echo in medicine because we are not concise. Medicine actually has also got a social endeavour in that we are there to help people in the real world, to help them with their unhappiness and their disease. The purity of our academic endeavours must always come a very poor second to the urgency of our services. I think that is a more defensive statement about the kind of research that we have to do; it is a statement about reality. In the end we need to know better how to serve our patients.

**Dr. Gilley** On the tube I was reading the latest Drug and Therapeutics Bulletin. It was saying that even properly constructed research of the statistical sort that we can be dismissive of at its best has not been shown to influence prescribing.

**Dr. Marinker** I was not being dismissive of numerate research at all; that would have been stupid of me. Numerate research has been one of the most important steps forward for mankind. It just does not help us at the moment, here. I mean, airships are great, but they are lousy under water.

**Dr. Lucas** Dr. Tunnadine was referring to the IPM study on non-ejaculators. I remember that a large proportion of these men were twins. Now I have found that this has got in the way. I find myself thinking, "Is he a twin or not a twin?"

**Dr. Marinker** But isn't that like all good research? What happens in research is that ideas are generated. Some of these ideas are going to be enormously fruitful; others will be ideas which don't work or which are dead ends. The whole point about research is, we must have a willingness to junk that which is no longer useful. It wouldn't matter one little bit if in fact the classification of unconsummating women into queen bees, gentling Brunnhildas and sleeping beauties was no longer useful. It served its purpose at the time and illuminated and it took us forward. The whole history of all research in all fields is constantly renewed. Newton was not a fool because Einstein followed him.

**Dr. Main** But they were both poets. Each of them made a creative step after which the world could not be looked at in the same way. They knew



quite a lot and suddenly they put things together with a new vision. Physicists are quite good at doing sums but the significant thing about the imagination of the best physicists is how creative they are. This is why I think they are a kind of artist.

**Dr. Marinker** Bronowski gives a beautiful analysis of what science is about in his series of essays, "The Indentity of Man". He says that in the end science is about three values: 1, creativity; 2, the habit of truth; 3, the sense of human dignity. None of us would be ashamed to aspire to those three guidelines in the kind of world we want . . .

- - - - - -

**Dr. Gill** I would like to go back to what you said about the most interesting exciting things happening on boundaries. I was thinking that boundaries can be the growing edges of things, and then you threw in energy and I was wondering about the connections between them.

**Dr. Marinker** I do think that the boundary is the most exciting place for finding things. One is at home in neither part and one has to be creative on the boundary. You can't be at peace. You can't rest. The lovely boundary that was described in "Virgin Wives" was that between examining the woman's feelings and doing a physical examination, that boundary between two different subject worlds. What came out was something that happened on that boundary.

**Dr. Gill** There is also a boundary between personal and general . . .

**Dr. Marinker** . . . and that between art and science.

**Dr. Tunnadine** I think there is another fuzzy boundary which makes it difficult for us to report the kind of research the world would want. If our training does anything it gives its doctors a new bit of equipment like other doctors have laparoscopes. We learn to look a bit deeper inside. For doctors with laparoscopes you can decide things, learn things and then do things. The trouble with our area is that investigation and treatment are inseparable.

**Dr. Marinker** In classical medicine there is a wish to divide things up with impermeable boundaries like "The History"; followed by "The Examination"; and then "The Investigation". We know that in the real world this is ritualistic. Every part of the history is part of the treatment.

**Dr. Skrine** One thing you said was that science defines itself by its research. I think that psychosexual medicine is very new. Some people in this room seem to think that it is a sort of entity, but I don't think that we have quite got our boundaries defined. I think that is because we have not done enough research. We have some like "Virgin Wives" and "the non-ejaculating man". My feeling is that we need to encourage ourselves to be descriptive even when we can't make that imaginative leap to explain it.

**Dr. Marinker** There is a sense in which the activities and disciplines of research are part of our every day clinical practice. There is a sense in which every management is an experiment. If we could find a way of having some kind of focus for our descriptions, then I believe we might see some kind of meaning in them. That meaning won't be a truth for all time. It is constantly changing. The notion that the way in which patients present will remain true

and therefore the diagnosis will remain constant is a nonsense.

One of the major cataclysmic changes in our society is the experience of being a woman. Marriage has changed out of all recognition. The tumult that this is causing in human lives and relationships is enormous. The notion that gives us the title of this Institute, that we have incorporated sexual unhappines into our ideas of what is medical, is interesting in itself. Perhaps it is something to do with the kind of society we live in, the kind of affluence. So the notion of where the boundary occurs is totally arbitrary and depends on where you are standing.

---

**Dr. Main** *(In response to previous discussion about the practical dilemma of scripting the work of IPM doctors)* I think that we should make sure that the findings made in the field of psychosexual medicine be communicated to this community. In other words, I would say our own Newsletter is a very good place for communicating beginnings of ideas.

**Dr. Lucas** The difficulty in writing cases up is that even putting it down on paper is somehow not the case, is not what went on on that occasion. Even in a seminar I have this feeling that when I have presented a case I have failed to communicate the real feeling of what happened in the consultation.

**Dr. Marinker** You assumed that you knew what went on between you and the patient! In the seminar the group as a whole begins to work with what went on, so that new things are revealed and more truths come from that triangulation of discussion. The writing up of that seems to me to be terribly important. . . . I think that writing up one's own case is important, but for me the research tool of the seminar form of discussion is a very under-explored and under-used one. I would like to see much more work coming out of research groups like this. To look actually at what went on in discussion, the process of discovery, the way in which ideas grew, were rejected, were shaped, new things came in — that has not been done. There is an enormous rich vein of research to be done there.

**Dr. Gilley** In writing that, isn't it actually like writing a play? Then this idea emerges gradually through the various doctors talking: it is an incredibly complex process. It *is* like writing a play! For people to sit and to read it and to make sense of it takes almost as much concentration as one is prepared to put into a production. People are terribly lazy and they want to read through the introduction and the conclusions. They don't want to fight through two hours of the development of the idea.

**Dr. Marinker** It is terribly hard work and probably the main reason why none of us has done it properly — but what a good idea it is!

**Dr. Gill** One of the interesting things to do would be to get each seminar member to go away and each do our own account of the discussion and then bring it back and discuss each one in turn.

**Dr. Marinker** That would be fascinating.

**Dr. Forsythe** I have been doing something similar. We had a meeting last week about ways of writing up the Institute work for the British Journal of Family Planning. Someone in that group made verbatim notes. I read it through three times and each time I got a new clue about it.



**Dr. Marinker** I was involved with a research about a similar thing. About 300 video taped general practice consultations were recorded. We drew up a very detailed questionaire that asked about what was going on in the consultations. We decided to try the experiment with "prestigious peers", groups of Professors of General Practice, the General Purposes Committee of the Royal College of General Practitioners. There was no agreement. They all saw something different. Some saw weeping; some saw none. Some heard discussion about alcohol; some did not. It was quite instructive! Unfortunately the epidemiologists took the view that we have got to have better classifications!

I was also asked to report on the study of women coming for hysterectomy to the Association of University Teachers of General Practice. All day we had structured papers. I gave the last paper in a very personal way, quite different. I talked about how the group formed and then gave some of the case stories and in a very tentative way some feelings that had stemmed from one or two cases that we had looked at quite hard.

The effect on the younger academics was unbelievable. They all felt, but couldn't articulate, this sense of being trapped in a false game that was not part of their world.

The Professor of General Practice at Manchester, David Metcalf, said: "Just knowing that that was true for that patient opens up so many new possibilities for me to look there again in the future and I don't care whether that is very frequent or sometimes; I want to know the possibility of it".

I think that an enormous amount of richness will come in the future from looking at just one case, one story in clearer depth and finding ways of doing that. I think we need a lot more thinking through of what kind of tools we are using.

---

I do think there is something about medical schools which concentrates on training and not on education. They do not concentrate on critical thinking but on remembering facts, which is very disabling. In poetry you can either think or feel. We know that these are indissolubly linked. I think it is bringing those two together that is what is absolutely necessary for the kind of work we are talking about.

---

In a scientific community the alternative to the truth is a falsehood. In art the alternative to a truth is another truth and there is no reason why those two truths can't go on side by side, each adding to our understanding. The physical diagnosis doesn't disappear, it doesn't even become irrelevant, because we have a different kind of understanding of what is going on.

**Dr. Freedman** When medical students are taught to focus on the disease process all the time, it gets them away from the narrative of the patient's life. When the narration is not allowed, the tribute to feelings is excluded. We should not have to go back and revitalise the concept that feelings are important. I think the medical schools do a lot of damage.

**Dr. Marinker** It is a sad thing that happens at medical school that this building of defences is inextricably linked to learning about the practice of medicine. Maybe we should postpone medical school until later on!

**Dr. Main** I think another thing that most of us have got to face is that seminar training is painful. It isn't possible to have this training without pain and it takes a lot of courage to persist in the face of pain. People must be pretty keen on the truth in order to stand it.

**Dr. Marinker** I think it is particularly important that people understand that in this kind of field it is hard, it is rigorous, it is a discipline.

- - - - - -

**Dr. Main** ended the discussion by thanking Dr. Marinker for the creation of ideas which he had so generously given. He thanked him not just for the intellectual effort but also the sensitivity behind the ideas. For everyone it had been a very interesting and stimulating time given by the generosity of an original thinker.



# LETTERS TO THE EDITOR

Dear Editor,

I congratulate the author of the Prospectus of the Institute of Psychosexual Medicine on an admirable production. I know it would have pleased my friend, Margaret Blair, to whom it is an appropriate memorial.

The Prospectus has prompted me to recall some retrospective memories of the 'grass root' origins of the movement.

In the early 1940s most doctors in family planning work had no training to help the increasing number of patients who used these clinics to raise problems about sexuality. The doctors also faced the antagonism of lay committees who had to make the clinics self-supporting, and so required doctors to see as many patients as possible in each session.

Time taken over problems limited these numbers and doctors not seeing the full quota risked cursory dismissal. Part-time medical work for women, especially if married, was then difficult to find. Some lay workers who supported the doctors, such as Mrs. Raphael, Mrs. Clifford Smith, Mrs. Sheridan and Mrs. Parker, are all remembered with gratitude.

A small group of doctors, including Dr. Mary Macaulay from Liverpool, Dr. Jackson from Exeter, Dr. Dawkins from Islington. Dr. Wright from Walworth and Dr. Redding and myself from North Kensington, began to meet regularly in the 1940s at the house of Dr. Joan Malleson in Paddington to discuss some of the difficulties we were experiencing in our clinics. These meetings soon became focussed on the psychosexual problems of our patients. Joan Malleson, Mary Macaulay and Helena Wright had each written books on the subject, which we younger doctors read eagerly, and recommended to our patients. But it seemed that the achievements of these our elders were more due to their personal charisma and commitment than to a rational system which we could learn to practise.

Those of us in general practice at that time were increasingly aware of our own inadequacy in treating the psychosomatic symptoms of our patients. Some of us, including Dr. Dawkins, Dr. Blair and myself, jumped at the chance of joining Dr. Michael Balint's seminars for general practitioners at the Tavistock Clinic. There we recognised the possibility of understanding some of the underlying causes of our patients' problems and behaviour. This understanding was the foundation of a new approach to treatment.

Our experience at the Tavistock Clinic led us to press the Family Planning Association to approach Dr. Balint to start a seminar for Family Planning doctors in 1958. Developments from then on are well recorded.

*Dr. Jean Pasmore, MIPM*

Dear Editor,

*Some more singing and a little hope*

I should like to respond to Dr. Valerie Thompson's article, Singing the Lord's Song in a Strange Land (Newsletter No. 29, May 1986).

Since 1977 I have run a weekly psychosexual clinic at North Middlesex

Hospital. This clinic originated in the following way. In time-honoured traditions of the Institute I began to "see" psychosexual problems in ordinary family planning clinics. Sometimes a problem could be dealt with there and then; at others a time would be specially made at the end of a session. As many before me, I became known in the clinic as "the doctor who is always finding problems" — a critical comment meaning it would be a late clinic that night. With the taking over of family planning clinics by the National Health Service in 1975 the idea of setting up a psychosexual session locally was accepted by the powers that be. I asked for it to be sited in the gynaecology department of the local hospital hoping thereby (craftily) to influence the consultant gynaecologists and also to give prestige to the clinic which, though not part of the hospital, was "in it". The room in which I work has curtained windows and two easy chairs. It became an object of curiosity for the medical and nursing staff. What did go on in that roŏm? One obstetric registrar (male) kept finding an excuse to knock at the door and come in "accidentally" (was he looking for seminar training?).

In 1984 one of the consultant gynaecologists, getting nonplussed and frustrated by the number of women attending his outpatients with "pelvic pain, laparoscopy n.a.d.", decided that perhaps a monthly meeting with the junior gynaecology staff presenting cases and me as a sort of leader/adviser might be one way out of the morass. Since then we have had about 17 lunchtime meetings. Despite the inevitable "bleeps" calling doctors to emergencies and changeover in staff, these meetings seem to have changed some doctors' attitudes and ways of looking at pelvic pain and have even inspired a few to consider seminar training.

What has emerged from these meetings about the women themselves? They seem to fall into two distinct groups. One group seems to bring out the sympathy and care of the doctor ("Poor woman, I felt so sorry for her, wished I could do more"), while the other made their doctors irritated and angry ("If I see that b----- woman again, I'll resign"). Is this, I reflect, two sides of the same coin? These women are either sad or angry about their lot as women. All the female aspects of their lives somehow or other go awry. Periods are painful and/or irregular or heavy, pregnancy is experienced as an illness, childbirth a total misery often resulting in a difficult/traumatic birth. And sex? Well, it never seems to have been very good and now, because of the pain, it rarely or never happens. Husbands are patient (with the sorrowful ones) or impatient and occasionally violent (with the angry ones). Their relationships with their mothers appear to be almost uniformly poor. Fathers are rarely mentioned. They hang on to their pain with ferocious tenacity collecting thick hospital files on the way.

The doctors attending the meetings, much like their patients with pelvic pain, wanted simple explanations and easy answers with much pressure on me to provide both. Failure to do this made some angry and frustrated, again much like their patients. Some, however, got intrigued — well, what was going on? These were the ones who were able to lift their heads out of the patient's pelvis, so to speak, and wonder about the rest of her. What were her eyes saying? How did she hold her body? What was happening in the rest of her life? What happened in the past? How did she treat her nearest and dearest and how did they treat her? For the more persistent doctor the



questions "And how does she make me feel and (more importantly) why?" became possible.

Prior to these meetings I tended to get lumbered with these patients dumped on me in the way with which we are all familiar, along the lines, "Well we, the proper doctors, can't do anything as we can't find anything physically wrong. Nevertheless, she has still got the pain so it must be psychological so we will refer her to the, whatsit, sex/psychological clinic". The patient usually attended in high dudgeon, furious at the psychological label and telling me in no uncertain terms that she wasn't mad. She usually ended up as one of my therapeutic failures. Now there are more sensitive and informed referrals and, better still, there is the occasional doctor who decides he/she would like to put in some more work with the patient. Hence there is a little hope and I intend to 'carry on' singing!

P.S. Pelvic pain might be a topic of research for the Institute.

*Dr. Elphis Christopher, MIPM*

# NOTICES

## THE RESEARCH ADVISORY COMMITTEE

Since this committee was formed by Council in February 1985, it has deliberated on a number of proposals. At the suggestion of the Scientific Committee we have been considering the evaluation of changes in doctors as a result of seminar training. A list of criteria has been drawn up and will be used in a Pilot Study by Leaders who are on the Scientific Committee. With this experience it is planned to carry out a further Study which will examine the skills which are acquired during seminar training.

The RAC has also spent considerable time discussing research projects and papers which are being carried out by Members:

1. Dr. Lisle's report on the Working Party that examined the work of Members.
2. "Randomised control trial of alternative treatments for late dyspareunia following vaginal delivery", in which Dr. Muriel Broome was participating.

Should any other members have proposals that they would like to discuss with the Committee, it would be pleased to hear from them.

## BIBLIOGRAPHY

The Bibliography has been updated and is available from Chandos Street, priced 50p + 20p p & p. Please could authors check their entries and let me know of any corrections, deletions or additions. It is hoped to update it again in about two years time. The guide to subjects which has been included is of necessity extremely brief and does not necessarily reflect the best work of the Institute. A more comprehensive subject index will be included in the next edition.

We would like to build up a small reference library at Chandos Street. I would be very grateful if authors of papers published in journals other than the Newsletter or in the proceedings of the residential weekends could let me have reprints of their papers in order that they may be included.

*Heather Montford, Publications Secretary*

## PSYCHOSEXUAL SESSION VACANCY

There will be a vacancy at Pine Street, Islington (N.E. Thames Region) for one psychosexual session weekly from January 1987. An Institute accredited doctor is seen as the ideal candidate.

Applications, please to -

Dr. Yasmin Khawaja, S.C.M.O.
Islington Health Authority
Insurance House, Insurance Street
London WC1X 0JB

as soon as possible



*NOTES FOR CONTRIBUTORS TO THE NEWSLETTER*

*Articles on all aspects of work in psychosexual medicine are welcome for publication in the Newsletter. Manuscripts should be typed on one side of A4 paper, double-spaced with wide margins. The first page should include the title and the name and qualifications of the author with appointments. Each page should be numbered and also bear the title and the author's name.*

## DATES FOR YOUR DIARY

**16/17 January 1987** Affiliated group meeting NAFPD, Bristol
**4/5 March 1987** Medical Administrator's Course
**1 May 1987** NAFPD Annual General Meeting, London
**17 September 1987** JCC Assessors' Meeting
**18/19 September 1987** JCC Conference
**29/30 October 1987** Current Fertility Symposium

## LIST OF NEW ASSOCIATES AND SUBSCRIBERS

| | |
|---|---|
| Dr. Gillian Baker | 3 Argyle Road, London N12 7NU |
| Dr. Lynda Berridge | 34 Wood Crescent, High Cross, Newport, Gwent NP1 0AL |
| Dr. Elizabeth J. Botell | 47 The Fairway, Lake, Isle of Wight PO36 9EG |
| Dr. Anne Burge | 56 Broad Oaks Road, Solihull, W. Midlands B91 1HZ |
| Dr. Jane E.S. Cooper | 12 Rydens Grove, Hersham, Walton-on-Thames, Surrey KT12 5RX |
| Dr. Tom Courtney | 12 Lyndale Avenue, Childs Hill, London NW2 2PY |
| Dr. Richard R. Davies | 12 Lonsdale Road, Cywcoed, Cardiff CF3 7JF |
| Dr. Heather M.R. Davis | 43 High Street, Watlington, Oxfordshire OX9 5PZ |
| Dr. Helen Dimson | 2 Arlington, London N12 7JR |
| Dr. Josephine K. Likierman | 15 North Square, London NW11 7AD |
| Dr. Anthony J. Lalor | The Surgery, Scots Gap, Cambo, Morpeth, Northumberland |
| Dr. Josephine J. Mason | Greenhill, Shotley Bridge, Consett, Co. Durham DH8 0NJ |
| Dr. Jane McEvoy | 6 Edgehill, Llanfrechfa, Cwmbran, Gwent |
| Dr. Peter M. Muir | 46 Leigh Road, Eastleigh, Hampshire SO5 4DT |
| Dr. Amanda Robinson | 110 Woodland Road, Sawston, Cambridgeshire CB2 4DU |
| Dr. Francoise Shenfield | Flat 1, 55 Frognal, London NW3 |
| Dr. K.R. Stewart | 75 Ermine Street, Huntingdon, Cambridgeshire PE18 6EZ |
| Dr. Grace Tang | |
| Dr. Judith M. Thomas | |
| Dr. Anne C. Turner | The Old Vicarage, Church Road, Combe Down, Bath BA2 5JJ |
| Dr. Deborah E. Williams | 2 Watcombe Road, Southbourne, Bournemouth, Dorset BH6 3LT |

## CHANGES OF ADDRESS

| | |
|---|---|
| Dr. Susan M. Horsewood-Lee | 37 Campden Street, London W8 7ET |
| Dr. S.E. James | 10 Sudeley Street, London N1 8HP |



## NOTES

## REGIONAL TRAINING CO-ORDINATORS

| | | |
|---|---|---|
| Northern | Dr. A.V. Smith | 6 The Crescent, Longbenton, Newcastle upon Tyne NE7 7ST Tel. Newcastle upon Tyne 66254 |
| Yorkshire | Dr. D. Anderson | 4 Newstead Road, St. Johns, Wakefield, Yorks. WF1 2DE Tel. 0924 372836 |
| Trent | Dr. S.E. Filshie | 2 Pembroke Drive, Mapperley Park, Nottingham NG3 5BG Tel. Nottingham 625632 |
| E. Anglia | Dr. R.D. Lincoln | 67 Yarmouth Road, Norwich NR7 0EW Tel. 0603 31628 |
| N.W. Thames | Dr. J. Kilvington | 122 Marshalswick Lane, St. Albans, Herts. AL1 4XD Tel. 0727 53156 |
| N.E. Thames | Dr. J. Gilley | 42 Avondale Avenue, London N12 8EN Tel. 01-445 1654 |
| S.E. Thames | Dr. A.J. Jones | 1 Minshull Place, Park Road, Beckenham, Kent BR3 1QF Tel. 01-658 6185 |
| S.W. Thames | Dr. R. Thexton | 41 Hillcroft Crescent, London W5 2SG Tel. 01-997 1748 |
| Wessex | Dr. Mary Thomas | Cliff House, Cliff Way, Compton Down, Winchester, Hants. SO21 2AP Tel. 0962 712183 |
| Oxford | Dr. J.E. Rogers | 11 Turners Road, Slough, Buckinghamshire Tel. 0753 22495 |
| S. Western | Dr. R. Skrine | Castanea House, Sham Castle Lane, Bath BA2 6JN Tel. 0225 65440 |
| Devon & Cornwall | Dr. J. Tisdall | 23 Furzehatt Road, Plymstock, Plymouth, Devon PL9 8QX Tel. 0752 42356 |
| W. Midlands | Dr. S.M. Snead | 30 Church Road Lilleshall, Shropshire Tel. 095 284 4560 |
| Mersey/N. Western | Dr. M. Upsdell | 85 Church Road, Woolton, Liverpool L25 6DB Tel. 051 428 5637 |
| Wales | Dr. D.A. Morgan | The Gables, Llangenny Lane, Crickhowell, Powys Tel. 0873 810176 |
| N. Ireland | Dr. J.G. Neill | 42a Cadogan Park, Belfast, N.I. BT9 6HH Tel. Belfast 662861 |

Scotland
No present Co-ordinator. Inquiries to the Northern Region.

*

## INSTITUTE OF PSYCHOSEXUAL MEDICINE TRAINING SEMINARS

**Advanced Seminar,** Newcastle, led by Dr. Freedman
**Advanced Seminar,** London, North East Thames: Dr. Tunnadine

**Basic seminars**

| | | |
|---|---|---|
| Cardiff | Lowestoft | Birmingham |
| Swansea | Bromley, Kent | Nottingham |
| Bristol | Sheffield | Newcastle-upon-Tyne |
| Southampton | London (Lisson Grove) | Essex |
| London (SW Thames) Sutton | Northern Ireland | Bradford |

**New basic seminars** (convening or under consideration)

| | | |
|---|---|---|
| London (NE Thames) | London (SW Thames) | London (SE Thames) |
| Winchester | Kettering or Northampton | Carlisle |
| Scotland | Chester | Hull |

Many of the above seminars have vacancies from time to time. Applications to the Director of Training or to the appropriate regional training co-ordinator, please.

*