access to the patient had been through the psyche, and almost all he had to relieve his patient's sufferings were reassurance, sympathy, suggestion, and often just plain humanity.

How absorbed were the new specialists in their fledgling specialties. How little time remained for them to consider the emotional aspects: how frantic was the general practitioner entering the impossible race to remain abreast of all the expanding knowledge of the growing specialties. How little time remained even to him to consider the emotional aspects. Even the psychiatrist, the specialist who had set himself the task of watching over the emotional aspects has been accused of becoming so fascinated by the workings of the psyche that he forgot the body. He too, like many other specialists, forgets the patient as a whole.

It is the general practitioner's unique responsibility to consider the patient as a whole. If you remember to listen for the four diagnoses in the situations involving the five cares, and remember that one primary aim is to keep the patient well and out of hospital, then you will have applied the art of listening in a truly complete way in general practice.

DISCUSSION

Dr Glyn Smith (*Sheffield Royal Infirmary*): In the absence of a sympathetic listener many people write to the problem pages of women's magazines. Does Dr Tonge think these columnists serve a useful purpose, and if so, should a professional psychiatric postal service be started?

Dr Tonge: First of all I must say that I have no intention of starting a psychiatric postal service. Actually, I have a great deal of respect for these columnists. I have heard accounts of these ladies when they have been giving talks, and my reading suggests that they are remarkably perceptive people. There are clearly very grave limitations in replying to questions by post, for there is so much which the questioner does not put down; but I am sure they serve a very useful function within those limitations and I would be against offering these good ladies a psychiatric consultation because they do the job so well that I prefer to leave them alone.

Chairman: I am going to ask Dr Tonge a question arising from that. How does he know they do them well?

Dr Tonge: I have been impressed by one of these women who gave a talk which was reported in the magazine *Mental Health*. She certainly

seemed to be 'with it' and 'on the spot' as regards emotional problems.

Mr Sanders: I spent a fortnight in Stockholm at the United Nations Congress with one of these very people from one of the popular papers. She studied some years ago under Mannheim; she is a juvenile court magistrate in London, and she goes to a tremendous amount of trouble, not only in answering questions herself, but also getting in touch with a psychologist, psychiatrist, social worker, doctor, in all sorts of areas throughout the country, and passes them on. I would have thought she did a very good job of work.

Dr Lord: Recently, a computer programme that carries out limited psychotherapeutic dialogues has been written and tested by three Stanford researchers in California. The programme is designed to communicate an intent to help as a psychotherapist does and to respond in questioning, clarifying, focusing, rephrasing and occasionally interpreting the subject's answer. The technique requires the subject to type anything that he wishes to say into a special purpose computer, which in turn is connected to an IBM 7090. When he desires a response to the programme, he signals the end of his transmission and receives a typewritten reply. The person then responds to this statement and a continuing conversation develops. Although the communications are written, the dialogue has many of the properties of a spoken conversation; it is reported to be dynamic, and demands an immediate reply. It strives to evoke as well as to express. To date, almost everyone who has participated in these dialogues reports that they become annoyed and frustrated by the programmed response. The greatest weakness of all is perhaps the programme's inability to offer interpretation based on a thorough knowledge of the patient. However, the researchers state that the programme could be further refined to imitate the performance of a human analyst. It could be developed to find a unique method of therapeutic communication, the absence of an actual therapist plus the constraint of written replies constituting important differences between such methods of conventional treatment.

If the method proves beneficial in genuine test cases, then it could provide a useful therapeutic tool for mental hospitals and psychiatric centres. Because of the time-sharing capabilities of modern computers, several hundred patients an hour could be handled by a computer system designed for this purpose. In this situation the art of listening is lost.

Dr Glyn Smith (*Sheffield*): What is the effect on Lord Wilberforce's listening mind, of an aching tooth, an attack of indigestion, or a recent argument with his wife?

Lord Wilberforce: In the first place the question is factually misdirected. I have practically no teeth to ache, and an argument with my wife is nothing but entertaining and stimulating; but of course there is a real problem with attacks of indigestion. Judges lead *ascetic* lives, precisely for the reason that psychosomatic interferences affect their work; that is why you find that judges have light lunches. Many of my colleagues say that one of the greatest trials in the course of their work is when they are sitting at the Old Bailey and have to have lunch with the

Lord Mayor and Sheriffs; as if these weren't enough, they have to sit through the barons of beef and the glasses of port wearing their robes with wigs on their heads. So the point is a serious one; it is necessary to ensure that one is in a calm frame of mind and without physical disturbances. I always insist on arriving at court a good half hour before we are due to sit, and I discourage my wife from telephoning me at that time with questions of a wordly character, because it is necessary to get my mind blank and cool, otherwise some subjective interference will come in. The question has a perfectly sound and sensible basis; you cannot do your job if you have a physical distraction. If unfortunately one does occur, I have to make the effort and hope that, when the time comes to take a critical decision or to give judgement, the malaise will have passed.

Mrs G. H. Pagdin (*Hackenthorpe, Sheffield*): How far would the panel attribute empty churches to the inability of the average parson to listen to his parishioner's everyday problems? Would holding a 'listening surgery' at the vicarage overcome this problem, and are the full doctor's surgeries of today related to these empty churches?

Bishop Wickham: I think it would be rather shallow to say that empty churches are due to the inability of the average parson to listen to his parishioner's everyday problems. That would be a gross over-simplification; indeed, with the large populations in our urban areas, most people have not met or heard a clergyman, except perhaps at the act of marriage when the individual is not in that state of mind conducive to good listening. We live in a situation where a growing number of our population have never heard of the proclamation of the word of God. This is really what we mean by a secular society, and we are moving in that situation. The clergy often are forced into a remoteness that makes it difficult for them to understand the everyday problems of ordinary people. I can only say that I think a wise bishop would always encourage his clergy to take a great interest, study well, and have a close relationship with the secular society, and not to hold themselves remote from it. We advise many young men before entering the ministry to go into a secular job, a manual job; we think this is very valuable.

Question: Would holding a listening surgery at the vicarage overcome the problem?

Bishop Wickham: Certainly the vicarage ought to be a listening surgery, without any question whatsoever. I think the well-structured church today does augment the concept of the clergyman and the mass of the congregation, with a multiplicity of small groups, but that they can themselves relate to each other and to him; I think there is a sense in which this should be therapeutic. I believe all good theological understandings should be therapeutic because it is a positive way of understanding our life without opiates and because there are many ways of understanding life that are purely adaptive, that give you comfort and yet shield you from the realities of life, whereas Christianity opens your eyes to the reality of life and makes you more sensitive to the hardness of life.

Are the full doctors' surgeries today related to those empty churches? The answer is 'Yes.' Many of the inadequacies of human beings that

ultimately express themselves in a psychological way and take them to a doctor are due to a society in which signposts are down, in which the sense of direction is minimal, in which values are questioned. This instability of life in contemporary society is conducive to many kinds of sickness that we are only just beginning to analyse; this is one of the reasons why I said that listening called for the sociological finger-on-the-pulse of our society.

Lord Wilbeforce: Do you not think that human skill in diagnostic listening can and ought to be assisted by scientific aids such as electrical reaction detectors, lie detectors or antirepressant drugs as a scientific fourth eye.

Dr Tonge: This is a long question and the answer is a qualified 'yes'. There are some things you can do very well with scientific devices; one can even tape an interview and study it afterwards, as a simple valuable procedure. The answer is that there is so much work to be done that we really have not got the time. It is a luxury to spend so much time on one or two people when we have a waiting list in the outpatient department of somewhere round about four weeks. A lot of the work that we do is little more than first aid, or we prefer to call it crisis therapy; you intervene in a moment of crisis in the life of an individual, help them over that and then retreat into the middle distance. It is in these very difficult circumstances that the use of the electrical devices tends to be left for specific points in treatment: in the behaviour therapy, for example, one really does need this type of scientific equipment, but we tend to reserve it for a few selected cases rather than general use.

Chairman: Are you satisfied?

Lord Wilberforce: Yes, thank you very much, but might I just say that in the law we have the same sort of problems; people very often say 'Why do you spend all this time questioning people? Why don't you put a lie detector on them?'—Americans do in many cases and they are quite accepted, and I believe you can buy a cheap Japanese one for about £25; so why not use it? Our traditional answer is really two-fold: one is a technical argument, judges and juries like to think that they are better judges of the truth that a machine can be. The other is really a moral argument; people who come to court don't mind being disbelieved by the jury or an old man on the bench, for it is just part of the game. Litigation is the judging of a contest according to particular rules, and litigants at any rate in civil cases would very much resent it if they really were shown to be lying by convincingly scientific means. As the object of litigation is to bring peace between disputants and send both people away satisfied, there is perhaps an argument for not being too scientific about it. Judges can be stupid and juries can be prejudiced; this is just the luck of the draw, but to be convicted by machine would be rather a different matter.

Dr Tonge: Can I come back to this? There is not a machine that detects lies, for the so-called lie detector only detects emotional disturbance at the time a statement is made; if you accuse me of something dreadful even though I am innocent, I will no doubt be emotionally disturbed about it and the lie detector will register a positive reading. The other thing one has to say is that technically the use of these machines is fraught with many, many difficulties, for they are now perhaps one of the most unreliable

types of equipment available for establishing base lies and things of that sort.

Dr Pagdin: Though I may have the time and the inclination to listen, my patient may be unwilling to talk. What advice can the panel give on the conduct of an interview which would otherwise result in silence?

Dr Lord: Terminate it. The whole point of an interview is to have mutual exchange of ideas and feelings. Some psychotherapists do whip their patients with silence, and this is a very unpleasant experience. All the other ones that I know who use it have been pretty skilful in their use of silence, but when the patients themselves sit solemnly mute and won't communicate at all, I think it is better to terminate the interview as politely as possible.

Dr Tonge: We must separate diagnostic and treatment interviews. In a diagnostic interview, where there was an initial consultation and the doctor raised topics which the patient was not prepared to follow further, then I quite agree; terminate the interview and wait until perhaps the situation comes back. It is bound to come back later when something else goes wrong. In the conduct of long-term psychotherapy when you are perhaps planning to give 30 seconds to the patient, silence can be a very valuable communication; depending upon what it means. Some silences are angry, some are relaxed and it depends on what interpretation you offer of the silence. This is a serious technical problem for the psychotherapist but I think this sort of relationship tends to occur only in specialist psychotherapy-clinics. As regards the initial interview I would agree with Dr Lord; terminate it and wait for a more opportune moment at a later time. May I just add something to this: the questioner does say that he may have both the time and the inclination to listen but his patient appears unwilling to talk. It would suggest that there is a pretty good opportunity for him to think about his own technique of metacommunication. Does he in fact fiddle with his pen, or touch a certificate or something on his desk, which indicates that he is restless? Is there soundproofing in his surgery? Does he sit back and listen? Does he look directly at the patient—in the face? Does he put on an interested expression? If the questioner will go back and review his own technique with respect not to what he says but what he does, and how he appears to his patient—get himself filmed interviewing patients, or get some of his colleagues, to watch him interviewing a patient through a one-way mirror—then perhaps he will find that more of his patients will be able to talk and that he is not embarrassed so much by this apparent silence.

Dr Cammock (*Tuxford*): Several speakers referred to doctors being 'too busy' to listen. Don't they really mean that the doctor is unable or unwilling to listen?

Dr Lord: This myth of the busy practitioner is something which was perpetrated on society by the advent of the National Health Service. People tend to think that therapeutic behaviour is the rightful province only of the medical profession, which I am sure it is not. But the population at large seems to demand therapeutic situations and management from people in general practice. This business of being too busy in general

practice is one of the symptoms of the present-day sociological disorder of general practice which we ourselves are perpetrating. Time can either be bought or it can be made and if you will remember this I think that the business of being busy in general practice or being too busy to listen will wilt away. If you organize your life efficiently, carefully, thoughtfully, you will always be able to arrange time to listen.

Dr Tonge: I am sure Dr Lord is quite right; but life can be very difficult, I know that when I have ten people to see in an outpatient department and I have got one hour left and sister wants to close, it is sometimes literally true that I cannot find time; we must remember that there are conditions in medical practice when for certain periods we may not have the time that we would like to give to people.

Dr Lord: You could always engineer a situation where you could beckon them on with a promise of more time a little later, but it is very difficult to stick to it.

Dr Tonge: From the point of view of the patient, I just wondered if Dr Lord is quite right in this. Consider also the difficult position that the patient is placed in; he may want to say something to the doctor and yet he knows there is a whole queue waiting. Unfortunately, some of the old waiting rooms are not soundproof, and he knows that other patients are going to listen-in anyhow. When I go to see my doctor, who is a friend of mine, he will start a conversation with me which I would like to continue on just a friendly basis, but I have to cut him short because I know that behind me there are a number of other patients. One could come back to my story about the enuretic girl; a lot of time was wasted by the general practitioner and this could have been avoided if there had been a better diagnosis and the case handed over to some other person able to deal with it.

Dr Lord: I think really what we are talking about is the next symposium which I suggest is: 'The art of delegation'.

Dr Bird (*Leeds*): Would members of the clergy be willing to visit old people living alone or with dependents, for about half an hour a week, just to listen to them talking of the past and generally taking them out of themselves, thus easing the burden on their families and their general practitioners.

Bishop Wickham: Theoretically one would wish to say 'Yes indeed,' and heartily endorse his proposal; it happens that one fifth of the population of our country is now over 65. It is a very large problem to know how good pastoral care can be given to older people in our community. In years gone by in earlier forms of society where you had your kith and kin around the corner—to a third and even fourth generation, there was no problem of older people in the community, but with our increasingly mobile society—and there is evidence to show that the more affluent a society becomes the more mobile it becomes—the problem of the old people is indeed serious. Anyone who has visited some of our large geriatric hospitals in Manchester knows how—in a way—these people are institutionalized. How tragic it is: the ward full of very old people, with just a foot or two of space between them, and all of them in advanced age and varying degrees of senility. To feel that the clergy must go and

talk to all of these people in our society is really unthinkable. A clergyman's task is quite a specific one, and I should like to say positively that this is a problem of community care, it is not simply a problem to be laid on the shoulders of the clergy. They will help old people in the limited time that they have, as doctors have to help them and to comfort them, and to talk with them and cheer them up and to stop them taking themselves too seriously, and in due course help them to die; all of which we need when we grow into old age. The continuing care of these persons in non-specialized medical ways ought to be through *community care*. We need great numbers of volunteers; men, women and young people who are willing themselves to undergo some kind of simple training to go and listen to other people, and to befriend an old man or an old woman or a couple of old people in a hospital. Why this is not organized on a wider basis I do not know. But that would be my judgement for the way that we meet the proposals in this question.

Chairman: Would anyone like to come in on that?

Mr Sanders: Sheffield churches have just appointed a social worker who will start on 1 November 1966, whose job it will be to co-ordinate officers of health and members of the churches, and they have thousands on their list. I have got lists in my office that were given to me, and I am told that I can contact any of these people. Quite frankly, it is too bewildering; it is quicker to get on the job yourself. But the job will be to select large groups of these all over the city and to give them some orientation and preparation rather than training, and then co-ordinate the need with the voluntary help. This is going to be available for all the services in the city: medical, psychiatric and social and so on. You might be interested if some of you are in the city, this is starting on 1 November, and this is really the way in which I think it should be worked, and the way the Bishop of Middleton had in mind.

Dr Scott (*Lincoln*): How can I get a social worker, psychiatric or otherwise, attached to my practice, and would she be classified as an ancillary helper under the new scheme?

Dr Lord: Never mind about paying him or her at the moment; this is generally done by the county council. All you have to do to get one is ring him up. If you don't know his name, ring up the local authority. They will fall over backwards to come and have case conferences and render case-work reports to you. One thing will lead to another and before you know where you are the social worker will be uncovering far more work than you ever dreamed of.

Dr Tonge: There is very little to add. Many of the patients who need psychotherapy or case work but cannot be handled from a clinic are dealt with by the mental health worker. Mental health workers feel that they are not sufficiently used by doctors, except to convey psychotics to hospital and back again. They are there to help with family problems and glad to be asked.

Dr Lord: I think that perhaps what Dr Scott really needs is to adopt an attitude in which he would be willing to accept either the psychiatric social worker or the ordinary social worker as a professional equal and

colleague; somebody who is called in consultation. Once he has accepted them at his level, I think he will find that they will come flocking round his practice and be of great use. Once you have established an intimate relationship with the patient the difficulty is to learn the art of delegating the continuance of his social problems or his psychiatric problems to somebody other than yourself; which brings me back to the original suggestion I made a minute or two ago, when I quite seriously suggested that the next symposium ought to be on the 'Art of delegation.'

Dr Alison Chapman (*Sheffield*): What do you do with a patient whom you know needs help but with whom you don't click or whom you cannot understand? Do you try to treat or pass him on to a colleague?

Dr Tonge: If you have a patient who makes you anxious—that is the way I can interpret this—you ought to pass him on to a colleague because if you are worried in that sort of way your help is not going to be very effective. You can help people very well, provided they don't trouble you; it is the ones that trouble you that you want to get rid of quickly. The other way round this is to talk it over with a colleague who can advise you; but don't be surprised if at the end of your counselling your counsel advises you to turn it over to somebody else. It is very hard to help people who disturb you.

Dr Fleming (*Mexborough*): Would the speakers care to comment on the patient's lack of the art of listening?

Dr Tonge: This is very important. I assume, Dr Fleming, that you mean a psychiatric patient. Most psychiatric patients are tense, and they are specially tense at consultation; it is literally true that they do not hear what you say. In my situation when I see a patient in consultation, perhaps on only one occasion, I try to persuade him to bring a relative, and when it comes to giving an opinion or advice I get the rest of the family in and give it to the whole lot. Somebody will listen to some of it; that is the one way I get round it. The second reply to this question is: 'I wonder if the doctor has really understood the patient's problem?' Going back to the example I gave: if you give simple reassurance which is not really what the patient wants, he will be unchanged. We think that we have coped adequately with the patient but the general practitioner refers him back a couple of months later with a new letter and it is clear to us that we did not 'bottom the problem'; I think that in these cases the patient was too tense and did not take it in or her concentration was too bad, or else one had not 'bottomed the problem'.

Dr Lord: There was some work done in general practice in Jerusalem, which was rather revealing, not only in regard to the absence of listening by psychiatric patients but by all the patients coming to a general practice. Before the patients went into the doctor, they were asked whether they thought they had a trivial or a serious complaint, or something which was neither trivial nor serious, but possibly troubling. After they came out of the consultation they were again asked the same question. The doctors in their turn were also asked whether they had communicated the nature of the patients' complaint in these three terms; there was absolutely no correlation between what the doctor said to any of his patients and what

the patient came out thinking about; this was pretty shattering.

Chairman: I may say that in Jerusalem at the moment, a Sheffield graduate is producing a book with the professor of medicine, Dr Groen, on 'Why do patients go to a doctor at all?' This I think should be quite revealing. In the confessional in the Roman Catholic Church (as I understand it) the priest's role seems to be largely that of a passive listener. Does the bishop feel that such passive listening would be useful in other denominations or would he regard it as a poor substitute for communication of a two-way character?

Bishop Wickham: This is not only relevant to the Roman Catholic Church; the confessional is also in the Church of England, and I would think that all churches have their mode of confession. We should not be too restricted in using this word 'confessional' in the narrower sense. The first thing about the confessional is its anonymity; a person goes to make confession *not* to the priest but to Almighty God in the presence of the priest; not to receive psychiatric help and not necessarily to receive advice, although a priest might dwell on many things and seek to give counsel or advise a penitent that he or she might consider seeking the advice of some other person such as a doctor. The essential thing that happens in the confessional is that a person confesses his sins to God and receives assurance—and I choose my own words here—of God's forgiveness. This remains the most important factor in the confessional. You do not go to the confessional for psychiatric advice; you should not go to the confessional for medical advice; you do not go to the confessional for legal advice and yet things that are said in the confession could well be concerned with medicine or the law or with psychiatry. You do not go there for that kind of advice; you go there primarily and almost solely to confess your sins and to be assured of God's forgiveness. Now I believe that psychiatrically this is a very helpful thing to a great number of human beings, but it is not ultimately this justification that is therapeutically useful. You could do this without any of the priestly rituals and we know that confession is good for the soul whether you go to a priest or whether you do not: you go there as you are with everything admitted, to be assured quite simply that God loves sinners. You are acceptable, if I may use that word, which is, like listening, a biblical word and I think now frequently used in psychological writings also. In other words, it is a *restored* relationship that is made, when you feel an alienation from the living God through things that you have left undone; that sense of acceptance is made real and is *affirmed* to you again on the authority such as the Church can give. This is the nature of confession. But stemming out of that, there may be things revealed. This is where the priest needs to be a good listener and sometimes ask a little question such as: whether something or other might not be considered, whether some other more specialized help might be taken; it might well be a lawyer or a doctor, or a psychiatrist, or anybody.

Chairman: Thank you very much. A good many comments have come your way Dr Tonge; have you anything to add?

Dr Tonge: Yes I have! When people talk about confession—I don't mean clergy but the non-clerical people—they seem to have two different views. Some people talk about confession as if they feel that they have broken the rules and they must ask for forgiveness and have 'the slate wiped clean'; 'the kettle scraped' as one of my catholic friends says. This I suppose is one view. There is another view of confession which is of great interest to me as a psychiatrist, namely, that confession is looking fairly and squarely at our limitations, disabilities, weaknesses, our mistakes, and doing it so to speak in the sight of God; even though you could not help doing it, nevertheless you realize this is your limitation. I don't know whether the bishop would consider the latter as being theologically acceptable, but if so it is a moot point whether confession is good psychiatry or psychoanalysis is good theology, which comes down to very much the same sort of thing.

Bishop Wickham: I am so glad to hear you say that, and I agree wholly. It seems to me that using the adjective 'theological' in addition to 'psychiatric' is to speak about an 'ultimacy' beyond the case and beyond you here. It is, so to speak, about an ultimate significance of you and this situation which I think belongs to the possibility of meaningfulness in our lives.

Dr A. P. Tait (*Chesterfield*): Apart from the obvious case of myxoedema, do you think that characteristics of a voice can give an indication as to organic disease?

Dr Lord: This is not quite so outlandish as it seems. We are all quite familiar with the intonation of a deaf person; you can even diagnose a deaf patient on the telephone. Myxoedema we know about, and I think many of the aphasias can be diagnosed. The questioner probably has some theory about the arthritic having a musical voice. I think I would like to throw it back to him and ask him to develop it a little more.

Chairman: Dr Tait, would you like to add anything to this question?

Dr Tait: It so happens that I have been interested in this odd question of the relationship of voices to organic disease for a long time. I have carried out some research by simply putting on tape interviews between myself and patients with organic diseases. I was rather shattered to find that the tape recording possibly revealed more about my inadequacies as an interviewer than it did about my patients. However, by collecting and classifying cases of organic heart disease and arthritis and so on together with bronchitis and all the stress diseases—gastritis, sinusitis and so on—I think I can detect characteristics that one could almost begin to identify. The difficulty here is to produce a vocabulary which will describe adequately a human voice, its pitch and all the variations. I got stuck on this one because I found that without a tape machine to illustrate my point I couldn't really talk about this to anyone else, however meaningful the work was to myself. Many of my osteoarthritic male patients had a curious musical character about the voice: the sort of voice that set out to be charming, with almost a singing quality. This again emerged merely because of listening to these recordings. Another sort of voice which associated itself with a cardiovascular disturbance was a curious

'constipated voice'; the voice was far back and strained, with a hesitation in it as well and lacking ease of flow.

Dr Stuart-Harris: I think Dr Tait has made out a strong case for his producing a scientific paper on this subject.

Dr Baker (*Sheffield*): How long at a time can you go on listening and how does the character of your listener alter during this process?

Dr Lord: I think you can go on listening as long as you are interested. I think it is just as simple as that.

Lord Wilberforce: I suppose there is a scientific answer to this though I don't know what it is, but I am quite sure that, even with training, to listen for two hours is as long as the ordinary person can stand at a time, and four hours in a day is rather beyond what a person can stand. Of course there are all sorts of qualifications of that, depending upon whether it is the same person speaking, whether you have a change of scene or change of argument or a change of incident to help. It also depends on whether the subject matter is one which requires continuous attention, like an argument with figures and graphs and so on, or whether it is a looser type of argument. The American Supreme Court doesn't let anybody address it for more than half an hour at a time, that being their estimate of a useful period of argument, and I think most continental courts follow the same sort of pattern. We have extended our capacity and forced ourselves to go on longer but I think most of my colleagues would agree that we have just about reached the limit of psychological endurance with two hours.

Professor Stuart-Harris: I hope that none of the students are listening to this, because its bad enough to get them to listen for one hour.

Mr Sanders: I think that if you are talking in terms of dealing with patients, and case work and so on, I would have said an hour is the maximum that anyone should deal with a case, especially with matrimonial work, which we always try to limit to one hour; even that is too long. Beyond that, neither the patient nor yourself has gained any benefit and you must leave the interview in such a state that it can be continued anyhow on another occasion. I should hate an interview that had to go on longer than 50 minutes to an hour at any rate.

Lord Wilberforce: People frequently listen to music for five hours. This is a form of listening not discussed today but it is one which requires attention and intellect and emotion; if you can do this for five hours or so, there must be some latitude in this answer.

Bishop Wickham: I think, too, it is important whether one is listening to monologues or whether one is participating in a dialogue. A good dialogue is something that can go on for a very long time—all through the night—and is on the whole a creative part of human living.

Dr Clowe (*Lincolnshire*): I would like to ask a question which I think is very important to us all. Good listening very often leads to dependence. Dependence is very difficult to determine; sometimes it is a disadvantage not only to the doctor but to the patient. Dr Lord's answer to this might be delegation, but delegation is not always possible nor always the adequate

answer. I would like to hear the views of the panel on this.

Dr Lord: Patients do become dependent on many other things apart from drugs and they do, as you say, become dependent upon the drug 'doctor', but it is just as easy to switch off the doctor as it is to refuse to prescribe the tablets. The difficulty is when you come to dealing with the withdrawal symptoms. Fortunately the number of occasions when the patients come demanding to be heard at times when it is not convenient are pretty few and far between, and then we always have the safety valve of the consultation. Consultations are marvellous things—we don't use them nearly enough, whether it is with other colleagues or with specialists or with psychiatric social workers. Very often in the consultative process a change of attitude and values takes place not only in the doctor but in his patient, and this very often is the answer to your need to terminate your listening time; it alters the patient, for he takes his demands elsewhere.

Dr Tonge: This is a very difficult problem. It must be accepted that there are some people who continuously require support in the way that a diabetic requires insulin for an intermediate period; it is not a pleasant fact but one we must face. You can avoid it by not allowing a patient to speak for more than ten minutes at a time, but then you will still have other troubles and they will perhaps have more symptoms. I think one has to learn to live with this dependency; I don't think we can avoid it; I find it a help with such patients to make appointments which are not too close together, and then it is not too much of a burden to them or myself. The real problem comes with *the type* of dependency, because you can be dependent in all sorts of ways. There is a type of childish dependency on the doctor which can be very demanding, and which occurs in the sort of case with which some psychotherapists have to battle. If in general practice a childish dependence develops, it is best to seek a second opinion. Apart from these difficult cases, one has to accept and live with a certain degree of dependency. The more secure people are in their dependency the fewer demands they make from you. It is the insecure dependent people who make the most outrageous demands; if they know that they can guarantee a certain portion of your time every so often, then it is surprising how many are content with that. I am very rarely rung up by dependent patients; it is surprising how often they will wait until the next appointment.

Dr Elliott (*Heanor*): This is not really a question but it is something to do with a question that was put to the bishop about crowded surgeries and empty pews. Can you explain how we poor general practitioners can just stick to being general practitioners? Nowadays, we find that people come to us with all kinds of problems when they should go to a solicitor, or they should be going to the parson, or should be going to a marriage guidance counsellor. In the end we say to them: 'It is not really a doctor you need, it is your lawyer or marriage guidance counsellor'. What do you think is the best solution to being put on this sort of pedestal? It even happens in trivial things like signing passport forms or any legal documents; the first person they think of in the community to sign these documents is the doctor.

Professor Stuart-Harris: In a way this is just a reflexion of the society's

dependence on a doctor.

Bishop Wickham: I think you cannot evade the consequences of being esteemed by society: the clergy have experienced this in history and in some periods of history have been prime ministers. They have done all kinds of things; there is hardly any job that they have not done. At some time they have been clergy, the people who were leading society in so many ways. In a secular society this is bound to change and I don't deplore this change. I welcome the inevitabilities of a secular society, and believe it falls within the providence of a living God. In the course of this secularization we shall see many new *élites* come into existence, and one will be your own. Because man is preoccupied with the body, I can well understand that a doctor in our society will tend to have the same kind of mystique that the priest had in an earlier form of society, so you cannot avoid being that: a friend, a philosopher, a guide. Just to know this is to be forewarned about it. The Church and her ministers must be much more attuned to a secular, modern society, and be able to help people a bit more, but I think it is inevitable that doctors will have many problems loaded upon them. One would like to think that we shall see proliferation of many forms of social service, for example, a greater provision of psychiatric services which undoubtedly would relieve the doctor of many things. Greater provision of social workers and of psychiatric social workers in our society would relieve the medical profession of many things that are simply dumped on its plate. There are consolations: your prestige in society is high even if you might not think so from the Chancellor of the Exchequer's attitude about stipends. In a recent survey published by University of London Press on religion in our society, people were asked to list those people in society whom they regarded as socially the most valuable to the community; it may interest you to know that doctors were at the top. This is how the ordinary people think: the doctors were at the top, the second were teachers, and the third to my surprise were clergy—the rate comparatively high. Whether this is really so or not I do not know, but they were rated high. I won't tell you the professions that were rated rather low, but I am telling you that you cannot avoid the significance of being part of the *élite*.

Professor Stuart-Harris: Now you can give yourselves a pat on the back.

Dr Elliott: I am sorry, but being a woman I have to have the last word. What I was really referring to were the paramedical things that we are asked to do. I was not meaning psychiatric cases, because they are part of medicine and it is our duty to treat them ourselves or refer them to a psychiatrist or get help from the psychiatric social-worker. I was thinking more of the people who don't need a psychiatrist but who need a marriage guidance counsellor or the vicar to help them.

Bishop Wickham: I would just say that we need a proliferation of other kinds of services to deliver the doctor from a lot of his burden, but I do not think that it can be otherwise, in the complex society in which we live and in which people's judgement about what is wrong may be decided by a physical symptom and something in their body. I cannot believe

that you can, as it were, leave this very bewildering generation the task of making a clear demarkation as to whether they want a psychiatric social-worker or whether they want a psychiatrist or whether they want a social worker. In our kind of society, I suspect more and more that they are going to consult the doctor; unless the doctor becomes so remote from our society in a bureaucratic structure that he is as lost as these other people.

SUMMING UP

Professor C. H. Stuart-Harris, *C.B.E.*: I should like to summarize if I may what we have been listening to; we have had five most outstanding addresses.

I think Lord Wilberforce set the tone of the subsequent discussions because he gave us the most penetrating analysis of a judge's mind as he sits up there listening for five hours each day. Everyone found this quite fascinating. He pointed to the interpretative type of listening with which as doctors we are familiar; though we may not be ourselves judicial in our approach, at least we have to interpret what is said, for the benefit of the patient, in order that the whole process of diagnosis and treatment may roll forward. I am sure you would want me to thank him specially for that particular contribution.

Then we heard of listening from Mr Sanders—listening for 'The cry for help.' This also was fascinating and the social apparatus in society today has emerged very clearly in this symposium as being part of the whole process of living. We must be very closely aware of the problem that is faced by those working as Mr Sanders does, in relation to apparently purely medical symptoms.

Dr Tonge gave a very good account of listening in a psychiatric sense, and this was listening in the third dimension. I would like to thank him for that because it was a very exciting and very interesting way of putting the psychiatrist's point of view. So often we do things without understanding why we do them, and I think now that most doctors, even family doctors who deal for a lot of the time with psychiatric illnesses of a varied character, must have appreciated what he had to say; listening for the things which have not been said—the fears and problems unexpressed.

Bishop Wickham gave us a very illuminating account of listening in the biblical and religious sense, and he told us to keep still or to be still, and listen; this I think was a splendid contribution. He also talked about the problem of listening with the sociologically-attuned ear. This is something which we cannot avoid; it is the doctor's burden in modern society. There is the lively expression too which he coined for us that 'in the world of steel and concrete, sex is the only green thing'. Thank you for that comment.

We heard from Dr Lord a most interesting account of the function of a doctor—all the various attributes of family doctors. We have so many family doctors here that you could express better than myself how well