passers-by) would approach me and tell me about their pregnancies and children. One lady even insisted on reading my palm to predict the sex of the baby (she was right!).

I worked until quite late on in my pregnancy (38 weeks) and on receiving days I began to correlate the patients' psychiatric diagnosis with how long it would take them to comment on my protruding abdomen.

Manic patients would tend to mention it immediately, pat my belly and then launch into a series of very personal questions regarding the baby's conception! Depressed patients would generally make no comment on their initial encounter with me, but I took their later enquiries about my preference for a boy or a girl as a fairly reliable sign that they were improving and taking more interest in people around them.

Patients with schizophrenia often seemed to incorporate pregnancy and babies into their symptomatology. One schizophrenic lad stopped suddenly mid-interview, mid-sentence and asked "Are you pregnant, Doctor?" When I replied that I was, he asked me in all sincerity, "Am I the father?" He felt he was experiencing such powerful bodily influence that somehow he had impregnated me without knowing. Thankfully this thought did not remain as part of his delusional system. Another acutely disturbed schizophrenic man threatened to pull a knife on me until he realised that I was pregnant and then offered to do a caesarean section! Luckily help was close at hand.

In psychotherapy, a female patient was able to talk for the first time about a termination she had had several years previously, and began to tackle very painful issues of loss and guilt surrounding this. It was interesting to observe this patient's ambivalence towards her own mother becoming evident in the transference as my impending motherhood drew closer.

Self-disclosure is a subject of some controversy in psychiatry but when the doctor is pregnant it is difficult for patients to deny the human component of their therapist and some degree of self-disclosure is therefore inevitable.

I am not sure whether pregnancy has such profound effects on the doctor-patient relationship in other branches of medicine, but certainly in psychiatry it enabled me to glimpse briefly into an aspect of my patients to which I might otherwise have never had access. For my part, perhaps now as a parent as well as a doctor I will have a more empathic understanding during my current placement in the Department of Child and Family Psychiatry.

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# Correspondence

## *The management of empathy*

DEAR SIRS

The reforms of the NHS are altering our culture. The three Es of the business world – Effectiveness, Efficiency and Economy – are becoming the dominant value. In some places this is happening at the expense of a fourth E – Empathy.

The task management has to create an environment in which efficient and effective treatment is provided with care and sensitivity. Patients who come for help expect a diagnosis which leads to effective treatment. But this is not all they want. They are in distress and so want care and concern. They want doctors and nurses who are willing to listen and able to understand how they are feeling. They need clinical staff who are empathic.

Empathy is a complex and demanding process which involves being in tune with the patient. It requires the clinician to put his own worries and concerns to one side in order to give his full attention to the patient: listening to patients, recognising their distress and responding to their emotional needs is taxing and demanding work. Although the capacity for empathy develops with training and experience it also needs a therapeutic setting in which sensitivity and understanding are possible. Privacy, quietness and uninterrupted time are essential. This means designing wards, clinics, consulting rooms etc in such a way that the necessary atmosphere of safety is created. Only then will patients be able to show their feelings.

Empathy needs management which involves attention to the corporate culture as well as to

the physical environment. The aim, the ethos, and the values of the service are fundamental and determine whether emotional needs should be recognised and responded to. In a therapeutic corporate culture the service is organised around the need to understand how patients feel. This contrasts with a persecutory culture in which emotional patients are regarded as a nuisance and their feelings as a burden which interferes with the treatment. Such cultures are fuelled by anxiety and staff are motivated by criticism and disapproval. Empathy cannot survive in such conditions.

Abusers have often suffered from abuse and the oppressed can easily turn into the oppressors. This is the danger of a persecutory culture. Staff who work for an organisation that ignores their emotional needs are in danger of being insensitive to their patients' feelings. If the persecuted tend to become persecutors, then the cared for tend to care. Empathy begets empathy. Caring for staff, recognising their emotional needs, valuing and supporting them is the best way to ensure that they listen to and understand their patients.

Managers and clinicians actually have the same goal. They both want a caring service that is efficient and effective. Effectiveness depends upon good clinical practice, efficiency upon sound management, and caring on an understanding of human nature. They must therefore work together to produce a well managed and clinically proficient service that is sensitive to individual need, to create a therapeutic culture in which the emotional needs of managers, clinicians and patients are attended to. Empathy is managed by empathy.

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## *Prescription charges and recurrent depression*

Recently a patient attending my out-patient clinic suffering from recurrent depression, became unwell again. She is normally maintained on a combination of lithium and a tricyclic anti-depressant. She relapsed because she had stopped her medication, claiming that she could not afford the prescription charges. Her insight has never been good, and she receives scant support from her husband, who is in full-time employment earning a low wage. My patient looks after her young children. The family just fail to qualify for help with prescription charges, although they are the typical sort of family described in a recent national survey as being likely to have financial difficulties (Laurance, 1992). It is well established that women in such families have a high rate of depression.

The World Health Organization now advises prophylactic medication for patients with recurrent episodes of unipolar depression. I have certainly found this strategy to be useful. I would have thought that a case could now be made for sufferers of recurrent depression to be made exempt from prescription charges. The Department of Health leaflet P. 11 states that sufferers of diabetes, epilepsy and hypothyroidism (plus others) are entitled to free prescription, presumably because they require medication to remain well as opposed to needing treatment to get better, so why not extend this principle to those who need maintenance psychotropic drugs to keep them euthymic? Perhaps the Royal College of Psychiatrists could take up this issue in its forthcoming campaign to "Beat Depression".

The recently announced increase in prescription charges does not, I fear, improve the immediate prognosis for my patient.

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*Professor A. C. P. Sims, President, writes* "Thank you for making this useful point; the matter will be discussed further at the Executive and Finance Committee of the College".

*Reference*

LAURANCE, J. (1992) More families fall into debt. *Times*, 27 February, 3.

## *Treating physical illness without consent*

DEAR SIRS

It is well known that the Mental Health Act does not contain provisions to enable treatment of physical disorders without consent. However, it seems less widely known that it is possible to first detain someone under the MHA, and then under common law treat a physical disorder without consent, if the physical disorder is *caused* by a mental disorder or is itself the *cause* of a mental disorder, and treatment of the physical disorder is considered to be in the best interests of the patient.

One of our patients who suffers from schizophrenia presented with a history and clinical signs consistent with a major head injury. He was unwilling to undergo investigation or treatment and the MHA was used to facilitate doing so. The patient was found to have sustained an extradural haematoma and underwent an emergency craniotomy and drainage.

Although initially detained at the psychiatric hospital under Section 4, the investigation of the physical disorder was carried out under common