Journal of medical ethics, 1982, **8**, 213–214

Correspondence

The dying don't need analytic psychotherapy

SIR

Dr Lawrence Goldie, *Journal of medical ethics*, September 1982: 128–133, made some telling comments concerning the apparent inability of many doctors and nurses to take the necessary time and trouble to tell patients the truth and help them cope with it. He did not, however, concern himself too much with why it is that after so many similar exhortations from himself and others concerning the need for time, trouble, talk and tolerance, the situation seems to remain unchanged. One possible answer I would suggest lies within his own article. For, having persuasively argued the need for a doctor to communicate properly, to listen carefully, to question intelligently and to counsel sympathetically, Dr Goldie then transmogrifies such a doctor into a 'psychotherapist' and advances the *non sequitur* that the appropriate interviewing method is derived from 'psychoanalysis and psychotherapy'.

Yet every example of poor communication advanced by him in his article points to the need for much more valid and justified psychological skills than those derived from psychodynamic psychotherapy. The patient whose GP never warned him of the possibility that his blood tests might reveal a serious disease did not need a therapist steeped in oedipal theory and ego psychology; he needed a doctor able to communicate simply, straightforwardly and sympathetically. 'Mrs S' benefited from being given the opportunity by Dr Goldie to review her past life, muse on her fortunes as well as her misfortunes and prepare herself for her death. There is no evidence, in his text at any rate, that what he did for her required any elaborate or technical psychotherapeutic skill. 'Psychotherapy' declares Dr Goldie, 'uses the psychoanalytic technique in searching for the truths which will help people to reduce unnecessary suffering and survive it when it is inevitable'. Quite what these techniques are is not at all clear from his article. But the techniques which are commonly referred to as psychoanalytic involve the measured interpretation of unconscious conflicts and mechanisms of defence leading eventually to the establishment of a transference neurosis through which the genesis of infantile conflicts and their intrusion into the present life of the patient may be resolved. Whatever one might say about the merits of this approach elsewhere it does not seem to have any obvious justification in the circumstances described by Dr Goldie.

This is not an academic issue. Many GPs, hospital doctors and nurses appear to share Dr Goldie's confusion and assume that any form of psychological intervention, if it is to be any good, must be infused with psychoanalytic values and techniques. Many of them, lacking Dr Goldie's familiarity with such matters, understandably shy away from talking to their patients, fearing that their untutored efforts will cause damage and that 'appropriate' psychotherapy requires a time-consuming training and a familiarity with a complicated metapsychology. Dr Goldie only reinforces such misconceptions in my view.

In fact, there is a growing body of evidence (1) which suggests that by using much more basic psychological skills doctors can bring about improvements in the doctor-patient consultation and even in patient outcome which compare quite favourably with those achieved by more time-consuming methods or more highly-trained therapists. The most urgent priority at the present time would appear to be improving the basic interviewing skills of doctors and others engaged in the clinical management of patients. The skills concerned include the provision and probing of verbal and non-verbal cues, the use of open-ended questions, the maintenance of good eye-to-eye contact, the ability to listen without being overwhelmed by the garrulous and the nervous, and the judicious use of time.

It is these and allied skills, which have little to do with psychoanalysis or indeed with psychoanalytically-derived psychotherapy, which we should be developing and fostering in doctors and nurses. It is interesting to note that had those who were responsible for the care of the patients in the various examples provided by Dr Goldie possessed such skills to a reasonably developed degree then the complications which reportedly ensued would almost certainly have been avoided.

References

(1) Goldberg D, Steele J J, Johnson A, Smith C. Ability of primary care physicians to make accurate ratings of psychiatric symptoms. *Archives of general psychiatry* 1982; 39: 829–833; Hogan D. B. *The regulation of psychotherapists*. Cambridge, Mass, USA: Ballinger Publishing Company, 1979; Marks J N, Goldberg D P, Hillier V F. Determinants of the ability of general practitioners to detect psychiatric illness. *Psychological medicine*; 1979; 9: 337–353.

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Confidentiality and occupational health physicians

SIR

While clearing out an old filing cabinet I came across the enclosed letter. It seems

to me to illustrate clearly the pitfalls confronting doctors involved in occupational health, and precisely how not to resolve the dilemma of confidentiality.

'With reference to past correspondence . . . Miss P went sick on 11th October. Dr I visited her on October 12th and certified her to be suffering from pharyngitis. He said he would call again on October 14th. He did so and stated that her temperature was normal and that she should be fit to visit the surgery yesterday, October 18th, to be declared fit for duty.

This morning, October 19th I confirmed that Miss P had not visited Dr I and received a message from her that she was too sick to do so. I rang Dr I and asked if he could call to see Miss P. Dr I called about 10.45 am and saw Miss P and said that she had recovered from the pharyngitis but was now suffering from nervous debility following the attack. He had asked her permission to discuss her medical state with me, but this was refused. Dr I however gave as his private opinion that she was completely unsuitable for the position she now holds. He implied that she was a neurasthenic subject, mentally disposed towards sickness to the extent that she would never be able to carry out continuously or adequately her duties. In view of the fact that Miss P refused her permission for Dr I to discuss her medical state with me, Dr I was, naturally, very reluctant to express himself freely. He did however make it clear to me that he considered her to be entirely unsuited for employment here. . . .'

It is not clear from the file of correspondence what precisely happened to Miss P but there is a letter saying she should be dismissed on medical grounds.

This correspondence was dated 1966. One hopes that occupational health physicians twenty years later will be guided by the Faculty of Occupational Medicine's *Guidance on ethics for occupational physicians* to a more acceptable ethical stance. However, too often such decisions reflect not the moral codes of the medical profession but rather the personality of a doctor who desires so to please that he forgets his moral obligations.

For obvious reasons I should be grateful if you would withhold my name and address.

Workshop on medicine and science-policy

The Society for Applied Philosophy is holding an introductory workshop on philosophical and ethical issues in medicine and science-policy from 2–6 pm on Saturday, March 12, 1983 in the Philosophy Department, Bedford College London.

The workshop will provide an opportunity for members of the society and others to discuss and work together on some philosophical issues within the theory and practice of medicine. Short papers (of around 1000 words) are invited to form the basis for discussion. These may address wide issues such as the nature of health and illness; decision-making in the allocation of resources, and aspects of the doctor-patient relationship. Alternatively they may address more particular issues such as the question of when it is permissible to treat a person without his consent; the ethical implications of the commercial advertising of drugs and the implications of accepting particular definitions of death.

The Society for Applied Philosophy was established to provide a focus for philosophical research with a direct bearing on areas of practical concern which are capable of being illuminated by the critical, analytic approach characteristic of philosophy, and by direct consideration of questions of value.

Anyone interested in attending the workshop should contact: The Convenor, Society for Applied Philosophy Workshop on Medicine and Science-policy, Gavin Fairbairn, 25 Russell Road, Whalley Range, Manchester M16 8DJ.