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Comments on psycho-oncology


In a recent study by Watson et al (1999) of 578 patients with early breast cancer, the association found by Greer (1979, 1990) between fighting spirit and a longer period of survival was not confirmed, although the association between depressive symptoms (as measured on the Hospital Anxiety and Depression Scale) and worse survival was. This is an important finding given the significance attributed to fighting spirit by many patients and their resultant anxiety if they think they do not have, but should have fighting spirit.

Montgomery mentions Spiegel et al's (1989) finding that metastatic breast cancer patients randomly assigned to receive group therapy lived on average 18 months longer than the control patients. This has been challenged by Fox (1998) who pointed out that the treatment group did only as well as the national and local average while the control group died at a faster than average rate. This suggests a sampling error and casts doubt on the supposed positive effect on survival of this type of treatment.

A major problem for psycho-oncology remains the low esteem in which psychological treatments are held by oncologists and cancer surgeons. Underlying this is a dilapidated Cartesian dualism, that is the mind and body are two very different substances, so different in fact that an interaction between the two can hardly even be conceptualised. Psycho-oncologists, for their part, have failed to suggest an alternative model—or even to show any interest in the problem.

References


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Stigmatisation of psychiatric disorder


As a registrar, I was once asked to see a known patient, suffering from schizophrenia and 'hearing voices' in casualty. I asked what had brought him into hospital and he described a severe chest pain. I checked the casualty card on which was simply written "hearing voices—refer psyche". After further investigation, it became apparent that his only concern was his chest pain and that the hallucinations were incidental, chronic and not bothering him in any way. No physical examination or electrocardiogram had been
attempted, so I asked the casualty officer if the patient had indeed complained of chest pain on admission. "Yes" was the reply, "but he was also hearing voices".

With up to 80% of psychiatric patients suffering from physical illness (Hall et al, 1981), this example highlights the great need for adequate training and education, especially at medical school, if discrimination and stigma are to be reduced.

**Reference**


**Writing to patients**

Sir: In his editorial entitled 'Writing to patients' Marios Piérides (Psychiatric Bulletin, July 1999, 23, 385-386) says that "There have been no published data on the effects of writing to psychiatric patients". This is not true. In the 1980s the Department of Psychiatry at Milton Keynes carried out a randomised study of writing to the patient after an initial out-patient consultation compared with the usual procedure of writing to the general practitioner. Outcomes in terms of satisfaction, comprehension and adherence with treatment were assessed by a clinical psychologist. Patients who received a letter were significantly more satisfied than patients who did not (Asch et al, 1991) and this was confirmed by their comments on the procedure (Price & Asch, 1990). It was suggested that writing to patients should become part of medical education (Price, 1993) to supplement other training in communication skills.

The possibility of writing directly to psychiatric out-patients was also addressed by Thomas (1998), who found that, with the exception of patients with schizophrenia, there was considerable interest in receiving a letter. This confirms our experience in Milton Keynes in which the small number of patients with psychosis did not respond favourably to the letter, whereas the great majority of patients without psychosis were enthusiastic — some of them commented: "Why can't all doctors do this?"

**References**


