Public perceptions

Ultimately, of course, it's the voters—the users and carers—who matter: what do they think of the changes to date? Christine Lowthian, of Newcastle Alzheimer's Disease Society, says the local authority has tried to look at purchasing care in innovative ways. Some people have begun to receive care that is more closely adapted to their needs: for example, day care that is available at weekends as well as during the week; respite care for a couple of days, rather than a couple of weeks, at a time.

But still bigger changes are needed, she says. For example, many people who have the traditional type of day care might spend two to three hours of the time they are away from home on a bus. Ms Lowthian says suggestions have been put forward to use smaller vehicles or taxis so as to reduce travelling time. "This seems a relatively small alteration to make but it's a big change when you consider that things have always been done that way in the past."

Ms Lowthian says the council also needs to do better on informing the public about the changes. People do not realise that social services can now provide a broad

range of help for an elderly relative, rather than just a place in a home. Carolyn Stephenson also quotes examples of types of care that are beginning to break the mould of the old style of provision. The department is negotiating with mental health charities and housing associations, which want to provide "housing with care": homes for people to live in that include domiciliary help and care of a befriending nature. Another scheme involves helping several families each with a member who has a learning disability; the families are planning to set up a company to employ people to provide the care that their relatives need, in a determined effort to keep them out of long stay hospitals.

Many staff do have political reservations about the community care reforms: they believe the new system was introduced in order to cut costs and introduce a "gatekeeping" process for those entering residential care. However, there are also advantages. Carolyn Stephenson says: "In social services there is also a real professional attraction to having some money freed up to provide more choice and flexibility. There's a lot in it for professionals and their clients."

Assessment of training in psychosexual medicine

Nigel Mathers, Morag Bramley, Katherine Draper, Shirley Snead, Alexandra Tobert

The Institute of Psychosexual Medicine offers training in the treatment of psychosexual problems to medically qualified doctors. Training takes place in fortnightly seminars in which trainees present and discuss real cases. Assessment of cases presented at the beginning and end of the six term basic training showed appreciable improvement in doctors' abilities. The proportion of doctors meeting each of the 14 predetermined clinical objectives rose. Factors which affected the amount of improvement were the initial score, the number of cases presented at the seminars, the occupation of the leader, and the duration of training. Accreditation by the Institute of Psychosexual Medicine was shown to be an appropriate outcome measure for the achievement of the required standards for practising psychosexual medicine.

"We cannot manage to have sex," "why is sex so painful?" "I don't want sex since the baby," or "why can't I get it up, doctor?" are complaints often heard in today's medical practice.¹ Many agencies offer training in the treatment of sexual complaints,^{2,3} but in the United Kingdom the Institute of Psychosexual Medicine is the only professional body in this subject which confines its training and accreditation for membership to medically qualified doctors.⁴

In this paper we describe the institute's training process, illustrate changes in the clinical skills of doctors treating psychosexual and related psychosomatic problems and assess these changes quantitatively to determine the relative influence of factors associated with the training.

Origins and setting

The Institute of Psychosexual Medicine evolved from the in service training initiated by the Family Planning Association in 1958 and led by psychoanalyst Michael Balint.⁷ The demand for training grew as doctors discovered that patients' sexual problems required skilled help. Tom Main, another psycho-

analyst, pioneered a workshop where psychosexually trained doctors could acquire leadership abilities.⁸ The accredited leaders then provided psychosexual training throughout Britain. When family planning, but not psychosexual medicine, was assimilated into the NHS in 1974, the Institute of Psychosexual Medicine was formed to promote training and research and to safeguard standards.

Training process

Basic training consists of a six term course of fortnightly seminars over two years. Trainees must be currently treating patients with psychosexual problems in a setting where physical examination is appropriate. Those with special aptitude can do a further six terms of advanced training and present work for accreditation and membership of the institute. In 1993, 182 doctors were training in 20 centres in the United Kingdom.

The training uses problem based methods of learning rather than books and lectures. About eight doctors meet with an accredited leader. The trainees describe encounters with patients, listen to the comments of their peers, and then do the same for the other doctors. Through these processes the doctors learn that active participation of patients is essential to treatment and that only by listening, looking, feeling, and finally thinking about the consultation can the patient's (often unconscious) messages be grasped. The real distress is picked up in the patient's behaviour with the doctor and not by direct questioning.

There is group discussion of difficult problems, in which members focus on the events and feelings in the consultation. Was the patient eliciting sympathy, being polite, portraying himself as a victim? Was the doctor reacting? The relevance of these interactions emerges as discussion focuses on the doctor-patient relationship.

Trainees are given no protocols on procedure. Instead they are taught that each encounter with a patient is unique. Total attention to the patient's words

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and behaviour and thinking about the meaning of what has taken place are essential. The ability to interpret this meaning to the patient is acquired gradually.⁹ Patients need to be helped to discover the root of their problems themselves by patient, non-questioning doctors. Comparison of cases is discouraged since each individual doctor-patient relationship requires careful thought.

Special attention is paid to events and feelings during genital examination. This examination, as well as being physical, gives the doctor entry into patients' thoughts and feelings about their sexuality.¹⁰

The leader gives a model for listening and keeps the group thinking independently about understanding and interpreting doctor-patient encounters. The doctors have to sit where the patient sits and to be aware of and empathise with the patient's distress. They must then learn to detach themselves and think logically from "outside" the consultation about the patient's emotional input, their subjective response, and the interaction between them. This is interpreted back to the patient in terms of the patient's complaints. For example, a woman came to her doctor describing her methods of birth control and how unaesthetic and difficult they were. She related this with distress in her voice and manner. The doctor heard the sadness and asked, "Was sex also difficult?" "Since my baby I've hated it," she replied. With no formal history the doctor had felt that patient's distress and interpreted the meaning of her complaints. A fruitful consultation then developed from the birth control complaint, which was her "visiting card." Such encounters are well illustrated by Bramley¹¹ and Smith and Draper.¹² Personal problems are not discussed since the seminars are for training and not therapy.

Effect of training

We assessed qualitatively a sample of first and last case presentations given during basic training by 14 doctors. An account of the first presentation of all trainee doctors in two seminar groups was written immediately by the leader to ensure no disruption of training. After two years the trainees themselves wrote down a recent clinical encounter as if reporting to a seminar. These written case presentations were assessed qualitatively and then double marked by using the questionnaire shown in the box by a non-participating seminar leader, an independent Freudian psychoanalyst, and a seminar leader who took part in the study.

Twenty eight written cases were sent to the three assessors, who independently assessed that there were qualitative improvements in understanding in each trainee. There was 100% concordance among the assessors in the identification of the first and last cases for the 14 doctors. The cases below illustrate some of the changes in the skills of one doctor.

FIRST CASE OF DR X

An unwashed patient presented with sexual problems at a clinic saying, "I am too big to satisfy my husband." They had not had sex recently but I did not learn why. On examination I saw vulval spots and asked the woman if she thought they were serious. She replied "Yes" so I told her firmly that they were not and that the dermatologist would treat them. (Her general practitioner had made a referral.) I did a pelvic examination with reassuring patter. She became silent and walled off as if "below the waist" was absent. Flummoxed by no vaginal laxity and her disgusting odour I told the patient "your vagina is normal and you should see a psychosexual counsellor." She defaulted.

The doctor did not explore the lack of sex and complaint of a big vagina. The patient was reassured without her anxieties being understood. Why did she fear these spots? The doctor fled from difficulty by

Psychosexual medicine questionnaire

- 1 Did the doctor examine the timing and mode of presentation and relate these to the patient's difficulty, whether new or return case?
- 2 Did the doctor note appearance, manner, and non-verbal communications?
- 3 Did the doctor recognise the hidden needs behind spoken complaints?
- 4 Did the doctor allow the consultation to develop spontaneously rather than going into detailed history?
- 5 Did the doctor listen and think and use silence and observation rather than asking questions?
- 6 Did the doctor recognise the patient's defences or flight from difficulties?
- 7 Did the doctor tolerate confusion and lack of understanding, rather than feeling put down or lacking in skill, and did he or she accept not having a comment or answer to everything?
- 8 Did the doctor recognise feelings arising during the consultation as evidence of the patient's difficulties and have the ability to interpret these to the patient?
- 9 Did the doctor accept and tolerate pain coming from the patient, understanding its meaning rather than resorting to superficial reassurance?
- 10 Did the doctor use genital examination therapeutically or did he or she recognise why it had not been considered and why not undertaken?
- 11 Did the doctor recognise and deal with the patient who uses sexuality or any other familiarity to deprofessionalise the doctor and make him or her impotent?
- 12 Did the doctor recognise his or her flight from difficulties by sending for the partner, referral, giving distant appointment, taking a detailed history or by giving directive advice, or prescribing unnecessarily?
- 13 Did the doctor help the patient to see that solving the problem is the patient's work, not the doctor's sole responsibility but will involve the patient's participation?
- 14 Did the doctor recognise those patients with difficulties outside the psychosexual doctor's field (for example, personality disorders, psychosis, sexual deviations)?

Scoring:

NA=Not applicable, 0=Quality glaringly absent, 1= Quality shown slightly, 2=Quality usefully moderately shown, 3=Quality excellently displayed.

passing responsibility to the dermatologist. The vaginal findings were not related to the complaint of being too big. The examination was purely physical and the walled off feeling was not explored. He defended himself against not knowing the answer and rejected the patient by sending her to a psychosexual counsellor. He had not tried to understand the patient's dirtiness. (She had driven to the clinic in a Mercedes.) The patient had not received help with her sexual problem.

LAST CASE OF DR X

A woman presented at family planning after a cervical smear test reminder. She was tense and feared being hurt. "What's the worry?" I asked. "I'm having problems down there, especially with sex. Afterwards I feel sore and swollen for a week." Her location of pain was vague. I asked if it had started with a difficult birth. "No" she said, "The birth was wonderful. I just do not like anything to do with down there now. It's awful isn't it? I don't know why I feel like this." Her two year relationship with her partner was happy. I suggested examination. She got on the couch hesitantly. Vaginal examination was normal and a smear taken easily. I commented, "The examination hasn't upset you." She replied, "I have been extremely upset after a miscarriage." An unplanned pregnancy had miscarried 18 months previously. She had tried again and immediately conceived but the miscarriage still devastated her. The new baby, although

loved, was not a replacement and her partner had lost his sadness with the new arrival. Could the pain be connected with the miscarriage? She felt it could and would discuss it with her partner. "I'll come back in six weeks."

She had been in control. I only gradually realised it. She controlled the information given by "I don't know." She wanted to avoid mentioning the miscarriage, a painful area for her. She used pain to control sex at home. She loved her partner but was angry that he still didn't mourn the miscarriage.

As I hadn't discussed this I wasn't sure if she would return. However, she did. "How are you?" I asked. "Oh, I am fine now, the pain just disappeared." Clearly she understood the emotional cause of her genital pain and had come to terms with it, sharing her feelings with her partner.

The doctor tried to understand the feelings underlying the sexual pain, although he could not wait till the patient revealed the cause, jumping in with his own suggestion of a difficult birth. He had learnt not to reassure the patient without understanding her anxiety. He was able to use the interaction between him and the patient to make a therapeutic comment, remarking that the patient wasn't upset despite saying she didn't like being touched. This enabled the patient to mention her real upset—the miscarriage. The doctor

was also aware of how he might have done better. Despite this the patient understood her pain and her sex life improved.

Quantitative assessment

We identified 14 clinical objectives of training in psychosexual medicine and devised a questionnaire for seminar leaders to measure the achievement of those objectives by doctors in training (box).

We invited all the institute's accredited seminar leaders to take part. Participating leaders were asked to grade every case presentation by doctors in training from 1988 to 1991. Questionnaire scores were calculated for both individual questions and the total score achieved on each case presentation. The statistical analysis system SAS-PC was used for the analysis.

Fourteen seminar leaders and 187 doctors entered the study. A total of 1526 cases were presented, most (1091) at basic seminars. Each seminar leader assessed a mean of 109 case presentations. Female doctors in training presented almost four times as many cases as male doctors, partly reflecting the larger number of women in training (150 women and 37 men).

Table I shows the proportions of doctors who achieved the standard for each clinical objective during basic training. The proportion of doctors achieving most of the objectives increased significantly over the training period ($P < 0.05$, McNemar test). The largest increases were seen for objective 6 (the recognition by the doctor of patients' defences or flight from difficulties) and objective 10 (therapeutic use of the genital examination). The smallest increases were observed with objective 4 (allowing the consultation to develop spontaneously) and objective 13 (helping the patient recognise that solving the problem is as much the patient's as the doctor's responsibility).

The total questionnaire score for the last case presentation of all doctors at the end of training was used for a multiple regression analysis which included the initial score of each doctor as a weighting factor. The variance in score could be accounted for by the initial score; the number of cases presented during training (the more cases presented the greater the final score); the occupation of the seminar leader (those with a general practitioner leader had a greater score than those with community doctor leader); and the period of training (table II). No other variable had a significant effect.

Overall, the most important variable explaining a doctor's score at any point in training was the number of cases presented. The second most important variable was the sex of the doctor. Table III shows the odds ratios of each variable for individual scores. The assumption of proportional odds was checked by modelling the different binary splits of each outcome variable (question score). The direction of the odds ratio of each parameter in each model was not different between splits and the assumption was judged reasonable.

We compared 14 doctors who successfully applied to become members of the institute with 14 doctors who were unsuccessful or who did not apply for accreditation. The doctors were matched for sex and occupation of doctor and leader, number of case presentations, and duration of training. The total questionnaire scores for final case presentations of successful candidates were significantly higher ($P = 0.025$, Wilcoxon test).

Discussion

Courtenay was able to show that leaders of small groups can make effective assessments of the quality of work of members.¹³ Bacall *et al* showed that a scale

TABLE I—Numbers (percentages) of doctors achieving standards at beginning and end of basic seminar training in psychosexual medicine

Objective No*	No of doctors assessed	Case presentations		P value
		First	Last	
1	154	43 (28)	77 (50)	<0.001
2	166	88 (53)	128 (77)	<0.001
3	164	47 (29)	74 (45)	<0.001
4	163	58 (36)	82 (50)	0.001
5	164	35 (21)	69 (42)	<0.001
6	158	34 (22)	78 (49)	<0.001
7	155	33 (21)	69 (45)	<0.001
8	161	18 (11)	53 (33)	<0.001
9	149	27 (18)	62 (42)	<0.001
10	107	15 (14)	43 (40)	<0.001
11	14	3 (24)	5 (36)	NS
12	95	19 (20)	34 (36)	0.026
13	145	21 (15)	44 (30)	0.007
14	7	2 (32)	3 (50)	NS

*See box for details.

TABLE II—Multiple regression analysis of total questionnaire scores*

Variable	Regression coefficient (SE)	P value
Initial score	0.61 (0.02)	0.001
No of cases doctor presented during training	0.14 (0.04)	0.001
Seminar leader occupation:		
General practitioner	-2.36 (0.36)	0.001
Community doctor	-2.84 (0.44)	0.001
Period of training		
(Compared with 1st/2nd terms):		
3rd/4th terms	1.32 (0.38)	<0.001
5th/6th terms	0.95 (0.53)	0.072
7th/8th terms	3.19 (0.71)	<0.001
9th/10th terms	2.80 (0.87)	0.001
11th/12th terms	1.33 (1.38)	NS
Constant	10.34 (0.54)	0.001

*Every case presented by every doctor during basic, advanced, and continuing seminar training.

TABLE III—Odds ratios of logistic regression analysis for individual question scores*

Variable	Objective No													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
No of case	0.93	0.92	0.94	0.94	0.94	0.93	0.94	0.91	0.93	0.94	0.93	0.92	0.96	0.89
Sex of doctor	2.62		1.88	1.85	2.36		1.85	1.84	3.17	1.96	1.38		1.90	4.41
Occupation of trainer	1.34	2.05	1.41	1.99	1.80	1.02	1.97	1.07	1.17			1.36	1.22	
Occupation of doctor	1.28	0.92					0.81							
Sex of trainer	0.61	0.60	0.57	0.53		0.70	0.69		0.75		0.53	0.65		
Period of training														
(Compared with 1st/2nd terms):														
3rd/4th terms				0.98	0.73		0.86						0.69	
5th/6th terms				1.67	1.17		0.93						0.54	
7th/8th terms				0.68	0.38		0.44						0.34	
9th/10th terms				0.71	0.31		0.32						0.32	
11th/12th terms				1.19	0.59		0.76						1.29	
Type of case														
(new/return)							0.74							

*See box for details. All odds ratios are significantly different ($P < 0.05$). Confidence intervals available from authors on request.

could be used to link the way a doctor worked within a group to his observed work with patients.¹⁴ Our assessment of training in psychosexual medicine shows a significant improvement in the clinical skills of doctors during basic training in 12 of the objectives. However, the study also highlights skills that need to be focused on by seminar leaders as fewer doctors met the objectives—for example, helping the patient to see that solving a sexual problem is not the responsibility of the doctor alone.

Few case presentations were assessed for two objectives: the awareness of the use of sexuality or other familiarity by the patient in the consultation and the recognition of patients with difficulties outside the discipline. Doctors need to feel secure within a group to discuss their own sexual feelings arising in the understanding of the doctor-patient relationship. Doctors therefore may not have reported this aspect of a case to their group. In addition, seminar leaders may have inadvertently colluded with the unconscious discomfort of a doctor and avoided discussion of the issue and hence assessment. Leaders may also have discouraged doctors from presenting cases in which the patient had difficulties that were outside the discipline.

FACTORS AFFECTING PERFORMANCE

The most important variable explaining a doctor's score at any point during the training was the number of cases he or she had presented. Contributing case presentations to the seminar group, rather than attendance, is therefore essential if a doctor is to achieve the necessary clinical skills.

A further important variable on performance was the sex of the doctor. For historical reasons there are fewer men than women in training and in addition many patients prefer to consult women doctors for emotional problems. Men who join the institute may be more likely to possess an aptitude for this type of work. The institute is keen to encourage male membership and there may also have been unconscious encouragement of male doctors by seminar leaders. Male trainees are predominantly self funded general practitioners while many female trainees are community doctors sent by their health authorities, which may result in less motivation. La Noue and Curtis found that women in mixed sex situations performed worse, rewarded themselves less, and attributed their poor performance to a lack of ability more often than men.¹⁵ This may be a partial explanation of women doctors' poorer performance in seminars.

The observation that the questionnaire scores of trainees with a general practitioner leader were higher than those of trainees with a community doctor leader may indicate that listening skills have already been acquired in vocational training.

Improvement in some clinical skills seems to reach a plateau during the third year of training, after which some scores fall. Subsequently a doctor seems less able to allow the consultation to develop spontaneously or help the patient to see that solving a sexual problem is a joint responsibility. As doctors' confidence in dealing with sexual problems grows they may revert to a more doctor centred style.

The final accreditation of candidates was by senior institute members who were not part of the study and the concordance of successful accreditation and final total questionnaire scores supports the conclusion that such accreditation is an appropriate outcome measure for training in psychosexual medicine.

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A MEMORABLE PATIENT

The hand of life

Ruth is an 82 year old woman who lives with her husband and family on a kibbutz. I had treated her several times for arthritic pain. One morning I was asked to make a house call after she had tried to commit suicide and had been in hospital for two days.

I entered a dark room. Hardly able to open her eyes, she lay there, speaking very softly. I introduced myself, shook her hand, and sat down to listen. She talked about her daughter, who had died four years ago from breast cancer and how close she had been to her. Every day she used to go to the graveyard to speak to her. She told me how angry she was to be healthy at 82 while her daughter had died at such a young age. She told me how she had accumulated sleeping pills in order to rejoin her daughter.

I felt well prepared for this encounter as I had just returned from the United States, where I had studied the subject of "the family physician and the dying patient." I said all kinds of wise things and invited her to see me again in a few days in my clinic.

She arrived in a somewhat euphoric mood, anxious to tell me a story. When she was 6 years old, in Poland, she

was enuretic and a stutterer. Her mother was afraid to send her to school in such a condition so she took her to see a famous doctor who came once a month from Vienna to the local hospital. The doctor examined her and gave her some medication. All in vain. Her grandfather told her mother to take the child to their rabbi in a nearby city. So the whole family travelled in a horse drawn carriage for an entire day to the rabbi's house. She distinctly remembered that rabbi, who had blue eyes, white skin, and a long beard. He put his hands on her head and said: "Go home child, and with God's help you will be well." He gave her a good luck charm to wear for a whole year. On arriving home, she was no longer enuretic and spoke perfectly. From that day on she thought that the rabbi had given her his blessing and that she would be protected and safe for her whole life.

"I don't remember what you told me when you came to visit me last week," she said, "but I do remember your hands. When you shook my hand I felt my rabbi again. You gave me the hand of life. I will never try to commit suicide again. My daughter must wait for me until my time comes."—DOV STEINMETZ is a family physician in Afula, Israel