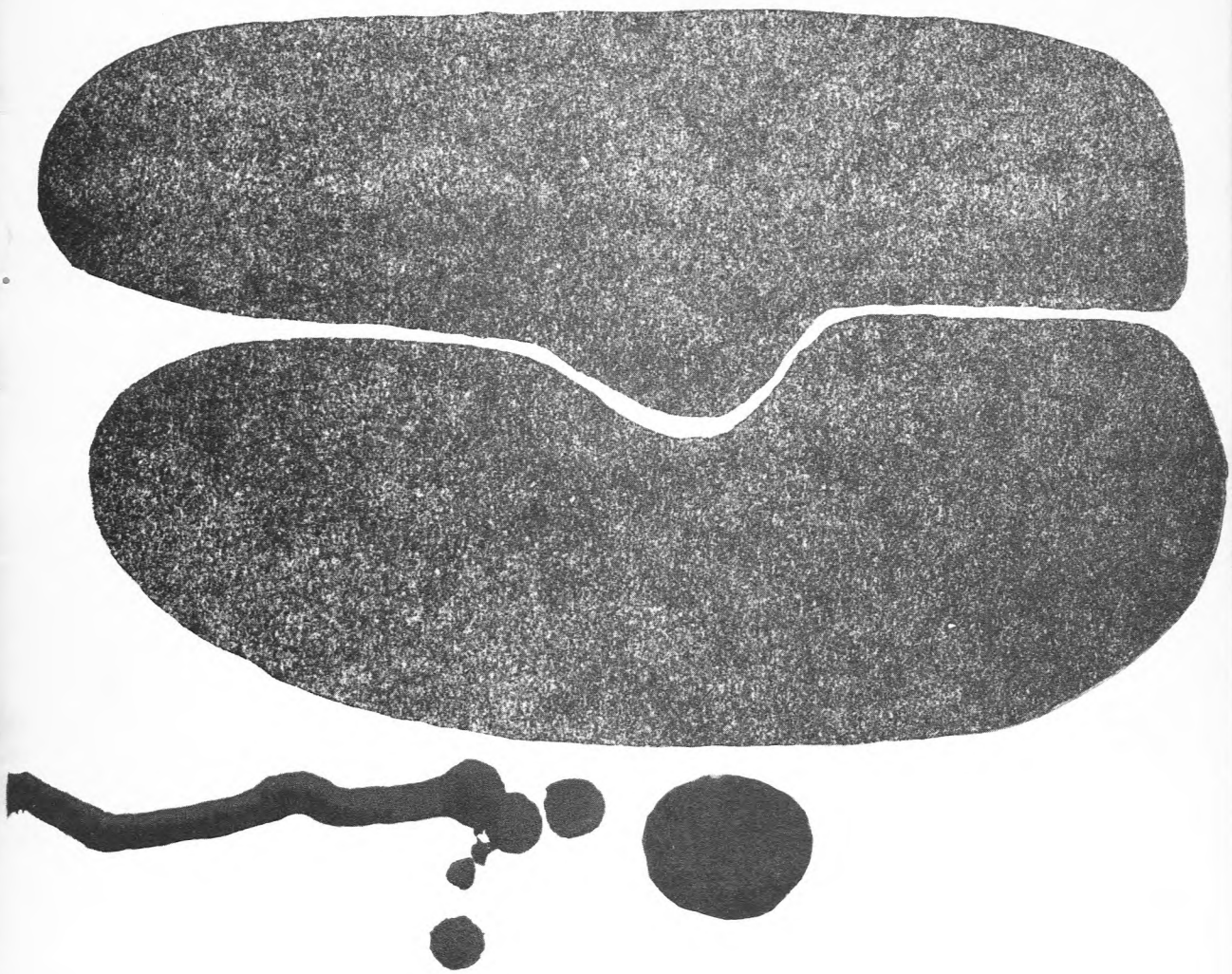
JUNE 1971



JOURNAL

OF

THE BALINT SOCIETY

Vol. 1, No. 1.

JOURNAL OF THE BALINT SOCIETY

Vol. 1, No. 1, June 1971

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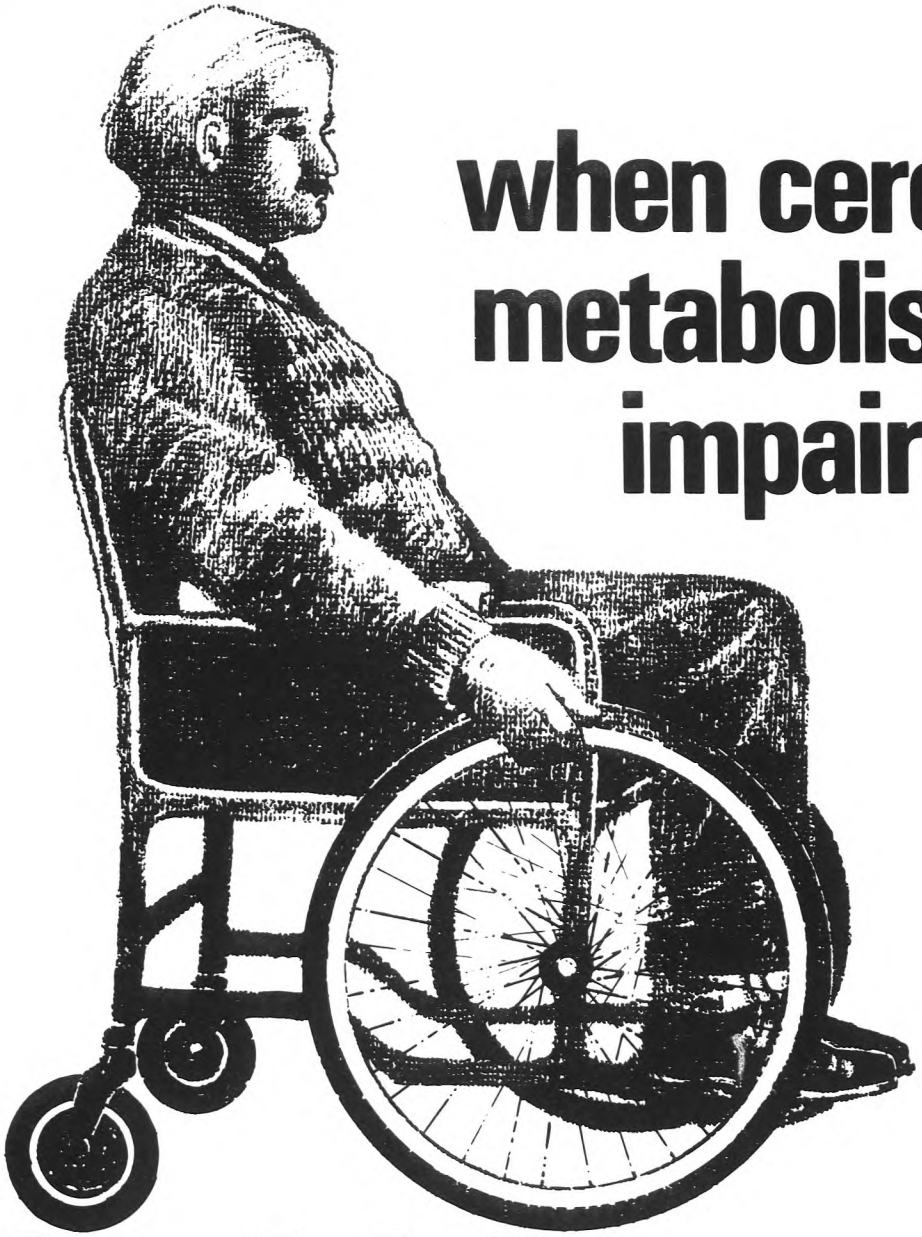

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EDITORIAL

With this first issue of the Journal of the Balint Society, all members will feel both sadness and pride. Sadness, because Michael Balint is no longer. He died on 31st December, 1970, leaving us bereft of his guidance, friendship, and fellowship. The formation of our Society was a source of pleasure and gratification for him. Pride, because by producing and publishing this Journal we shall no longer remain a private society with private discussions in a small private world. This Journal will expose us, our ideas, our discussions, to the views and criticisms of informed public medical opinion. This is an important event, not only for our Society, not only for our specific fields of thought and research, but for general practice and thus for medicine. We represent a certain point of view of human pathology and nosology, and we believe that this is an advance on traditional concepts in medicine. Michael Balint's ideas, and our thoughts that are built on them and have developed them further, have proved of considerable usefulness in our daily work. How far they can be further developed into a frame of reference for scientific medical thought will be up to us.

Those of us that have been working for years with Michael Balint have become so immersed in this new realm of thought that, perhaps, we are accepting as fact and established truth, what to many others may be completely novel, assumptions, and at times perhaps even esoteric. Self-criticism and criticism by others should help us to formulate our thoughts and ideas, so that they may become free from hasty assumptions and conclusions.

This Journal is meant to be a forum for scientific discussion, especially in the fields of the doctor-patient relationship, its use in diagnosis and treatment, and of a medicine that takes into account not only the illness, but also the doctor, and the patient in his total situation.

As yet, human pathology is still restricted by preconceived notions, by our bias, fears, inhibitions. It will take a great deal of courage, clearness of mind, abnegation of prejudice, and honesty of thought to build a new framework on the great achievements of medicine, a framework that rests not only on anatomy, physiology, and related disciplines, based on the natural sciences, but also on the discoveries in the vast and as yet much unscripted field of emotions, the domain of human relations, and the realm of social interactions.

This Journal will also be open to papers from workers outside our Society who wish to make contributions to the particular subjects in which we are interested.

Would members please forward a complete list of their publications with yearly additions to the Editor.

The Editor would welcome personal news of members, reports about lectures they have given, appointments, etc., for publication in the Journal.

Will members please send one copy of any book or pamphlet and one copy of reprints of any papers they may have published, to the Editor for the archives of the Society and for review in the Journal.

Mr Victor Pasmore, C.B.E., has kindly designed the Front Cover of the Journal. We owe thus a great deal of gratitude to this distinguished artist.

We wish to acknowledge with thanks the financial assistance of Messrs. Lloyd Hamol Ltd., which enabled us to print the first issue of this Journal.

The Balint Society
(Founded November 1970)

President:	Dr. Philip Hopkins
Vice-President:	Dr. Margaret McNair
Hon. Secretary:	Dr. Stephen Pasmore 21, Edwardes Square, London, W.8. Telephone: 01-537 2600
Hon. Treasurer:	Dr. Aaron Lask
Hon. Editor:	Dr. Max B. Clyne 150, Lady Margaret Road, Southall, Middlesex. Telephone: 01-574 2812
Member of Council:	Dr. Michael Courtenay
Member of Council:	Dr. Max Meyer

Manuscripts and communications for publication in the Journal should be forwarded to the Hon. Editor. They should be typewritten, double-spaced, on one side of the paper only, with margins of 4cm.

CONSTITUTION

1. **The Name of the Society:**
The Name of the Society shall be 'The Balint Society'.

2. **The Aim and Objects of the Society:**
The Aim of the Society shall be to promote and advance research and studies on the psychological aspects of general practice, with special reference to the doctor-patient relationship, and to disseminate this knowledge beyond the Society for the improvement of the medical care of the public at large.

Powers in Furtherance of these Objects. In furtherance of these objects, but not otherwise, the Society through its Council shall have the following powers:-

(i) To provide an opportunity for the study of similar problems as experienced by members of branches of the other helping professions, and in this connection to support and promote seminars of the Balint type already established in this country and elsewhere.

(ii) To promote the publication of the transactions of the Society and other relevant material.

(iii) To establish relationships with similar charitable Societies.

(iv) To assist any charitable body or bodies financially or otherwise.

(v) To obtain, collect and receive money and funds by way of contributions, donations, affiliation fees, subscriptions, legacies, grants, and other lawful method, and to accept and receive gifts of property of any description (whether subject to any special trusts or not).

3. **Membership of the Society:**
Membership of the Society shall consist of Ordinary and Honorary Members with power for the Society at a future date to establish a class of members to be known as Associate Members as provided by sub-clause (iii) of this clause.

(i) **Ordinary Membership.** Ordinary Membership shall be open to registered Medical Practitioners who have taken part in Balint-type seminars for not less than two years and who are preferably in General Medical Practice. The names of the first Ordinary Members of the Society (for the purpose of this clause described as "Foundation Members") are set out in the Schedule hereto. The Foundation Members prior to the first meeting of the Society have taken the following action:-

(a) Elected a President, a Vice-President, an Honorary Secretary, an Honorary Treasurer, an Honorary Editor and two other members of the Society, who together form the first Council of the Society.

(b) Approved a list of persons as Ordinary Members of the Society.

(c) Approved a list of persons as Honorary Members of the Society.

Subsequent candidates for Ordinary Membership shall be proposed by an Ordinary Member of the Society and shall have previously attended at least one meeting of the Society as a guest. The proposer shall submit the candidate's name and qualification for Ordinary Membership in writing to the Hon. Secretary two months before the next General Meeting. Nominations for Ordinary Membership will first be considered by the Council and submitted by them for election at the next General Meeting.

(ii) **Honorary Membership.** Persons considered to be of outstanding merit by the Society shall be eligible for Honorary Membership. Subsequent nominations for Honorary Membership shall be proposed by the Council who will submit names for election at the Annual General Meeting.

All candidates for Membership of the Society, after election, shall receive a letter of invitation to join the Society. Membership, except in the case of Honorary Members, shall then take effect on payment of the Society's subscription.

Election shall become void in default of payment of subscription within three months. Ordinary Membership shall automatically lapse when no single attendance at an Ordinary Meeting is recorded throughout the twelve months following the last Annual General Meeting or when the subscription has not been paid within three months of the Annual General Meeting unless the Council shall have accepted mitigating reasons.

(iii) **Associate Membership.** The Society shall have power at the Annual General Meeting or at a Special General Meeting convened for the purpose to establish a class of members to be known as Associate Members. Such Members shall be persons not possessing the necessary qualifications for election as Ordinary or Honorary Members. At the Meeting establishing the class of Associate Members the Society may impose such requirements as to qualification, election, voting rights and the like as it sees fit.

4. The Affairs of the Society.

(i) **Management.** The affairs of the Society shall be managed by a Council which shall consist of the President, the Vice-President, the Honorary Secretary, the Honorary Treasurer, the Honorary Editor and two others. Such Officers other than the Hon. Secretary, Hon. Treasurer and the Hon. Editor shall not be eligible to hold office continuously for more than two years. All five Officers shall be subject to annual election. Ordinary members of the Council shall not be eligible to hold office continuously for more than Three years and shall be subject to annual election and no Member shall serve on the Council in any capacity (other than as Hon. Treasurer, Hon. Secretary or Hon. Editor) for more than Seven years continuously.

(ii) **Election of Officers.** Candidates for election for the Offices of the Society and for the Council shall be Ordinary Members of the Society. They shall be proposed and seconded at an Annual General Meeting and shall be subject to election by a simple majority of votes. Nominations for the Officers of the Society and for the Council must be in writing and must be in the hands of the Secretary at least six weeks before the Annual General Meeting. Such nominations shall be circulated with the Notice of the Annual General Meeting.

(iii) **Meetings of the Council.**

(a) The Council shall meet before the Annual General Meeting and at such other times as the Council may determine.

(b) At all meetings the chair shall be taken by the President, or in his absence by the Vice-President, or in their absence by a member elected by the meeting.

(c) At a meeting of the Council four of its members shall constitute a quorum.

(d) The Council shall have power to fill executive offices and vacancies among members of the Council by co-option until the next Annual General Meeting.

(e) The Council may at their discretion invite other members of the Society to attend Council Meetings, but without the right to vote.

(f) The Council shall be empowered to appoint sub-committees.

(iv) **Subscription.** The Annual subscription to the Society shall be £5, subject to review at subsequent Annual General Meetings.

(v) **Bank Account.** The Council shall open a Bank Account for the Society and appoint two or more members of the Council to sign cheques.

(vi) The income and property of the Society whencesover derived, shall be applied solely towards the promotion of the purposes of the Society as set forth in this constitution, and no portion thereof shall be paid or transferred directly or indirectly by way of dividend bonus or otherwise howsoever by way of profit to any member of the Society. PROVIDED that nothing herein shall prevent the payment in good faith of reasonable and proper remuneration to any officer or servant of the Society or the repayment of out-of-pocket expenses.

(vii) The Society may appoint and determine the appointment of a custodian trustee or a trust corporation of not less than three persons to act as trustees for the purpose of holding any monies or property belonging to the Society.

5. **Meetings of the Society.**

(i) The Society shall hold a minimum of four Ordinary Meetings each year, one of which shall follow on the Annual General Meeting.

(ii) The Annual General Meeting shall be held each year before the 30th June on a date to be fixed by the Council, and each member shall receive three weeks' notice of the meeting.

(iii) At each Annual General Meeting the Council shall present a report on the affairs of the Society during the preceding year.

(iv) At each Annual General Meeting the Honorary Treasurer shall present a statement of accounts, audited by two Ordinary Members of the Society appointed by the Council.

(v) The President and Council may at any time call a Special Meeting of the Society, and shall do so on receiving a written request from at least 15 Ordinary Members. At least one week's notice of the date and business of this meeting must be given to every Member, and no business shall be conducted other than that notified.

(vi) Voting shall be restricted to Ordinary Members.

(vii) The quorum for an Annual General Meeting shall be 10 Ordinary Members.

(viii) The quorum for a Special General Meeting shall be 20 Ordinary Members.

(ix) At all meetings the chair shall be taken by the President, or in his absence by the Vice-President, or in their absence by an Ordinary Member elected by the meeting.

(x) Members shall be entitled to bring guests to an Ordinary Meeting.

(xi) The Society year shall run from April 1st to March 31st.

(xii) The Society may at any time be dissolved by a resolution passed by a two-thirds majority of those present and voting at a meeting of the Society of which at least twenty-one clear days' notice shall have been sent to all members of the Society. Such resolution may give instructions for the disposal of any assets held by or in the name of the Society, provided that any property shall not be paid to or distributed among the members of the

Society but shall be given or transferred to such other charitable institution or institutions having objects similar to some or all of the objects of the Society as the Society may, with the approval of the Charity Commissioners or other an authority having charitable jurisdiction, determine.

(xiii) Alterations to the constitution shall receive the assent of not less than two-thirds of the members of the Council present and voting. A resolution for the alteration of the constitution shall be received by the secretary of the Society at least twenty-one clear days before the meeting at which the resolution is to be brought forward. At least fourteen clear days' notice in writing of such a meeting shall be given by the secretary to the members and shall include notice of the alterations proposed provided that no alteration to clause 2 shall be made without the approval of the court or the Charity Commissioners or other authority having charitable jurisdiction.

(xiv) The interpretation Act 1889 applies for the interpretation of this constitution as it applies for the interpretation of an Act of Parliament.

SCHEDULE

Foundation Members of the Society.

Dr. Dorothy Arning
Dr. James Carne
Dr. L.A. Charkin
Dr. Max B. Clyne
Dr. Michael Courtenay
Dr. Stanley Ellison
Dr. Paul Freeling
Dr. Cyril Gill
Dr. A.J. Hawes
Dr. Berthold Hermann
Dr. Philip Hopkins
Dr. Erica Jones
Dr. M.A. Kalina
Dr. Aaron Lask
Dr. Frank Mallinson
Dr. Max Mayer
Dr. Margaret Macnair
Dr. Marshall Marinker
Dr. Shirley Nathan
Dr. Jack Norell
Dr. Jean Pasmore
Dr. Stephen Pasmore

MESSAGE FROM THE PRESIDENT

(Dr. Philip Hopkins)

It is with very mixed feelings that I welcome the first issue of the Journal of the Balint Society. Originally I had intended to welcome it as a joyous occasion – as was the formation of the Society, being as it was in the lifetime of Michael – now, however, it is a sad reminder of the great loss we have suffered by his death.

Nevertheless, it may well be that the Journal will eventually become the most important part of the Society itself, which can only remain a means of gathering together doctors interested in the Balint approach to medicinal practice for discussions of various aspects of their work.

It is here that the Journal will fulfill it's most important function, that of disseminating the results of Balint's work, both from his own personal activities and that of those with whom he worked.

In an interview, published elsewhere* shortly before his death, Michael Balint said: "It will be very uphill work (to interest more doctors in this work) because of the lack of trainers", and it seems to me that this Journal will help enormously to spread the necessary information and ideas far beyond the small circle of the Society's members.

I am very pleased therefore to welcome the Journal and to wish it all success for the future.

* Interview with the late Dr. Michael Balint. *London Doctor,* 1971;17.

Photographed by Dr. Edward H. Stein

Michael Balint
1896–1970

MICHAEL BALINT

M.D., Ph.D., M.S.C., L.R.C.P., L.R.C.S., Ed., L.R.F.P.S.,Glas.

Michael Balint was born on 3rd December, 1896 in Budapest, Hungary, where his father was a general practitioner. He graduated M.D. Budapest in 1920, and went to Berlin to work under Professors His and Zondek at the world-famous Third Medical Clinic of the Charité Hospital. He also became interested in the use of psychotherapy for the treatment of what is now called psychosomatic disorders (asthma, peptic ulcer, thyrotoxicosis, obesity), and in 1929 he published a paper on psychoanalysis and clinical medicine, which places him among the pioneers of psychosomatic medicine.

Michael Balint returned to Budapest in 1924 and continued his psycho-analytical training under Sándor Ferénczi, a pupil of Sigmund Freud.

His first interest was biochemistry, and he published a number of papers, chiefly concerned with intracellular pH and histochemical methodology. He became interested in psychoanalysis and began to train under Hans Sachs in Berlin.

He was appointed training analyst to the Budapest Institute of Psychoanalysis in 1926, and he set up in practice as a Psychoanalyst. In the early thirties he established Seminars for general practitioners to study the possibility of using psychotherapeutic techniques in general practice. In 1939 Michael Balint emigrated to England, first went to Manchester, where in 1942 he was appointed Medical Director of the North-Eastern and Preston Child Guidance Clinic. In 1943 he became Honorary Consultant Psychiatrist to the Northern Hospital. He later moved to London and in 1947 was appointed to the Tavistock Clinic. There he began research work at the Family Discussion Bureau in the training of social workers dealing with marriage problems. He carried out this work part jointly with Enid Balint, his wife. In the autumn of 1950 he established his first Seminar for general practitioners for discussion of psychological problems in general practice.

The immediate post-war years were difficult times for general practitioners. A new medicine – enriched by the experiences of the war and the silent social revolution in Britain – and a new general practice were developing, as yet only vaguely definable. There was a considerable demand on the part of general practitioners for a new understanding of interpersonal relationships in medicine, and Michael Balint soon recognised that the teaching of psychological understanding required new, powerful methods. He evolved this highly discerning teaching method, which has now widely been adopted, both in Great Britain and abroad, by many teaching centres.

Michael Balint made fundamental discoveries in the field of the doctor-patient relationship and of the core problem of general practice, that of the attitudes of the doctor and of the use by the doctor of himself as a "drug". The pharmacology of this drug is described in numerous articles and books, the best known of which is The Doctor, His Patient and the Illness, which appeared first in 1957, is now in its second edition, and has been translated into many languages (including Japenese).

Michael Balint was an outstanding psychoanalyst, whose main contributions were the reconstitution of the early experiences of the child, of the mother-child relationship, and of new therapeutic techniques. The British Psychoanalytical Society elected him President in 1970.

Michael Balint was a man of great energy, with a brilliant searching mind, and of great intellectual honesty and sincerity. He will be remembered in the annals of the history of medicine as a great physician, by his colleagues, friends, and pupils as a great man as well.

Michael Balint's Funeral

The funeral of Dr. Michael Balint took place at Golders Green Crematorium, London, on 5th January, 1971. A large number of relatives, friends and colleagues were present. Drs. W.Joffe, T.Main, and M.B. Clyne presented orations. Dr. Joffe, a psycho-analyst, depicted Dr. Balint's work as a lasting contribution to psycho-analytic theory and practice, Dr. Main mourned the loss of a friend and colleague whose powerful personality had left its enduring impact on medicine, on psycho-analysis, and on his colleagues, friends, and pupils. Dr. Clyne's oration is given in full below:

I stand here before you as a personal mourner and as a representative of my friends and colleagues in our research seminars. We have lost a teacher, who taught by the example of his ever-searching mind and by the example of his unflinching quest for truth. We have lost a fellow-worker who unstintingly and unhesitatingly always gave of his best, who encouraged us when we were unsure, who counselled us when we were confounded, who supported us when we were faint-hearted, and who with his brilliant, penetrating, and creative mind inspired us to become creative ourselves. By Michael Balint's death my colleagues and I have lost a source of inspiration that had made us look afresh and with a sense of wonderment at our daily professional tasks, that had made us discover astounding new aspects of what we had thought was unexciting commonplace routine, and that had committed us, too, to the quest for truth, to the scrutiny of our work "without a wardrobe of excuses", to exploration without prevarication and fear. We became better doctors, perhaps better people, through working with Michael Balint: we became, in the words of Wordsworth:

> "more skillful in self-knowledge, even more pure
> as tempted more, more able to endure
> as more exposed to suffering and distress.
> Thence also, more alive to tenderness"

I am also standing before you as a representative of all general practitioners in Great Britain, many of whom will be mourning with us, because general practice in Great Britain owes so much to Michael Balint. The development of scientific medicine just before and during the second world war had made it seem possible that general practice might disappear altogether from the glittering medical scene of sophisticated diagnostic and therapeutic techniques, of the brilliant achievements of operative surgery, and of the striking advances of preventive medicine. Yet, the great mass of illness, with its resulting loss of working capacity, unhappiness, and ineffectual living, like a ghostly enemy had not yielded to these new weapons. Many doctors closed their eyes to this unpleasant fact or denied it. Others, of more inquisitive minds, began to search, but found no answer.

Michael Balint and some of his colleagues at the Tavistock Clinic in 1950 established seminars for General Practitioners, which were meant rather vaguely to give general practitioners some psychodynamic and psychotherapeutic training. Many general practitioners were anxious about their future role within the order of medicine, and they recognised that medical teaching and medical practice had been neglecting the emotional aspects of medical transactions. They were eager to learn, and the seminars flourished.

Here Michael Balint together with Enid Balint developed his specific teaching technique, which differed from group-therapeutic techniques and from classroom teaching techniques, through it was not unrelated to them. To do this without the seminars becoming either therapeutic groups or mere classes of pupils eager to learn facts, Michael Balint had to use all his skill as a psychoanalyst, his steadfast sense of purpose, and his scientific perspicacity and detachment, a task so difficult that perhaps only those of us who have worked with him for two decades are able to assess properly his great achievement.

Michael Balint once wrote that the most powerful drug was the doctor himself. This had, of course, been known vaguely and instinctively before. But he was the first to study scientifically the pharmacology of this drug and by the use of his teaching technique to achieve a limited, but significant and important change in the personalities of the doctors who took part in his seminars.

Michael Balint had recognised early that the teaching of psychodynamics and psychotherapy, his own teaching method, and the limited change of the doctors' personalities – important advances though they were – by themselves were not enough to solve the problems of general practice that had been thrown into highlight especially by the advent of the National Health Service. He therefore took the decisive steps towards the scientific investigation of the core problem of general practice, that of the doctor-patient relationship. Michael Balint was certainly the most fitting, qualified, and competent professional worker to undertake this task, by his sense of human responsibility and professional obligation, by his humility and his open-mindedness to learn, by his splendid, enquiring spirit, by his freedom from prejudice and narrow-mindedness, by his psychoanalytic skill, and by the great esteem in which he held general practice; this perhaps because both his father and his analyst, Sándor Ferénczi, had been general practitioners.

Michael Balint's discoveries in the fields of teaching of psychotherapeutic methods to general practitioners, of the use by the doctor of himself as a diagnostic and therapeutic instrument, and of the doctor-patient relationship, and the work of those general practitioners whom he encouraged and stimulated to carry out their own research work in these fields, have changed the face of general practice in Great Britain and in many other countries. These are indeed the heritages in the field of general practice, which Michael Balint has left to history.

When I was called upon to deliver this oration I had felt some misgivings. No doubt, some of you will feel that it is good for solemn words to be spoken over our dear beloved teacher, colleague, and friend. I do not fully share this feeling. Acts deserve acts, not words, in his honour. Michael Balint himself would not have wished for eulogies, but for his work to be continued. Let it then be our firm resolve to do so. Thus he will not die altogether; a great part of him will escape death. Yes, Michael Balint is dead, but Michael Balint lives, and Michael Balint will live, for he lit the torches that he handed to us to pass to those who will follow us, and they will shine brightly evermore.

Meetings of the Society:

First Meeting of the Medical Society of Balint Groups (now The Balint Society), held at the Royal College of General Practitioners on 29th October, 1970.

The President welcomed Dr. Michael and Mrs. Enid Balint as the first Honorary Members of the Society.

The Integrated Interview

COMMUNICATION BETWEEN PATIENT AND DOCTOR

Dr. H. Stephen Pasmore

It is natural that the first paper this evening should be concerned with the patient's complaints, for it is the patient who takes the first step to seek out the doctor for help. I have therefore chosen as a title for this paper, 'Communication between Patient and Doctor', and I have deliberately placed the word 'patient' before the word 'doctor' in order to ensure that the patient shall have a better hearing than the doctor. It has not been easy for me to do this, because I was brought up in the conventional 'I-know-what's-best-for-you' type of atmosphere, where the doctor assumed a superior position in relation to the helpless suffering patient and expected the patient merely to answer those questions which he chose to put to him. Even now, though I have managed to make a slight change in my approach to my patients by allowing myself to become more sensitive to their efforts to communicate with me and by letting them question me, I am constantly surprised to find how seldom they want to talk about the psychological problems that we have unearthed together, and how little they appear to change as a result of the pearls of wisdom I place before them, either as interpretation of the transference situation or as revelations to them of the recurring patterns of behaviour common to their present and their past.

How does the patient try to communicate with the doctor? What does the patient communicate to the doctor? Why does the patient communicate with the doctor? All these questions seemed so simple to answer in the early days of the Balint Groups, when we G.P.s were making our first discoveries. The patient communicated with the doctor by using words and phrases different from those he used when talking about the sympton stemming from organic disease – his language was more indirect. The doctor became aware when the average healthy man or woman asked for a check-up that they were probably wanting to know something about the state of their sexual organs. He became aware that when some people demanded an X-ray, it was with the vague hope that someone would be able to see through them and find out why they felt so miserable. He became aware of the significance of the last words of the patient when the consultation was practically over, and how the patients could only express their real fears when they knew that they could make a quick exit, if the doctor showed signs of laughing at them. And apart from verbal communication, the doctor became aware that the patient could communicate by behaviour, by gesture, by dress, and even by silence. What did the patient communicate to the doctor? His fears, his anxieties, his depression. Why did he want to communicate? Because he wanted the doctor to understand him completely and relieve him of his discomfiture and unhappiness.

A case report may clarify these questions and my answers:

Miss Mudie, who had complained of bad nerves, of feelings of tenseness, and as if she might collapse and lose control of herself, and also of phobias when inside buses and shops, was a smart, nice-looking, intelligent woman, aged 30, working as a joint secretary to two men in a business partnership. She had consulted me 2½ weeks earlier for similar symptoms, saying she had had a previous attack 4 years before, which was associated with an affair with a man and an abortion. She did not want to talk about it, and I prescribed a tranquilliser. She had consulted me again, because she had felt much worse. I noticed that her eyes filled with tears and her face turned scarlet, when I asked her to tell me about her unhappy affair. I told her that I thought it was closely connected with her present complaints. Miss Mudie described how 'awful' the abortion had been; she had loved the man but had had not intention of marrying him. Just after he had gone abroad she found herself pregnant and arranged to have an abortion, but unfortunately she started to abort a week early whilst staying with her parents. She recalled the 'agony' of finding herself bleeding in the night and of having to call her mother for help. She said she could not possibly have had the baby, although she would have liked to have had it. I then hazarded the interpretation that her present upset was due to the two business men

leaving her in the lurch, just as the man in her past whom she had been living with. The consultation then came to an end, and Miss Mudie left in silence. I felt sorry for her and asked her to see me again in 7 – 10 days time, when she had finished the anti-depressant tablets, which I prescribed for her.

On looking through Miss Mudie's notes later that day I discovered she had undergone a dilation and curettage for the abortion, which had been followed by a reactive depression six months later, when she was referred to a psychiatrist. The man had been 20 years older than herself, and she had broken off the affair after the abortion. As a child she had been her father's favourite.

Miss Mudie did not return. She called 2½ years later, when I had forgotten the incident, to ask for a sickness certificate as she was still feeling unwell after an influenzal chill. I gave her the certificate. Six months later she called again because she had had a relapse of the depression and of the feeling of panic in ships. She particularly asked to see my partner – whose patient she really was - and she told him that she did not know why she felt as she did, because she had no problems. She now had a very good job as a secretary to an important director. My partner, knowing my interest in the case, asked her if I had helped her 3 years ago when I have gone into her problems in some detail. Miss Mudie said I had not, because it had been far too disturbing, pulling things out of the past, when she had wanted to suppress them.

Much can be learnt from this case about the problems of communication between patient and doctor and their relationship to each other. If the doctor had given in to the patient and kept off the subject of her past, he would have been able to maintain a better superficial relationship with her; for when he did this in the first interview she returned to him later, when she felt worse. But the collusive agreement between patient and doctor to keep quiet about the past would have limited the doctor in his efforts to help her with her recurring depression. The case would have become a "repeat prescription case", where communication between patient and doctor is carried on a level of mutual appreciation – the patient appreciating what the doctor is trying to do for him without prying too deeply into his private thoughts, while the doctor is showing his appreciation of the brave way the patient is trying to cope with his problems by denying their existence.

In the case of Miss Mudie, the doctor tried to do better, but failed, partly because he did not take the transference situation into account. He could not possibly have interpreted it, because he did not know at the time of the consultation that Miss Mudie was her father's favourite, that her boyfriend was 20 years older than she, and that therefore he – the doctor – probably represented a parent figure to her at the consultation. But the doctor could have shown his recognition of the transference situation by saying to the patient at the moment of her embarrassment (and she offered him two opportunities to do so – the first when she spoke of how 'awful' the abortion was and the second when she spoke of the 'agony' of having to let her mother know about the bleeding in the night) that he thought it must be awful or agonising for her to have to tell him about it. The doctor made the mistake of linking her feelings of awfulness and agony to her own material situation outside the immediate situation inherent in the patient-doctor relationship. As a result the patient felt acute embarrassment and all channels of communication between her and the doctor were cut off.

One of the difficulties doctors experience in trying to maintain communication with their patients is the problem of interpreting the transference situation, because this is not easy for any doctor who has not had a personal analysis to acquire this facility. There is no doubt that the recognition of the transference situation and its appropriate interpretation to the patient is a major factor in the maintenance of good patient-doctor communication.

In contrast to the above case I should like to quote the case of Mrs. Farmer, another doctor's patient. The doctor, by skilfully interpreting the transference situation and by using a technique of momentarily identifying with the patient, was able to maintain a good communication with his patient, without needing to have a detailed knowledge of the patient's past, which he could have obtained by using the technique of inquisitional investigation.

Mrs. Farmer attended her doctor by appointment on one occasion, looking much smarter than usual. The doctor felt that she wanted to attract his attention, but at the same time keep her distance. With his past knowledge of the patient, with whom he had been having talks about frigidity, he was able to identify himself sufficiently with her to be able to say, 'I feel your husband and I are missing what you really want'. The doctor scored a bulls-eye with this remark, which led the patient to mention the sexual feeling aroused in her when one of the owners of the shop for whom she worked paid her any attention. She said she had told her husband, but he did not understand

her. He had become jealous and had made her stop work at the shop. The doctor showed her how she was punishing her husband by her frigidity. Mrs. Farmer saw this and was offered a longer interview to talk over the problem, but she refused, and the doctor was able to interpret the transference situation by saying, 'So I must pay you enough attention and not too much', whereupon she smiled and said, 'That's right'. This interchange suggested that the patient was going her own way and making use of the doctor to clarify her thoughts. She wanted to see the doctor for ten minutes every fortnight, but only on her terms. It was therefore a real triumph for the doctor, when Mrs. Farmer came to a later interview and said, 'I have been thinking about what you said and it seems you were right, that I have been having an argument with my husband without words'. She went on to say that though she could now see how she had been behaving towards her husband, she still wanted to pursue her own way and find out for herself if she wanted more than a flirtation.

In this case there was meaningful communication between doctor and patient at a deep level, and yet the two were not closely involved with each other. The doctor was able to help the patient but had no need to act like an investigator and pry into every corner of her life to do so. He was able to help the patient help herself.

These two cases demonstrate the difficulty of separating the subject of communication between patient and doctor from the technique employed by the doctor at the time of the consultation. If the patient is suffering from some organic disease and is unable to give a clear history, the doctor rightly intervenes and by skilful questioning is able to elicit all the information he needs to make a diagnosis and prescribe treatment. If, however, the patient is suffering from some emotional problem, he is usually less able to give a clear history, and this leads the doctor to ask even more questions in an attempt to make sense of the patient's communication. This procedure in turn causes resistances in the patient, which prevent him from attempting further communication about his real problem. It would seem that if a patient is suffering from an emotional disorder as opposed to an organic disease, a different relationship has to be established between patient and doctor to ensure the maintenance of a good communication between the two. The patient must be allowed to set the pace, and be allowed and encouraged to express his thoughts without any conscious or unconscious interference from the doctor. There should be no need for the doctor to 'structure' the interview, except when he wishes to make a suitable interpretation. The thread of the patient's communication must be taken up by the doctor and be allowed to unwind. The thread will break if the doctor imposes himself too much, such as by thinking more about what he should do to elicit the information he wants, rather than by letting the patient develop his own theme in his own time.

In conclusion, it should be noted that communication between patient and doctor depend on the doctor's technique, and that the very establishment of meaningful communication between the patient and the doctor forms the basis of treatment.

TIME AND TECHNIQUE

Dr. M.J.F. Courtenay

Mrs. Branch came through the door of my room. I had seen her ten days previously, when it had emerged that she had had two unsuccessful marriages and was contemplating marriage for a third time. She was ambivalent about it, and I had made an appointment to see her four days later, but she did not keep this. I had sent her a postcard offering another appointment, and now she had come. "I'm terribly sorry I missed the appointment, I had thought you meant this Monday". she said. "It seems that you feel that you are not worth spending much time on" I replied. "Good heavens", she said, "I believe you're right, and I haven't even had time to sit down yet!"

I recount this merely to remind you that an appropriate interpretation does not consume much time, though it must be based on understanding gained prior to offering it and delivered in an appropriate situation. The long interview is now so deeply embedded in our minds, that we "Balintophils" have come to consider it as more than an approach to the problem of psychotherapy in general practice; it has become thought of as a technique. But a long-interview per se is merely a period of time, and this might cover a cosy chat once a month or a psychoanalytic session five times a week. Clearly both form and frequency are closely connected with the intensity of the professional contact. Nevertheless, the long interview has been our stock in trade, and it is immensely useful. However, owing to the numbers of patients seen daily in general practice, long interviews have always remained foreign bodies in the setting of general

practice. Perhaps the problem of the long interview needs to be reviewed, for it tends to be something that is used largely either when the patient forces the doctor's special attention on himself or when the curiosity of the doctor is aroused. What, then, are the advantages of the long interview?

Firstly, it is evidence of special concern for the patient so selected, even though the motives of this selection may not always be as strictly professional as they seem at first. Secondly, it allows the doctor to practise a recognised type of psychotherapy. No doubt, this had made it so eminently suitable as an initial approach for synthesising the skills and insights of the psycho-analyst and the general practitioner in the original Balint seminars.

Thirdly, it allows time for the doctor to gather sufficient information about the person and the problem, so that he is able to make useful interpretations. It may include further specific approaches, such as the technique of focal therapy. In this the whole range of the patient's problem is discerned, and in the light of this diagnosis a key area in the psychopathology is chosen for treatment with a view to producing the greatest change in the shortest time. Whether or not focal therapy was employed there was always an element of what Michael Balint describes as "selective attention and selective neglect."

Lastly, the long-interview allows adequate time for silences. Michael Balint has repeatedly stated, usually to deaf ears, that negative findings are as important as positive ones. Silences are often great cries of pain, directly analogous to the effect of palpating an acute abdomen. In addition, they make the doctor aware of the patient's defences and so give an opportunity for dealing with them. The approach also allows time for the development of the doctor-patient relationship in a special way, so that interpretations based on the new relationship may be offered, and these are essential for a successful treatment. As a corollary it allows time to work through the negative aspects in the doctor-patient relationship.

There are also disadvantages. Any method of treatment that involves giving a patient five to ten times the average duration of a general practice consulation is unlikely ever to meet the needs of all who suffer, and its very advantages can on occasion become a stick with which the doctor is beaten, in that once he is committed there is no turning back. This consideration apart there are various other features which may make it less than ideal.

The method may insidiously encourage a dichotomy between what Michael Balint has called illness-orientated and patient-orientated medicine, rather than discouraging it. It is difficult anyway to preserve a holistic approach to our patients. The slight but significant change of the doctor's personality may possibly lead towards the doctor wearing different hats at different times to the benefit of a few, while the rest are relatively ignored. Furthermore, the absence of recognition of such special skills under the National Health Service demands strong motivation on the part of the doctor, which again tends to engage his commitment only in special cases.

Finally, it produces a theoretical problem which has been largely ignored, viz. that after the end of a series of long-interview the ongoing doctor-patient relationship may be in jeopardy. It is after assumed too readily that the new relationship will automatically be a continuing asset. While this may be and frequently is the case, sometimes the most successful treatment may produce a feeling of independence to the extent that the patient may wish to forget the period of dependency that was its price. Often this is dealt with by the patient by consciously ascribing the cause for his recovery, even in the presence of the doctor, to some adventitous event. Occasionally there seems to be a need to totally repudiate the doctor's involvement, though it seems nearly impossible to discover why patients change their doctor deliberately. It may well be that we rest too securely on our laurels, real or supposed.

What then are the alternatives? The obvious one was to try a shortened form of the usual longer contact. Our research seminar attempted to discern a focus as part of the original formulation with a view to practising focal therapy, albeit in a modified form. In the event short interviews rarely supplied enough information for the doctor to be aware of a focus crystallising out of doctor-patient contact, and the idea of using focal therapy died a quiet death. In its place the paradox of a "mini-long-interview" developed in which the patient was allowed to direct the doctor's attention towards important areas of disturbance within himself. Inevitably, just as in the case of true focal therapy arguments arose as to whether the doctor had indeed chosen the area most likely to yield the best results.

Miss Eves came complaining of morning sickness. It soon became clear that she was not pregnant, but had just broken off an unsatisfactory sexual relationship. The thought of

bearing the man's child was the final impetus that enabled her to break free from what had been a state of torment. She had subsequently become engaged to a former boy-friend and now had guilt feelings, which had led to a feeling of being unworthy of marriage. It emerged that she had started the unsatisfactory affair so as to escape from her mother.

The doctor chose to work with the faulty relationship between mother and daughter rather than with the sexual difficulty itself. The members of the seminar criticised him for this. The doctor defended his choice on the grounds that the patient had been able to accept the facts of her mother relationship and that the sexual difficulty was in any case probably based on it. It was pointed out that perhaps the doctor's reluctance to work directly on the sexual difficulty might be based on a tacit agreement between doctor and patient not to threaten the patient's defences, which meant that the doctor was ducking his professional responsibility by acting rather than by interpreting. This case report illustrates both the pressure felt by the doctor in seeing a patient for only fifteen to twenty minutes at regular intervals and one of the dangers to proper treatment.

The disillusionment occasioned by the difficulties of shortening the theraupeutic hour produced a feeling that the doctors' sights ought to be lowered. This philosophy came to be known by various phrases such as "restoring the patient's balance", or "putting the patient back on course". The fallacy of this technique was that the patient might not have been in balance before, and also that the doctor's assumption of the balanced state being axiomatic precluded proper examination as to whether this was so. For example:

Mr. Haydon came complaining of being so obese that he was developing breasts. The doctor attempted to treat the patient's impotence without appreciating that his homosexuality had never been properly examined, so that the attempt at treatment was doomed to failure from the start.

Gradually the seminar became aware that although the patient must be allowed freedom to use the doctor in his own way, it was still incumbent on the doctor to be aware of the undertones and to remain consciously both selective and neglectful, as the patient needed it. Quite early on in the research there was an intimation of the possibilities.

Mrs. Jolly presented with a tension headache, and wanted to change her job for medical reasons. This had become a recurrent pattern, and the doctor's curiosity prompted him to probe. The patient responded freely, painting in colourful cockney terms the story of her life. She had been put in a children's home at the age of five when her parents separated. She had coped in slum conditions after walking out of a domestic situation in rebellion. She had made an unsatisfactory first marriage, and now lived with a taciturn, older, second spouse. On the way to the third consultation a remark by her husband that she should try and get a part-time job suddenly illuminated her life with the realisation that someone might want her company for its own sake at last. What was far from clear was how the contact with the doctor had made her more sensitive for this discover.

The case of Mrs. Morden, who presented with a stiff neck, was illuminating. She described her anger with her husband, who had been staying too long in the pub on his way home. From this flowed a host of expectations of his role with respect to her and the children. The patient came from a large family many members of which were under the doctor's care. It had always been noticed that the patient was the only member who came to see the doctor by appointment, while the rest of the family were very casual and just came on the off chance. Suddenly and for no reason the patient's whole personality seemed to come into focus for the doctor.

This sudden raising of a curtain "or non-directive flash" seemed to grow in importance in our work. Eventually, we felt that it represented a mutual and simultaneous illumination of both doctor and patient, which could displace the inquisitional question-answer approach, which we had called the "detective inspector" approach.

Mrs. Vickery presented complaining of a spotty face. She was a virtual stranger to her doctor and appeared most unprepossessing. The prescription of some cream did not satisfy her. She said she also felt depressed. The doctor had to take a grip on himself, as he had a busy surgery. It transpired that she had no children, because she had what she described as premonitions. The doctor decided to see her again, but she was worried that she might not be able to see him personally and alone. The doctor didn't fully understand what she meant but said "Is this another of your premonitions?" Her impenetrable exterior gave the flicker of a smile and for a moment there was real contact.

This had arisen in the context of minimal information without a previous doctor-patient relationship. The eventual understanding had been by a conscious decision of the doctor,

arising out of his sensitivity to what the patient was trying to convey. He was tuned to the right wavelength and was able to develop the contact in the next few interviews.

Experience with cases in which this kind of "flash" interaction had occurred soon presented problems regarding continuing treatment. Should one expect such a "flash" at every interview, or should one squeeze the last drop out of the mutual insight that had occurred? In the event it became obvious that there was a temptation to treat the flash interaction as a focus, and so live on the capital gained by keeping the curtain raised as long as possible. This in turn led to a reduction of sensitivity on the part of the doctor, engendered by the complacency of having achieved a "flash".

When it was realised that a "flash" was a beginning and not an end in itself, the prospect of seeing a "flash" case for the second time became somewhat daunting, and at least one member of our research seminar expressed acute anxiety at this point.

Further experience seemed to indicate that the "flash" situation was more analogous to the psycho-analytic setting than the standard long interview and demanded a radically different approach. The doctor would have to be intensely receptive at each interview and, while remembering the flash clearly, prepared to "spin the dials" of his receptive faculty in order to pick up the signals made by the patient at each succeeding contact.

In this way a completely fresh concept of patient-orientated treatment was born. Instead of being content with pursuing good traditional general practice interspersed with selective bursts of therapeutic libido aimed at certain individuals for a limited time, a new prospect had dawned. This embraced the idea that the general practitioner was potentially engaged with an increasing proportion of his patients in an entirely new relationship, a Nirvanaesque state of waiting for the patient, and yet at the same time actively encouraging him or her to communicate at a new level at every opportunity, always remembering, and yet being ready to forget, in order to extend and deepen the relationship, and giving the patient days, weeks or perhaps years to gather motivation instead of paltry silences measured in mere minutes, while always being ready to respond when the time was ripe.

It seemed that the length of time that an individual remained the doctor's patient had become a gigantic long interview with "flashes" occurring as significant growth points of mutual understanding along the way.

The difference of a "flash" from the usual long interview has a musical analogy. If the latter is likened to Beethoven's late quartets embodying an apotheosis of the sonata form, then the former resembles Weber's late chamber music where single notes stand as intensely bright points in a starry sky of sound.

Diagnosis

Dr. Max B. Clyne

In a research seminary, led by Michael and Enid Balint, a number of general practitioners and psychiatrists have been studying the ordinary doctor-patient interview as it takes place every day in British National Health Service general practice, the essence of the interaction between the doctor and his patient, and the impact, both diagnostically and therapeutically, produced by these normally brief sessions.

I will briefly and somewhat light-heartedly describe our findings in the field of diagnosis.

The traditional diagnosis of our medical text-books and clinical records leaves much to be desired. It is an illness-orientated diagnosis and is thus divorced from the individual patient: The actual treatment of our patients, our prognoses, our successes or failures often bear no relationship to the traditional diagnosis itself. We had been searching for a long time for a type of diagnostic assessment that would enable us to understand the patient's total condition or situation, including his relationship with the doctor, within the limits of our available knowledge. Michael Balint in 1957 called this the "deeper" diagnosis.

Perhaps I may briefly present a case history as an illustration: A man, 44 years of age, came to ask the doctor for a National Health Insurance certificate to return to work. The traditional diagnosis was: "lumbar disc lesion". The overall diagnosis as given by the doctor was: "He has a sense of failure; he could have got a better job; he is homosexual, tied to his mother and female relatives; he is angry with his manipulating mother; he himself manipulates the doctor. He wants a doctor who can tolerate his "dirty" illnesses (he has had syphilis) and allow him to have stress illnesses instead, such as his backache.

This overall diagnosis indeed goes much farther than the traditional diagnosis, in that it includes some understanding of the roots of the anxiety that had brought the patient to the doctor. It also elucidates the disturbances of the

relationships of the patient, the way in which he views his own role, and the doctor's feelings for his patient. It further describes a number of aspects of the patient's total life situation:

(1) his failure at his job = work aspect
(2) his homosexuality = sexuality aspect
(3) his being tied to his female relatives, and his being angry with his manipulating mother = family aspect
(4) his manipulating the doctor: he wants a general practitioner who can tolerate him = doctor aspect
(5) his desire or need to have stress illnesses: he has a bad back = self aspect.

We have thus five aspects or areas of this patient's world, each of which is disordered or disturbed. Obviously, they need further investigation. Which area is to be investigated: All or several or one?Why that particular one?What further details do we need? Is he actually homosexual or only in his phantasies? What does he do with his aggressive feelings? Is his physical illness an expression of self-desctuction? We could unendingly go on asking such questions, all of which are pertinent and relevant.

As we continued our studies of our case reports in our seminar there was a restless feeling among some members that the brief general practice interview, which we were studying, did not really lend itself to obtaining the overview that would enable us to formulate a proper overall diagnosis. The old argument of "not enough time" came up, and we were somewhat vexed, although most of us felt in our bones that this was really a nugatory argument. Even in our successful cases we often found it extremely difficult in our case presentations to formulate an overall diagnosis at all, because our knowledge of the patient's total situation seemed so scanty and patchy. The members of the seminar frequently pressed the reporting doctor to carry out further enquiries, and a kind of inquisitional detective work followed then in in which the doctor tried to assemble more factual material to enable him to formulate a proper overall diagnosis, somewhat reminiscent of the kind of psychodynamic diagnosis we had attempted to formulate in our earlier training seminars and akin to the diagnoses of dynamic psychiatrists. Extensive investigation of all areas of the patient's life experience seemed impracticable, even impossible and was, in fact, not our normal procedure in our general practices. We thought therefore that what actually happened in our successful cases and what we should do was to focus our attention on one particular aspect of the patient's world that seemed to be the major pathological domain. We called this the focal area.

But we soon found ourselves in difficulties. in the case quoted the doctor determined his therapeutic plans by focussing on one particular aspect of the patient's illness. He thought that he should get the patient to acknowledge his sense of failure, and he predicted that the patient would let the doctor share with him his sense of failure, with therapeutic consequences. The predictions were, however, not fulfilled. We had similar disappointments in a number of cases, because the focus seemed to change in subsequent interviews or apparently had been inappropriately chosen. Although the patients of many of our case reports seemed to present in their first interviews some areas that appeared to the doctor to be the focal area of the patient's illness, in our discussions we found other apparently more important areas that had not been touched by the doctor.

Another very brief case report may illustrate our further development. The patient was a woman of 35 suffering from asthma. The overall diagnosis as first formulated by the doctor was: "asthma so as to conceal problems, e.g., fear of being afflicted by a familial mental illness, and difficulties relating to men". The seminar added during the discussion of the case report: "she compartmentalised her problems between her general practitioner and a woman psychotherapist, whom she kept on seeing privately. She felt that marriage-wise she was on the shelf, because her psychotic mother had always told her that she was too ugly to find a man. The doctor, however, saw her as an acceptable, attractive woman".

Here again both the doctor and the seminar had some difficulty in determining how to continue diagnostic and therapeutic work with the patient. Should he deal with her compartmentalisation? Should he try to normalise the relationship between doctor, psychotherapist, and patient? Should he deal with her sexuality? In fact, the patient had very quickly improved after she had seen the doctor. The frequency of her asthma attacks had been greatly reduced after the very first interview, and she had bettered her position at work. In that first interview something had happened, of which, apparently we had taken comparatively little notice at first. The doctor had told us that the patient had looked disgruntled and that he had suggested that she was angry with him. She agreed, but with a smile said that the doctor was not doing much for her. She had then talked about her anger with her boss in her office, who by installing a smelly office machine had in-

creased her asthma. The doctor suggested that the boss and he were not really such ogres, but that both needed prodding into sympathetic action. This brief interchange, that at the time of reporting appeared casual and introductory, made a deep impact on the patient as both the doctor and we recognised later on. The doctor evidently had at that time perceived something in the patient that had struck a chord in him, and he was able to convey this understanding to her. The doctor did not even mention this interaction in his first formulation of his overall diagnosis. We hardly discussed it in the first discussion following his first report. Later however, we found that such interactions that had the character of a flash of lightning often happened in our reported cases and, if followed up, resulted in therapeutic success. This "flash", as we called it, appeared to be the basis of yet another kind of diagnostic assessment.

It certainly did not arise when we eagerly tried to collect material for an overall diagnosis by the usual inquisitional interview technique. It arose out of an intuitive perception or unconscious recognition that something important had been experienced by both doctor and patient and that this had been conveyed to and had been accepted by the patient. It was an intuitive act that was different from ordinary everyday intuition in that it was controlled, and it differed from everyday unconscious interactions in that it was consciously and professionally used. It was a kind of focus, but a focus that was specified by an unspoken agreement between doctor and patient and that carried a high emotional charge. It needed the mutual agreement of doctor and patient, because we also experienced flashes that seemed to be internal to the doctor only. The responses to those by the doctor led to no response in the patient. They gave no useful results.

The recognition of the flash established a particularly close relationship between doctor and patient and led to exploration of the area of the flash. When this flash was allowed to go to sleep, then nothing further happened and diagnostic and therapeutic progress ceased. It appeared that further progress needed a revival of the original flash or a new flash either in the same or in another area of the patient's life experience. In the case quoted there was an improvement after the flash in that the patient's asthma became better and in that she had bettered her position in her firm, in other words that she had been able to deal with her boss more effectively. But then nothing happened in further interviews, and the research seminar felt that the doctor ought to have been alert for another flash.

We found that the "flash", or the acute perception by the doctor of something going on between the patient and him at a given moment, required a kind of relaxed attentiveness and a good deal of receptivity in the doctor. Flashes of this kind seemed to happen in about a third of all interviews during our surgery sessions. It was difficult, if not impossible to sustain this relaxed attention for all patients during one given surgery session. The successful exploitation of the flash gave the doctor a feeling of success and the patient often a feeling of gratitude.

I have now stipulated the concept of a three-dimensional diagnostic assessment. There is first the traditional diagnosis, centred on the illness and based on traditional examinations. The overall diagnosis is the second dimension. It embraces emotions and relationships and is centered on the patient as a person. Like the traditional diagnosis it requires investigation, based on the patient's previous history and the detective work carried out during the interview. The third dimension is the flash, centred on the interaction of the unconscious of both doctor and patient, and based on controlled intuition rather than on investigation and enquiry. The technique of the flash requires the raising of the unconscious content of the interaction to conscious levels, though this does not necessarily imply verbal expression. The flash experience to be effective must be simultaneous in both doctor and patient, in other words, both doctor and patient must be tuned in simultaneously to the same wavelength.

This discovery of the "flash" and the ongoing development of a technique, as yet imprecised and ill-defined, that would enable us to recognise and utilise the flash in our daily work, is very important and an advance on existing methods of diagnosis and treatment. The traditional treatment plan as designed on the basis of the traditional diagnosis is commonplace and almost computer-like. The traditional prognosis is usually based on statistical evidence: e.g. a certain ratio of patients has been found to recover from lobar pneumonia, when given a certain dose of ampicillin. There is thus an equivalent percentual expectation of recovery for a particular patient. The treatment plan and the prognostications that are derived from the overall diagnosis are difficult to formulate. The determination of the focus of treatment requires further inquisitional investigations, and

the treatment proposed in our cases often was psychotherapy by the long interview technique that in a sense is alien to general practice. When we tried to predict the outcome of our proposed treatment based on our overall diagnoses, we often found ourselves in difficulties because these treatment plans were inexact and lead to inexact or unreliable predictions. The flash technique has a built-in treatment plan, and predictions based on the flash are simpler and easier to confirm.

Our concept of the flash as a true description of diagnostic and therapeutic interactions between doctor and patient and our proposed further development of a flash technique are indeed exciting. Undoubtedly, it would be the crowning glory of our studies of diagnosis and treatment if we were able to develop a definite flash technique that could be taught. We have of course, not been the first in this field. An ancient Chinese doctor, by the somewhat weird but true name of Chang Chung-Chang, who flourished between 170 and 196 AD, wrote in one of his works:

"The skillful doctor knows by observation (= our flash technique); the mediocre doctor by interrogation (= the "detective work" of the overall diagnosis); the ordinary doctor by palpation (= the examination leading to traditional diagnosis)". Thus, by their diagnostic methods shall ye know them!

The Results Of Our Research
Dr. A. Lask

We tried to understand and express our findings in conformity with our methods and expectations, and we have tested our predictions in the follow-ups of our case reports. Indeed we accepted that if predictions could not be made, then our case material was incomplete. We have no model available to guide us here. Traditional medicine was of no help, because it does not include the overall diagnosis. Psychoanalysis and psychotherapy work in a different context of doctor-patient transactions. We found the work of Malan et al. on short psycho-therapy most stimulating and helpful. These authors analyse "improvement," often equated with symptomatic improvement. They had found that it was possible for patients to achieve this by withdrawal from stressful situations, without any changes in the underlying emotional conflict. In general practice much of this kind of improvement is observed. It need not be decried as all too often it is as much as circumstances will permit. But it should be remembered that it does not lack any fundamental change in the psychological state of the patient. We found it necessary to devise our own techniques and criteria arising from the doctor-patient relationship in National Health Service general practice.

We discussed extensively the problem of the areas of the patent's illness and life, where improvement could be measured, however crudely, but with sufficient agreement in the group as to its validity. In this respect the doctor's statement about the patient's illness made at the initial interview (which we called the overall diagnosis, and the predictions made at that time, were crucial guides as to the value of the result. If the follow-up showed that the predictions had failed and the results were in no wise in conformity with the overall diagnosis, then clearly the case had been misunderstood.

Attention was paid to the severity of the illness in terms of its outcome. Thus a severe schizophrenic kept out of hospital was a far greater success than a moderately anxious patient who still attended the doctor regularly, as did the schizophrenic. A "plus three" score represented the maximum improvement the patient could be reasonably expected to achieve. A "plus two" indicated a lesser but nevertheless good improvement. "Plus one" meant some improvement, and zero meant none. Minus scores were also available.

(1) The assessment of symptomatic improvement

Sometimes the reporting doctor tended to gild the lily unwittingly, or minimised inconvenient facts, but the group soon learned to recognise inconsistencies of this sort and to put them in the right perspective. At no time did we ever think highly of symptom improvement that was not in conformity with the rest of the clinical picture. This first group of symptom improvement represented objectively the factual data contributed by the reporting doctor at the follow-up. It was the closest we could get to the objective reporting of measurements and results in clinical medicine.

(2) The second group concerned the doctor-patient relationship.

The group formed its own judgement here after listening to the follow-up report and the very full discussion that followed. The final score rested on the concensus of the group members.

(3) We then tried to assess the tensions around the patient, in other words we tried to assess the patient's relationships with spouses, family,

friends, neighbours, work mates, and so on. Important items in these settings had already been discussed and explored in the various sections of the doctor's report. It was here that judgment of the changes since the initial report had to be both perceptive and discriminating. Guess work had to be recognised as such, and lack of information explicitly stated. There were no absolute standards or criteria here: scoring was based on movement and changes in the clinical history, a method more acceptable to the observer when seen in an actual case presentation. With the limited time available I will try to show it at work in one or two cases.

Mrs. A: An attractive fair-haired, married, upper class woman had been seen as a temporary patient in the practice by several partners for four weeks before the reported interview. She was about five months pregnant, complained of vaginitis and pruritus and was booked at a provincial hospital. She asked for sleeping tablets, and the doctor asked what was on her mind. She referred to financial and housing difficulties, and to resentment at having to work full-time when she would have liked to ease up, and her husband. Later on she mentioned that her brother's two children had some congenital malformation, which she feared she had to a mild degree.

The doctor formulated the overall diagnosis by saying that this apparently self-possessed woman seemed to be shaken by the occurence of congenital malformations in close relatives, and that she felt uncertain about the health of her own unborn child.

1. She would become attached to the doctor, open up more and show a great deal of badness.

The Group considered as focal areas:

1. Congenital malformations anxiety. 2. Reality problems of home and money. 3. Sexual problems initiated by her symptoms and implied critisism of absent husband.

At the first follow up, she had spoken about her bad-tempered father who had died on the same date as that on which her nephews had been born.

The overall diagnosis shifted to "a woman with sexual difficulties because of her ambivalent fixation to an irascible father".

The group predicted that she would become attached to the doctor and would show him a great deal of her "badness". If the doctor could free her from her fixation, her relationship with her husband might be improved, and she might be able to have a less complex relationship with her child. Three weeks later she was able to express hostility towards doctor and husband. Tension had mounted, the doctor was giving long interviews and had been persuaded to give a joint interview to husband and wife.

At the last follow-up six months later she had become able to enjoy her baby, and she wanted another, her sexual relationships had vastly improved, and her husband was much more potent. She had managed to humiliate the doctor, but the relationship was relaxed and easygoing. The score was plus three for all three sections.

DISCUSSION

Dr. Clyne: The research seminar had not set out to invent new techniques for general practice. They intended to study what went on in the ordinary general practice interview.

Dr. Kalina: The timing of the "flash" was important: if it occurred at the wrong time, it would fall on stony ground.

Dr. Carne: It was difficult to define the "flash". It was necessary for both doctor and patient to receive it at the same time. The question was also where to go from the flash.

Dr. Balint: The papers had left out that it was not enough just to do something, but to predict what the doctor aimed to do. If this was done, some uncertainties would disappear. It had been a condition of the research described that at the end of every case report the doctor was to relate his therapeutic plan for the future and what he expected the outcome to be in what period of time.

Dr. Gill: For a "flash" to be successful it must be mutual between doctor and patient and must involve their relationship.

Dr. T. Main: The terms that had been used were new to most people who had not attended the research seminars. It was a private language for people who knew what they were talking about. He said he felt estranged, and that the Society should study the problem of communication.

Dr. Hopkins: With anything new a new vocabulary must grow up.

Mrs. Balint: I want to return to what Dr. Clyne had said because the aim of the exercise had

not been to invent techniques but to look at what happens in the ordinary surgery consultation.

Dr. Chisholm: There was communication between the patient and doctor all the time; the "flash" meant that something emerged into sudden consciousness between the doctor and patient.

Dr. Balint: The Seminar was studying what was happening in the doctor-patient relationship in the normal surgery. The only difference was that it was studied in very very great depth. He agreed that "flash" was a bad word, but it had not been possible to find any word that would describe the very sudden understanding that emerges.

Dr. Jones: Nobody had mentioned non-verbal means of communication, also it would take a long time before predictions would be confirmed.

Dr. Balint: If predictions were not made then everything that is happening might be turned into a success.

Dr. Bacal: An objection is often made to an aspect of the scientific method, viz. something has happened, but this may or may not have to do with the doctor's predictions. One must understand the connection between the transaction and the prediction. The chances are that the result will be due to the doctor's intervention, if the prediction has been based on an assessment of what the doctor has done.

Meeting of the Medical Society of Balint Group (now The Balint Society) held on Thursday, 26th November, 1970, at the Royal College of General Practitioners, London, S.W.7.

Aspects of Repeat Prescriptions in General Practice

Dr. M.Marinker described the genesis of the book "Treatment and Diagnosis: A Study of Repeat Prescriptions in General Practice" by Michael Balint, John Hunt, Dick Joyce, Marshall Marinker, and Jasper Woodcock, which arose out of a research seminar led by Dr. Michael Balint. The participating doctors studied "repeat prescriptions" by counting the number of patients in their practices who were receiving repeat prescriptions, what kind of relationship they had had with them previously, what kind of drugs they were getting and how long they had been having them. They ended up with details of 1,000 consecutive cases. About 20 percent of patients seen on one given day in April 1965 and again in May 1966 had received nothing but a repeat prescription at the time of the consultation. In the book the patients were described thus: 'Possibly as a consequence of an unfavourable balance between gratifications and frustrations, repeat prescription patients are who depend on others for something which they need badly, though they cannot state exactly what that something is .

This need was demonstrated statistically in that these people tended to marry early; they made frequent contact with their doctors asking for help, the original form of which was a long sequence of symptoms and illnesses. The second major conclusion was that although the need for help was obvious, it was difficult both to recognise the nature of the help and to satisfy the need which could not be easily identified.

It seemed that this group of people, as opposed to a control group, tolerated badly any proximity to or intimacy with their partners. This was shown in the statistics by the fact that there was a much greater tendency to become what was called 'secondarily single,' that is they lost their partners, one way or another, early on. There was a tendency to create only an indirect contact with their doctors.

(1) James A had been on Dr. Willow's list for 20 years. He was 67 years old, married, with no children. In 1948 he had an ethmoidectomy. In 1950, he was thought to have a duodenal ulcer, in 1952 pleurisy. A year later he was diagnosed as having pulmonary tuberculosis and was advised to give up his work in the clothing trade. He was an expert cutter, highly prized by the firm he was working with. It was not at all clear in the doctor's story why he had been encouraged to give up this job.

Since then he and his wife had run a small haberdashery business. In 1954 he had a little difficulty in passing urine and was referred to hospital, but again nothing very significant was found, and in 1957 he was again investigated in hospital because of pain in the right shoulder. Following this, he attended a dermatologist for treatment of acne rosacea, and in 1961 he presented with fecal incontinence, had a sigmoidoscopy; nothing abnormal was found. He was again seen in hospital because of his skin complaint in 1963; in 1964 he had ingrowing toenails. In August of 1964, he had his first prescription of 100 mg of pentobarbitone at night. Since then, he had always been sent a prescription by letter, had never asked to have the dose increased or decreased, had seemed to have no more illnesses, and had never been seen

by the doctor again, although the prescription was renewed monthly.

Almost all the details of the pattern that emerged from the study later on are present in this rather threadbare story. There was an initial period of considerable unrest in which the patient made several offers of illness, which we designated "polemics". In the notes there are 20 letters from hospital doctors covering the 14 year period prior to August 1964. The history of nasal obstruction ended up with ethmoidectomy, the duodenal ulcer required a gastrectomy; pleurisy led to a diagnosis of pulmonary tuberculosis and the pattern emerges of medical crises, of heroic investigations and heroic diagnoses to meet them. The first prescription for pentobarbitone was a kind of armistice agreement. This was followed by a prolonged period of peace. By and large James A communicated with his doctor only through a letter, and in almost every one of our cases, some mechanism for containing the doctor-patient relationship within tolerable bounds, some way of preventing any intimacy, any examination of private areas in the patient's life, emerged clearly from the story. The request by letter is typical.

Traditional commerce between doctor and patient is based on a three-tier structure; first comes the collection of data, a history, an examination, and investigations; then follows the formulation of a diagnosis; finally a remedy is prescribed. In the case of James A the repeat prescription situation took the pace of all these. Somehow the patient saw the repeat prescriptions as being a way to help him function in his life. There was no pretence that the pentobarbitone was even symptomatic treatment.

(2) A Czech patient, aged 80, after several hospital investigations and one hospital admission, was prescribed one tablet of Franol three times a day, which he has been taking for the past ten years. Every month he sees his doctor and they talk about the future Czechoslovakia, its people, its food, its politics. The patient's physical symptoms, the repeat prescription, which the doctor writes out, are hardly ever mentioned, they are almost a taboo subject, and there's a warm, easy, peaceful relationship.

This kind of conversation was called a "scenario" by the group and, time and again it was found that doctor and patient came to the decision to talk about something which was interesting to both, which was non-threatening, and which became a way of containing the relationship between them. Even when the pathology is quite frightening, the repeat prescription regime can hold up and can have a very important place.

Dr. John Hunt thought that repeat prescriptions stand for a kind of hope that something might yet happen to recharge the lives of the patients involved and that this is one reason why in the research we found such resistance to change. If you take away this hope you are left with something rather bleak. Cases seemed to fall into two groups. In one very broad group the patient was trying to disturb the prescription against quite strong resistance from the doctor. In the narrower group the doctor was trying to disturb the situation. He thought it should be remembered that this was in doctors who were alert to the situation - the research group was to study what happened when prescriptions were disturbed, but even so they could not bring themselves to do it. G.Ps would think that anybody was mad who tried to disturb a peaceful repeat prescription.

A case in which the repeat prescription was disturbed unilaterally by the patient was that of a woman who had been a widow for ten years, after having been married three times. She was looking after a very cantankerous private patient of the doctor's. She began having headaches and was worried that, like her sister, she might have high blood pressure. He guessed that she was finding life difficult with the patient and prescribed amytal. When she retired from this job about three years later she reduced her dosage of amytal and then, shortly after her fourth marriage to a blind man, she came in to say that she was finding life with her husband very satisfying and she did not need the tablets any more. There was a suggestion that this woman to function effectively needed to control the situation. The fourth husband was the kind of man she liked and she could drop her repeat prescription.

Out of all the cases that were reported Dr. Hunt could find only three in which the doctor himself disturbed the repeat prescription. In all cases he met very strong resistance. The research group thought the relationship survived in two cases because in one the doctor had been a 'lamb' and in the second had not tried persuasion but had accepted that he could do very little. If they'd tried to do something more than this we thought the patients might well have changed their doctors.

In the third case the patient wanted support but could not accept any serious involvement with her problems. When the doctor revealed that he had a clue about the significance

of the repeat prescription she changed her doctor two to three weeks later. The research group thought this was a cautionary tale because the distance that has to be preserved was broken. The doctor tried to get closer and she could not tolerate this. So disturbances must be approached very cautiously.

Repeat Prescriptions

Dr. Leonard Ratoff

In April 1969 we introduced into our practice repeat prescription cards. This was purely an administrative procedure to help us cope with the ever-increasing requests for repeat prescriptions. These were coming in on grubby bits of paper and usually involved a time-consuming search through the patient's records to find out exactly what "the little white pills" were.

We have printed cards in different colours corresponding to the degree of anxiety we felt about these repeat prescriptions. Hence a red card was issued to those on steroids, insulin etc. Only small amounts were prescribed, and we saw the patient at frequent intervals. A blue card indicated moderate anxiety associated with drugs like Librium and barbiturates on which we felt the patient might become dependent. The yellow card represented prescriptions where anxiety was minimal, the repeating interval long, and the situation between the doctor and the patient peaceful.

Dr. Balint predicted that patients would have strong unconscious reasons for losing the repeat prescription card, and that we would constantly be replacing these lost cards. In point of fact the figures as follows. Out of 487 cards issued in the last 18 months only twenty or less than 4% have been lost. If we think about the enormous investment which both the doctor and the patient have made in the repeat prescription situation, it is hardly surprising that the patient guards this symbol of his investment very carefully indeed, even to the extent of providing it with a special plastic jacket!!

My present interest in this subject has been the varying ways in which our patients have responded to the repeat prescription cards. In fact the cards themselves mirror many of the findings of our seminars researches.

(1) **Peace** An example is the card "Norah". This card has survived over eighteen months constant use and remains in good condition.

Patients of this kind use the card in an obsessional manner. The card is submitted regularly at the stated interval and when the word SEE appears in the observations column the patient submits himself for interview like an obedient child.

(2) **Scenario.** Here the patient continues to visit the doctor whenever a repeat prescription is due. The observation columns of the card are full of the words SEEN, and usually there are elaborate screens and scenarios constructed equally by the doctor and the patient. These patients seem to need the limited shallow personal contact with the doctor and will not be denied by the mechanism of the repeat prescription card.

(3) **Disturbed Repeats.** In the cases the whole story is written on the card. An example is the card of Robert S. The original prescription for Valium 5 mgs was changed by a consultant to Serenid D but he was not satisfied. So Valium 10 mgs was given but this was subsequently changed again to Diazepam 5 mgs. Only when the prescription was written as Valium 5 mgs was peace restored.

(4) **Rejection by the Patient.** In a few cases it was the doctor who tried to initiate the repeat prescription regime. The card was issued, but the patient forgot to collect it, and the card lies unused in the records. The patient does not need the doctor as much as the doctor would like to think.

Finally I would like to raise the subject of the "grand multip" in the repeat prescription situation. The whole subject of the multiple repeat prescription, usually four or five items on each script, was not systematically studied by the research Group. I feel this is an ommission we really should try to remedy. The "grand multip" prescription, i.e. nine or ten items per script, is a special example of this problem. The implications of this situation are pretty obvious, but I wonder how many of us here tonight have similar cases in our own practices?

The whole subject came to my notice when I had to write this letter admitting a patient to hospital:

Dear Dr.

Thank you for admitting Mr. A.B. who is very frightened and who is in L.V.F.

A business executive - Had a coronary last year and subsequent viral pneumonia - Recently has been deteriorating and getting very breathless.

O.E. Pale and frightened man.
Very orthopnoeic – depressed – a Cheyne Stokes quality to the rhythm of his breathing.

B.P. 110/70. Apex very quiet. Ht. rate 140. The lung bases are wet anteriorly but not at the back – no peripheral oedema or hepatomegaly.

His drug therapy is extremely complicated and certainly needs rationalising.

1. Phenformi, 50 mg daily.
2. Orabolin 2 mg. b.d.
3. Lasix, 1 b.d.
4. Slow K. 3 daily.
5. Ampicillin, 200 mg. q.i.d.
6. Aminophylline suppositories, p.r.n.
7. Mogadon at night
8. Gly. Trinitrate, p.r.n.
9. Ipecac. et. Morph. Cough mixture.
10. Codeine Linctus at night.

N.B. Digoxin conspicuous by its absence.

I do think he needs careful reassessment – but the prognosis does not appear good.

Kind regards,

I vividly remember writing this letter. I remember the feeling of helpless impotence on my own part, and the utter confusion and bewilderment of the patient as he handled the tablets and explained how many times a day he took each type. On occasions he would have to consult with his wife to work the whole thing out. In this situation one gets the feeling that the patient's illness is like an enormous amoeba. Every time a new symptom emerges, like a pseudophodium, it must be counter-acted by a new drug. The doctor no longer tries to justify his prescribing, and he appears to be defending himself against overwhelming odds.

I would like to quote one more example again from a letter admitting a patient to hospital. These patients are usually very seriously ill indeed with organic diseases and in fact both these patients have since died. It may be that in some way the doctor is trying to protect himself from the impending death situation by prescribing more and more drugs to ward off the inevitable end.

I wrote the following letter to hospital:

"This patient is managing to confuse all the doctors that look after her. She attends the cardiac unit, the respiratory unit, and myself, and we still do not seem to have a grip on her problems. I think in some way she is manipulating all the doctors and one of the symptoms of this is the gross polypharmacy. Despite all my attempts to rationalise therapy she usually comes and tells me exactly what tablets and things she wants and then complains that she is very confused and does not understand how to take them. I have a list here in October, consisting of 1) Cedilanid b.d. 2) Prednisolone b.d. 3) Lasix t.i.d. 4) Slow K 2 b.d. 5) Aldomet 1 t.i.d. 6) Spincaps Intal 1 t.i.d. Over and above these items she is not above asking for Riddobron Inhalers, tabs. Alupent and tabs. glycerine rinitrate. You can see that I am hopelessly confused about her therapy and I am sure the patient does not know one tablet from another."

I found several other examples of cases like these in my own practice but time will not permit me to relate them. However, I can say that everyone of the cases that I have unearthed tended to validate what I would like to propose as

Balint's First Prescription Law.

"The therapeutic potency of the prescribing doctor is in inverse proportion to the number of items prescribed."

DISCUSSION

Dr. Lask: I am enjoying the discussion very much and I should like to congratulate the seminar on the research, which was first-class. I have not yet read the book, but I have listened to the discussion with interest. I think that all pharmacologically ineffective prescriptions are really repeat prescriptions. So far as the case of James A. is concerned, after a series of interventions it had reached the stage of a repeat prescription, when the patient had told the doctor to keep away from him. If this was so, it made good sense on the part of the patient!

Dr. Marinker: I want to make a comment about the whole project. None of us had been very proud of what had been discovered about their practice of medicine, but we had tried to look honestly at our cases. As the findings unfolded, we had first been surprised, then embarrassed, and finally intrigued. Not much is known about the patient in the repeat prescription situation and so not much of a diagnosis can be made.

Dr. Clyne: The subject should be dealt with in two parts: (1) the study of what really goes on in general practice. The feeling of embarrassment and guilt about repeat prescriptions was interesting, because it also existed in the patient, and (2) whether it was good to give repeat prescriptions or whether there was something better to offer? Some patients definitely do not want the integrity of their bodies or of their minds to be disturbed and want to be left alone. What is the function of the repeat prescription as given in general practice so far as

Transvasin at the summit

The summit of Annapurna 8090 metres high, was reached on 20th May 1970, by Owens and Day of the British Nepalese Army Expedition. During the 3-hour climb from Camp 5 at 7400 metres, oxygen breathing apparatus was used. The only previous ascent, by Herzog and Lachenal in 1950, took 8 hours. They had no oxygen and suffered severe frostbite, losing all their toes and Herzog his hands. The temperature at the summit for Owens and Day was—30°F.

ON ANNAPURNA the members of the British Nepalese Army Expedition chose Transvasin to relieve muscular pain. Three British climbers used it:

"One suffered badly strained back and chest muscles following involvement in an avalanche. The second developed severe intercostal fibrositis, and the third had badly bruised himself after falling 30 feet and jamming in a crevasse. Transvasin gave considerable relief to all three climbers." Personal communication, 3rd September 1970.

Transvasin was also used with great success by many other members of the party who complained of various other aches and pains.

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diagnosis, treatment of the patient and the doctor-patient relationship are concerned?(1) In a repeat prescription case the doctor-patient relationship is peaceful; it may become more active if the patient wants. (2) In repeat prescription cases symptoms are often dormant. (3) What about the relationship of the patient with other people around him? This did not seem to have got worse, and perhaps even a little better, in repeat prescription cases. Are repeat prescriptions bad? If not, are they legitimate?

Dr. Kalina: Repeat prescription patients are not all the same. Repeat prescriptions have different meanings for different patients and different doctors. The problem is to get at the patient and find out what is really going on.

Meeting of the Medical Society of Balint Groups (now The Balint Society), held at the Royal College of General Practitioners on January 26th, 1971.

In Memoriam Michael Balint:
The President (Dr. Philip Hopkins)

This evening's meeting is a particularly sad one for all of us. Although it is customary on such occasions to ask members present to stand and pay tribute to our friend who has died, I do not think that Michael Balint would have wanted us to do that. In fact I think Michael would much rather that we had gone on talking, as he always encouraged us to do.

I would just like to make a few personal remarks, because Michael Balint was more than a psychoanalyst, a teacher, a tutor, a trainer to me. He was a friend of considerable standing and to me, as perhaps to many others here, he was the father of all father-figures. I find it very difficult to speak about him even now some weeks since his death without feeling emotionally very upset.

The first time I met with Michael Balint was in 1952, when I answered an advertisement in the Lancet announcing that there was to be a course of discussion meetings for a limited number of general practitioners to start on 1st October, 1952. And the first letter I had from him asked me to send him 10 shillings for the course, the best 10 shillings I have ever spent.

I have a letter in my possession dated December 1952 and giving me further details of the courses that were to be organised. Even in this letter, writing to me as a stranger, he showed his customary consideration and kindness by saying that he hoped it was going to be mutually convenient and that he hoped the course would suit me, and so on. It was quite typical of his general attitude.

I have here the letters I received from Michael over the last few years. I am not going to read them all to you, but there are one or two that show some of his characteristics. I had been to his house one evening and had said something like "What a lovely wine this is". He wrote me a letter the next day in which he said "Here is the name of the Hungarian wine which you loved so much....." – I thought this very touching at the time. Later, he asked me to read the proofs of one of his books. I was highly delighted to do this, and this gave me an opportunity of meeting him and seeing him on a number of occasions and of really getting to know him better. He became a person of great importance for me. He was not just a teacher. He inspired us in a way that no other medical teacher that I know of has done.

The official climate about Michael Balint has changed a great deal. In 1952 the N.H.S. authorities would not recognise the seminars as post-graduate training courses. Prescribers' Journal, sent by the Ministry of Health to all general practitioners on the National Health Service list, in April 1970 contained an article, in which was written "The intuition of generations of medical men and women has been crystalised by Balint in 1964 when he asserts that the physician is himself one of the most powerful drugs available to his patients". Michael Balint was highly delighted to see this – the thought that his sentence should get into a ministerial publication pleased him very much.

Michael Balint's consideration and kindness to his friends was showing when the first edition of his book "The Doctor, His patient and the Illness" was published. He had a specially bound copy prepared for each of us in the Research Seminar – whom later he called the Old Guard – with the member's names inscribed in gold on his copy. This was a delightful gesture showing his thought and the way he esteemed those who had worked with him. Michael Balint indeed made us feel that we were working with him, not as pupils of a teacher. I visited Michael Balint at his home only a week before his last illness, and we talked for about an hour and a half. I tape-recorded this interview, and published it in the "London Doctor". He was delighted to see the publication later.

I want to put it to you this evening that the name of our Society should be changed from "Medical Society of Balint Groups" to "The Balint Society". I would like you to accept this principle, so that we finalise this at an A.G.M.

of the Society.

Dr. Michael Courtenay

It is very hard really to speak of somebody like Michael Balint, whose effect on me in my work and life is second only to a parent or a wife – such is I think the impact that he had on me in the last 13 years. In a sense one was always aware of his greatness when I was working with him but perhaps never saw it in perspective until he has died. It is astonishing how great and yet how intensely human he was. I was re-reading, a book of his the other day: sometimes when one reads a book he can visualise somebody's voice, manner, gestures, but when I was reading this book I felt as if something was speaking inside me. I feel somewhat guilty in my mourning, because it seems we did not pay enough attention to expressing our feelings to him when he was alive – a problem met with often when one has a loss. It is a great comfort to me in this situation that some members here tonight took the initiative to form this Society whilst Michael Balint was still alive and was able to see this as a living tribute to what he meant to us all.

Dr. Aaron Lask

The impression Michael Balint left on me must always remain intensely personal. I do not think that at this stage one can really be objective about him. I feel about him as I have responded to his work and his presence. I found him not only a great teacher, as all of you have done, but a great inspirer. He was able to inspire lazy people to work, and he certainly could drive. He was able to drive us along, spurred on to work hard, to get on with your work, and not just to see our everyday work as a daily drudge for bread and butter. He was able to show how we could be inspired by our very ordinary daily work. This, is one of his greatest contributions to general practice. May I remind you that the purpose of this Society is not only to honour him, but also to stimulate, encourage, and persuade all of us to produce our work, however inadequate, however incomplete it may seem in our surgeries, to produce incomplete and inadequate work here for comment, criticism and stimulation of others. This is something he taught us, and this is something I hope we shall continue to do.

Dr. Stephen Pasmore

There are two things I should like to mention in paying a tribute this evening to Michael. The first one concerns what Michael did for the general practitioner and his patient, the second what Michael was himself.

What did Michael do which none had attempted before? Michael was the one man who was desperately concerned with the real needs of the patient as opposed to his demands. Michael saw that to meet the patient's real needs he would have to train general practitioners not only to recognise those needs but to treat them. To do this the general practitioner would have to learn more about himself and more about the relationships he formed with his patients.

Michael's method of training general practitioners differed from all other methods, in that instead of telling practitioners all he knew about the problems of human behaviour, he insisted on the doctors taking full part in his discussions about the patient's problems so that practitioners discovered the answers for themselves.

The tribute I would like to pay, then, is that Michael, by giving us more insight than we had before, enriched all our lives and through us many of our patient's lives. I know of no other man in my time who could enter into another person's life with such rewarding results.

What sort of man was Michael himself? What was the other side of Michael? I will finish by reading you some notes I made at the time of my last meeting with him when he was in hospital. It was Monday, 21st December, 1970. I found I had some time to spare in the afternoon and decided to visit Michael at University College Hospital. What should I take him as a little present? I looked in a shop hoping for inspiration and found a little ruby candle-holder made of Swedish glass – very strong like a round pebble and small enough to fit into a waistcoat pocket. Michael always lit a cigarette during the Tuesday seminars and invariably looked vaguely around for an ash-tray, 'If he would produce a magnifying glass from his pocket, why could he not also produce an ash-tray?' I thought as I purchased the small glass holder. A little later I was treading the familiar path through the front doors of the hospital and up the main stairs to the third floor to Ward 32. I was shown Michael's room, and as I opened the door I was delighted to see him in good form, sitting in his dressing-gown by his bed, talking to some of our friends. We exchanged greetings and a few pleasantries – 'There are three of us here, what about taking a seminar?' Then a nurse arrived with a huge bunch of flowers, which Michael thought had come from me, but on hearing, that they did not, he looked at the card to find out who had

sent them. 'My present is much smaller' I said, producing my little packet carefully wrapped up in Christmas paper, 'You will never guess what it is'. Michael started to open the packet eagerly, like a child, and we all enjoyed the fun. First the wrapping paper was removed and then the tissue paper, and Michael had the object upside down in the palm of his left hand. Michael turned the object over and, as his right thumb found the hole in the glass, he exclaimed 'It's an ash-tray'. Uncanny, I thought, how Michael was always right. Anybody else would have said it was a candle-holder.

I looked at Michael as he sat in his chair and was struck with his unlined relaxed face and his kind smile. We asked Michael what had happened, and Michael told us he had not felt very well that Tuesday evening after the seminar and felt his lungs filling up with water in the early hours of the morning. A neighbouring physician was called in, and Michael was whisked off to hospital. Michael recalled the difference in his condition, as soon as he had been given an intravenous injection of aminophylline.

And then the talk drifted on to everyday life in hospital and Michael told us of how he had asked if there was a barber to shave him. There was. It was all on the National Health, he said with glee. The barber would not take a fee, not even a cigarette. Michael went on to say that the barber automatically called next day and asked him for his advice. He was nearly 65 and would be pensioned off next month. He had worked for 30 years in the hospital and was very attached to it. What should he do? Michael said he told the barber that he himself had received just such a letter when he had had to retire 14 years ago, but somehow he was still working at the hospital. And I have no doubt that the barber derived great help in being shown how some initiative on his part might lead the hospital to continue to employ him in some way.

Michael then told us he hoped to go home on Thursday and resume work in February. 'We can't do without you,' we said, and Michael replied that it was very good to know that one was wanted. The time had come for us to go, for I could detect in Michael that sign of fatigue patients show when they have talked enough. We bade our farewells, but Michael insisted, with that unfailing courtesy of his, in getting up and walking down the passage to see us out of the ward. We shook hands with him again, never realising that this would be the last time we should see him alive.

Dr. Jean Pasmore

F.P.A. patients have always consistently asked us F.P.A. doctors for advice with their sexual difficulties, and nearly 20 years ago we doctors were insistently asking for someone to teach us how to deal with these patients. Michael Balint answered us by starting a seminar to discuss these requests and to try to find out their real meaning. Because we worked in a setting new to him, Michael even came and sat in with some of us to find out what went on in F.P.A. clinics – not the treatment that we were really accustomed to from our medical school teachers. This attitude on his part allowed a change in ours: we had come to be taught but we stayed to explore, although we scarcely realised what a wealth of learning we were drawing on in him.

Dr. Marshall Marinker: Michael Balint was the greatest teacher that I ever had, and he was also a father-figure, and like all fathers he could be very awkward. Like most of you who went to his seminars, I had a preliminary interview with him, when we were supposed to see whether we were suited to each other. I was astounded at the end of 40 minutes at how much of my life I had covered and how much about myself I had said, and at the end of it he said to me – very very pleasantly – "I think you're going to enjoy enormously this seminar and get a great deal out of it, because after all you are a little bit crazy!" One of his fellow analysts wrote to me the other day and told me a lovely story about how in Michael's Manchester days they had gone to a concert – it had been a concert of Mahler – and at the end of the concert someone had said to Michael Balint "It was marvellous, wasn't it?" and he said "Yes, Mahler has everything – except genius". If I can tell a personal story; we went out to dinner one night, a few members of the Wednesday Group. We were terrified because it was the first time that Michael was going to meet our wives, and I had told my own wife "Whatever you do, behave naturally, but don't say a word!". I felt that we had got the wives absolutely buttoned up, but he would have none of this. When Michael and Mrs. Balint came into the room he said "You go over there, I shall sit between the two women". After about the first glass of wine he turned round to my wife and said: "Your husband has been with me now for two or three years, what changes have you noticed in him?" I interposed "Now I talk to my patients with a Hungarian accent". My wife said "Well he's much more

livable with now. He's still a difficult man, but he's much more livable with", and in the middle of this rather quiet restaurant he leaned across and said "You see, Enid, she's prepared to live with him but only sometimes".

People have said tonight that he was a very great teacher and then have gone on to say what other things he was to them as well. For me I think that when I have said that he was the greatest teacher that I came across in my life – I think that I have said everything: that means that he was also an inspirer, that he was also a kind of ideal father for me in many ways. And I can think of no man who has affected my life more than he has. I also think that there is no man who has affected general practice more than he. I sometimes wonder whether we realise even now how much he has changed the face of general practice, how this College that we are sitting in now is a totally different place, because Michael Balint taught and saw what general practice had to offer people.

Further tributes were paid by Drs. Dorothea Ball, Leon Ratoff, D. Wilson, and Max Clyne.

Psychosexual Problems as they Present in my Practice.

Dr. Cyril Gill

In the last four months three women have come to me with a direct complaint of sexual problems, not wrapped up in any covering complaint. During the same period of time only one man has even mentioned sexual problems without my prompting. He was an Indian, who mentioned poor erections amongst a number of other failings associated with being a stranger in London. It would not have been appropriate to make too much of the sexual part of his complaints, as this was not central in his mind. Perhaps that was why he was able to mention it so easily! Indian men, in marked contrast to the average European male, who defends his sexual potency to the last, often mention sexual failure. Male doctors as well as their male patients, have this defensive feeling.

There are quite a few couples who come with marital sexual problems, and again I think the wife usually makes the first move, to me anyway. Some couples present their marriage as a delicately woven tissue of immaturities and conflicting needs, with the warning "Don't touch us, or we'll fall apart". They expect to be referred to a specialist Marital Unit. One might almost say that they deserve it. Doubtlessly, they mostly benefit in the end. However, one newly married couple came to me recently, asking for referral. They both had had psychotherapy in the past, they had read Masters and Johnson's books, they were eager to tell me what to put in the referral letter. I am afraid that such eagerness for an audience of experts in the bedroom will make it unlikely they can ever be helped to manage without.

However, there are many couples that let the general practitioner feel that he can help them. Such a couple came to one of our colleagues a year or so ago, and after introductions the husband got up to go. He said, most revealingly "All right, dear, I'll wait for you outside". The wife could not get an orgasm, but she asked for the doctor's help in a very businesslike way. She clearly wore the trousers, and in fact she went to bed first, tried to work up an erection, then summon the husband to bed. However, she seemed to the doctor to be sincere both with him and her husband. In two or three sessions he had enabled her to feel freer as a woman. She had always felt that her father had not given her permission to do so. The doctor gave suitable indirect messages to the husband, managed to get to know the wife, and within the limits of the relationship succeeded in dominating her. At a suitable climactic moment of understanding he passed her back to her husband with instructions to her to leave the job to him. This was straightforward, painless, and the help was given entirely in the wife's terms. The problem was treated exactly as it was presented. One might say it was too shallow to do much good, but it seemed to have worked as far as it went.

Helping couples to adapt to each other is a rewarding task for general practitioners. The most surprising couples will stay together, apparently containing each others immaturities fairly successfully. An example is a man who got married and came on my list with his wife. He had a thick record envelope, containing summaries of admissions and consultations for anxiety, depression with impotence mentioned once or twice. Seven psychiatrists had seen and treated him briefly. The latest somewhat pessimistic letter stated:- "The prognosis is poor, I see he is about to marry a young and pretty wife. I'm afraid this is an unrealistic effort, which must end in disaster", But of course the psychiatrist did not know the wife. That was eight years ago. At first I was a bit on guard, waiting for an explosion and the husband indeed had several alarming episodes of panicky abdominal symptoms. But gradually he and I got to know each other, and I accepted his impotence and understood it with him to some extent. The young wife hardly uses doctors at

all, and is guarded with me, but she is not unhappy. From the husband I gradually got the picture that she is much concerned with her dead father, and that she is remaining a virgin. She would never discuss it or see a psychiatrist. All the husband has needed over the last eight years has been an occasional pat on the back, and a tranquilliser when things get him down – mostly relationships at work. There are many tensions, but my minimal support of the husband seems a pretty good compromise considering the untreatable immaturities of the couple.

A good many patients present problems that suggest a sexual content and seem to ask for a sexual interpretation. I think we all have to restrain ourselves at times from interpreting riskily instead of listening to the patient's distress stated in his own way. However, patients are often obviously crying out for help in the sexual field. A young professional trombone player came to me for sedatives. He was trying to settle in his first job in an orchestra. He felt embarrassed and unsure of himself in the solo bits and found he could not control his instrument properly. He had rather expected to be a sort of angelic trumpeter, and this was different from the realities of job competition and brassy pub talk of his fellow musicians. His sex life exactly mirrored this, and he was relieved to discuss the two aspects of his problem in parallel.

There was also a new patient who came to one of our colleagues, a girl of 21, who arrived with a sore ear. The doctor saw at once that she was depressed, so he tuned in to the idea that this could not be treated as "just an ear". He lifted the hair aside and was momentarily taken aback by the sight of her psoriasis all over the neck and ear. She had had psoriasis since she was 13. "If you lift up my clothes anywhere, you would see it", she said. Doubtless this presentation is enough for everyone to guess the rest. The doctor said "At 13 you must have just been starting to see yourself as a woman". She then told him the story of her very inhibited parents, and her recent first sexual encounter that had ended in disaster. She used the psoriasis as a defence against sexuality which was seen as a mutually damaging affect. She was eager to discuss this and was greatly relieved by doing so. Since then she has been playing the doctor up a good deal, since there is a part of her that would really like him to violate her defences.

These two cases were fairly obvious examples of the indirect presentation of problems with a large sexual component. Often the patient finds it very difficult to go to the doctor, has thought out what to say and what to keep back, and in so doing they reveal the lot, if the doctor is able to see the clues in the first few minutes.

A fat girl had been getting slimming tablets and dietary encouragement from my partner. She came to me saying "Can you help me to slim without tablets doctor? I rather think it might be something to do with another trouble, I can't get an orgasm". What a delightful challenge! I gave her three or four sessions, in which we went over the various aspects of her disruptive childhood and her confusion of needs for caring and sex. We delighted each other with our mutual understanding, and meanwhile she got fatter and fatter. She reproached me for this, gently at first, then more stridently. At last I realised what should have been clear from the first presentation, when she was seductive and asked for the impossible. Her life technique obviously was to seduce men and then to show that they are no good. I put this to her and she took it very well, till I suggested that she might be withholding her orgasm because she felt that her boy friend did not deserve it. At this point she burst into tears. I still hope one day to get her slim and orgasmic, but we are in much deeper water than I envisaged at first, and a long way from home. I should have guessed it in the first few minutes, but I would probably have been hooked anyway.

In general practice emotions and psychical symptoms are often medically mixed up. A woman came to see me with her fractious infant. She complained of gastritis and outlined her swollen stomach by gestures so as to describe her sensations, giving the clue of her wish to put the infant back in the womb again, in a way that she could never have admitted directly. A young man with piles and acute gastritis was led gently into a discussion of a crisis in his homosexual relationships.

The gynaecological presentation of sexual problems is very common, whether the patient is aware of them or not. Nothing could be more intimate and revealing than the vaginal examination. A great deal goes on at a vaginal examination, of which we may not be aware. Occasionally the patient may make use of this with no effort from the doctor at all.

An attractive married woman used to consult my partners, I did not know her well. She consulted me for an episode of recurrent cystitis. Investigations had been negative and I asked her "Why do you get cystitis so often? ". She gave no answer. Soon afterwards she came back to see me. She wanted to know why she had not conceived after several months of trying. I asked her a few questions and examined her

vaginally. I said she seemed a perfectly normal woman to me. I added "You do not really believe this?" I think she took this as reassurance, but she also noticed my surprise that she, an attractive woman, should feel unfeminine. She was impressed by my remark and agreed that she had always had doubts about herself. Her husband had tried to convince her that she was all right. She suddenly said:- "You thought my cystitis was psychological. Do you mean that I might not conceive for psychological reasons, too?" I said it was possible. We did not pursue the matter any further, she was evidently having private thoughts, she nodded and left. She came back a few weeks later. She was pregnant, but then miscarried. Later she conceived again and last Autumn had a baby. She has remained with me as my patient, and she has not had cystitis again. I once gave her the opportunity to tell me more about it, but she did not take this up. She and her husband have moved away now, but when they moved the husband wrote thanking me for my help. So whatever went on between us was taken into the marriage.

One could easily consider every patient who enters the door as a possible psychosexual problem. This would be a dreadful mistake, but equally there are many cases that make no sense in any other terms. I hope this Society will stimulate research into these problems, for example how to select patients who are ready for help in this field.

BOOK REVIEW

Diagnosis or Treatment:

Balint, M., Hunt, J., Joyce, D., Martinker, M., and Woodcock, J., **Treatment or Diagnosis:** A Study of Repeat Prescriptions in General Practice. London: Tavistock Publications 1970.

As usual when Dr. Michael Balint and his general practitioner colleagues examine what appears to be a perfectly ordinary aspect of the general practice scene, unexpected discoveries are made. Repeat prescriptions are stock in trade to every general practitioner, and at first sight appear as absolutely respectable necessities. After all, every diabetic needs his insulin, the myxoedemic patient needs her thyroxine, and the patients with hypertensive cardiac failure need their hypotensives, diuretics, and digitalis. It is only when proper examination shows that the vast majority of repeat prescriptions are not for specifics but rather for symptomatic remedies, especially psychotropic drugs, that the transactions take on a more curious air. In fact Michael Balint and his co-workers had found that some of the prescriptions made pharmacological nonsense.

However the doctor-patient transaction was far from being non-sensical. There was an extraordinarily similar pattern of events usually leading up to an established repeat prescription. After a series of medical crises, often involving one or more serious diagnoses, the patient settled into a state in which the doctor was not bothered, provided that the medication agreed between them at some stage of the critical period was maintained. The patients who came personally to collect their prescriptions often engaged in a strangely stereotyped exchange of words with the doctor, bearing hardly at all on any conceivable illness situation. On the whole, the patients kept their distance from the doctor, and it was seen that their life pattern tended to display a tendency to distance relationships with others, especially the spouse. The peace was only disturbed, if the doctor attempted to change the prescription, though it must be said that in some of the cases where the patient asked for change, the doctor was often resistant.

What emerges is that a repeat prescription is more of a diagnosis than treatment, and it is the embodiment of a particular kind of doctor-patient relationship, which allows the patient to function reasonably satisfactorily. This raises the question as to how important pharmacological considerations are in a number of maintenance therapies. How important are phenothiazines to continued good health of chronic schizophrenics, for instance? This may sound like heresy, but then the findings of this research would have been considered heretical by most doctors in general practice. For those who still think so, examination of their own repeat-prescribing habits will give them a shock. I say this with the conviction of one who has done it!

Michael Courtenay.

ART AND PSYCHOLOGY

A Note on the Design for the Front Cover of the Journal

Dr. Stephen Pasmore.

The cover of this Journal was designed by my brother, Victor Pasmore, for The Balint Society, and it may be of interest to members to learn how he came to design it.

At a meeting of the Council of the Society, when the first issue of the Journal was being discussed, the question of a suitable emblem for the cover was raised. I suggested that I should approach my brother for a design, as I thought his work was motivated in much the same way as our members' work was motivated when the 'flash technique' was being used. The Council agreed, and when I next met my brother, we had a long discussion on his approach to art and on our approach to the patient when using the 'flash technique'. My brother found so much common ground between our two approaches that he said he would be delighted to help the Society in any way he could, and would produce a design for the cover which he hoped would meet with Council's approval.

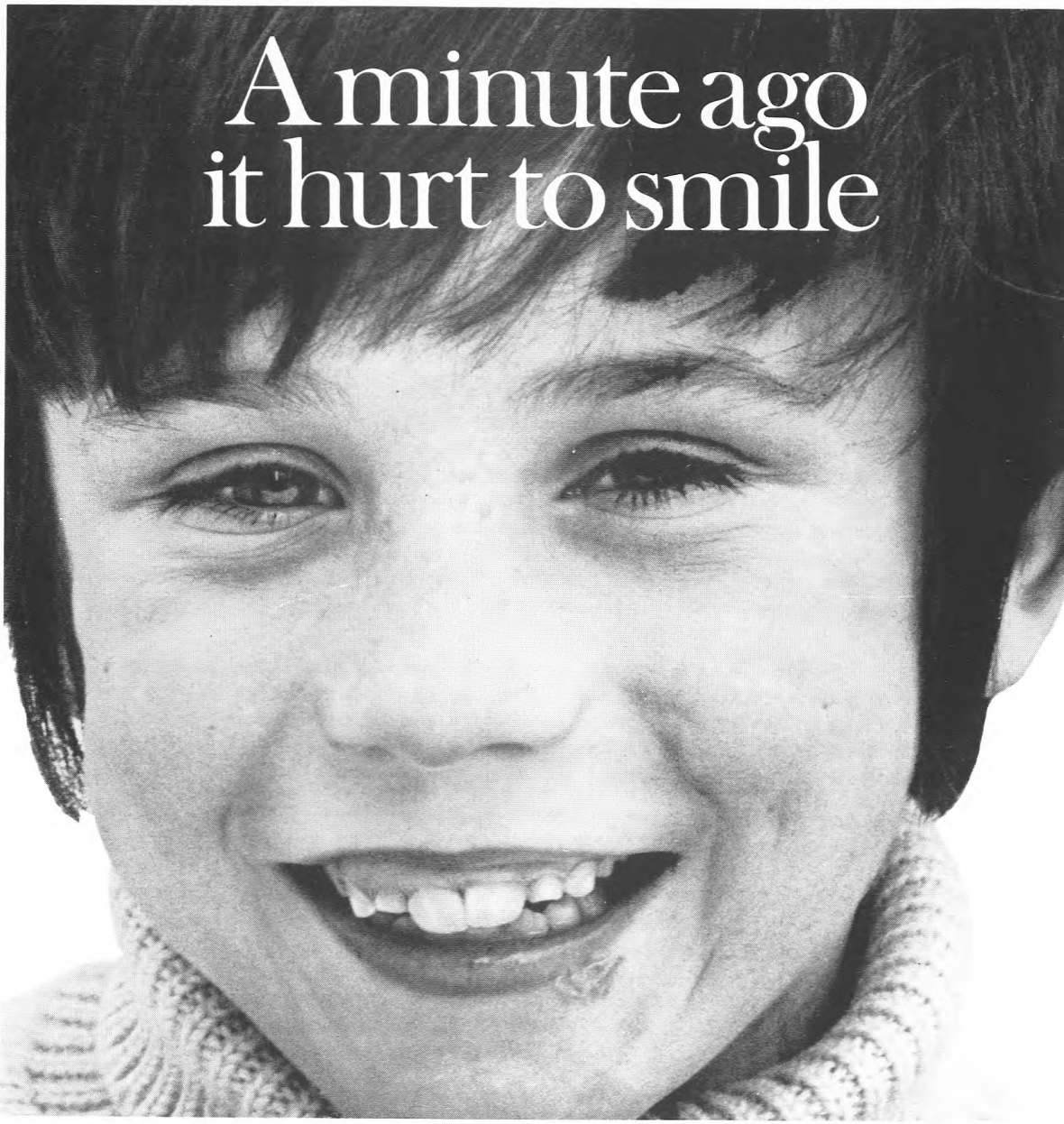
The design will puzzle those who choose to ask the question "What does it represent? " because it is impossible to appreciate or understand abstract art by attempting to judge it by the rules laid down for the appreciation of representative art. In representative art, judgement can readily be made by reference to the well-known rules of that art concerning proportion and harmony, light and shade, form and modelling, linear perspective, colour tones, technique of drawing and of handling paint, illusions of reality, and so on. In abstract art, judgement must be made by a different set of rules, and this judgement has become more difficult because the abstract artists have not been able either to enunciate clearly the principles that have motivated their work or to come to any agreement on a new set of rules.

There are two main forms of abstract art — the one where the artist, like Cézanne, gets his inspiration from outside by looking at nature and then abstracting from it, and the other where the artist gets his inspiration from within by composing with formal elements, like a composer of music who uses elements of sound, while the artist uses elements of colour or of simple forms like dots, circles, lines, triangles, rectangles, or squares.

The design on the cover is based on the latter form of abstract art, where the artist has composed his picture from a selection of simple forms. The essence of the cover design is the oval form created by the juxtaposition of two oblong interlocking masses, the one above the other. This form will evoke various emotions concerned with the close relationship between the two masses, such as calmness or disturbance, stability or instability, depth or superficiality. By itself the oval form would have looked rather heavy, but the artist has added a linear development below with a wormlike structure on the left and a circular object on the right, both in pitch black, to lighten the oval form above and at the same time to give it more stability by contrasting it with the smaller, darker and more dynamic forms below. The oval form and the linear development can now be seen as a new unit with a harmony of its own.

I do not know exactly how my brother built up this picture, but he would have started with a blank sheet of paper in front of him. He would have had no preconceived notion of what he was going to create. Then he could have made a small curved line which could have become the top left hand corner of one of the two main masses. He would have then contemplated this curve and interacted with it, so that it would have led him to make a further mark on the paper. At this stage he still would not have known that he was going to create, but the two marks he had made would have engendered a further emotion in him, so that he would have been inspired to take the shape further. And so the final design would have been created without any reference to represtational art.

It will be seen that this technique is very similar to the 'flash technique', where the doctor, instead of drawing his picture of the patient by studying every element of his make-up, uses the abstract artist's technique and builds up his knowledge of the patient by starting with a blank mind with no preconceived ideas of what he intends to do. The doctor then, in the words of Michael Balint 'identifies closely with the patient's feelings, withdraws and looks at what his involvement means, communicates his interaction with the patient in the patient's terms and then goes on repeating the process'.



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