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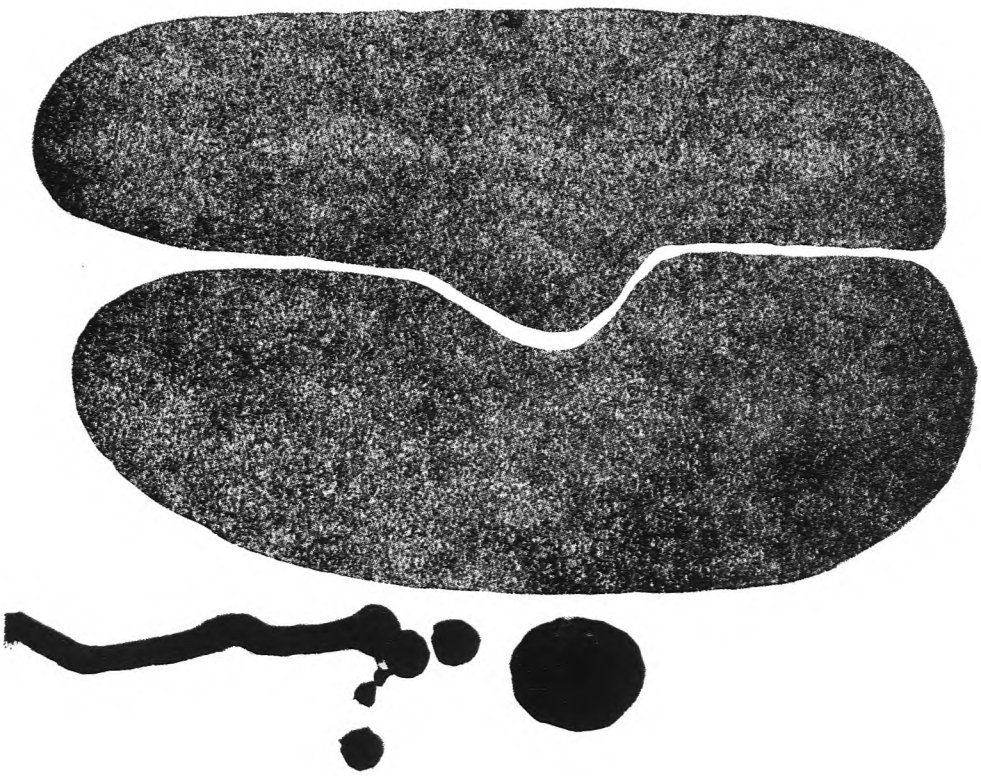

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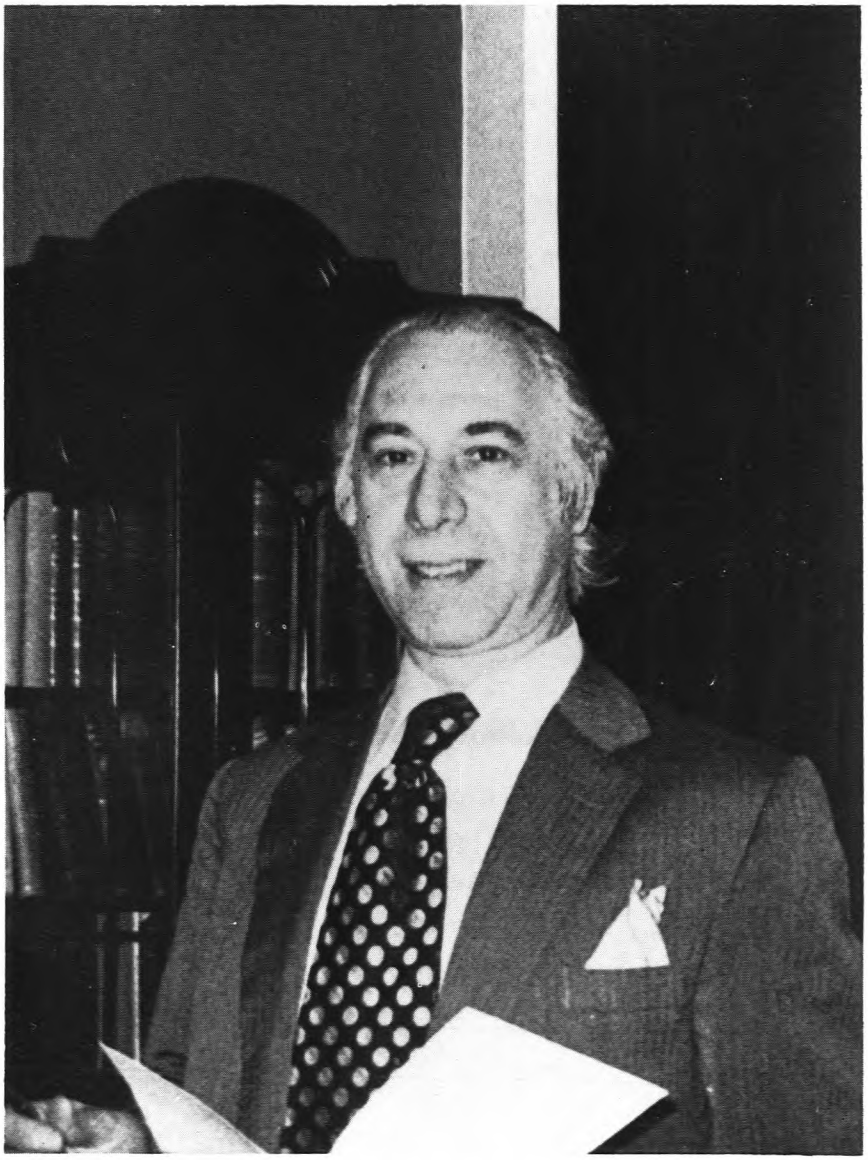

Philip Hopkins

First President of the Balint Society.

Editorial

We have kept our readers waiting rather a long time for a second issue of the Journal of the Balint Society. This was largely due to a need to obtain financial support, an obstacle which has now been overcome and the Editor is delighted to present the second issue of the Journal of the Balint Society.

The Balint Society is slowly growing in membership and expanding the content, frequency, and attendance figures of its meetings. Michael Balint's teaching is gaining wider recognition, here and abroad. The first International Conference of Balint Societies, held in London in March 1972, was a resounding success. Over 420 doctors from many countries attended, and the Conference was given wide publicity in the medical and national press. Numerous valuable contributions were made, most of which have been published in book form under the title of *Patient-Centred Medicine*, under the editorship of Dr Philip Hopkins, to whom the Society owes a great deal of gratitutde for this work.

A number of changes in the administration of the Society have occurred since the last issue of this Journal. Philip Hopkins has retired from the Presidency of the Society, having given the Society a great deal of his time and skill during his two years in office.

Dr Michael Courtenay, another of the Old Guard, has been elected the second President. The Society feels certain that the tradition begun by Philip Hopkins will be continued by his successor.

Michael Balint was not a man excessively fond of learned societies. He was even less fond of the adulation of the personality. Nevertheless, he approved of our Society, which at first bore the name of Medical Society of Balint Groups. He approved because he thought that his earliest pupils, fellow workers, and friends outside the psychoanalytical field, would be willing and able to continue the work he had carried out in general medicine. Even the seminars, which he started with general practitioners, had never been called anything but Balint Groups or Balint Seminars. The fact that our Society had Michael Balint as its first Honorary Member, and is now privileged to bear his name is not only an honour but also an obligation.

We are not a social club, we are not a society where people just listen to the presentation of polished papers, the publication of which is meant to promote the speaker's professional career. Our Society is meant to be a working society. Our general meetings bear testimony to that. Most of the thirty or forty people who attend the meetings take an active part in the discussions. Nevertheless, more could be done in the field of scientific work. The number of papers submitted by members of the Society for publication in this Journal is pitifully small.

No working groups have yet been formed to study problems of the doctor/patient relationship by the Balint method. Let us hope that the future will change all this.

MAX B CLYNE

The Balint Society

(Founded 1970)

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Manuscripts and communications for publication in the Journal should be forwarded to the Editor, Dr Max Clyne.

They should be typewritten on one side of the paper only, with double-spacing and with margins of 4 cm.

The Editor would welcome personal views of members, details of new appointments, lectures given and so on, for publication in the Journal.

Lists of publications by members, together with reprints, will be useful for the Society's library.

Habits

MAX MAYER

(*General Practitioner, London*)

When, a rather long time ago, I was asked to open a discussion after the next AGM and pressed to choose a title I said, much too quickly for my own liking, 'Habits'. I remember well that at the time I was very concerned about the tendency to declare people to have become 'dependent' on this, that or the other, and to produce biochemical evidence to prove it, as well as elaborate psychological inventories called 'profiles' into which they had to fit for purposes of 'identification'. Thus were made available new diseases for new therapeutic ventures which—mind you—were usually accompanied by rather pessimistic prognostications which was, of course, appropriate because non-illnesses are likely to be non-curable.

This trend went hand-in-hand with the term 'sub-culture' by which the process of alienation was completed: you are biochemically odd, you are culturally deviant, and though you can't really help it we are determined that you should because we cannot stand your ways, although we relieve you of the responsibility of having adopted them. I thought how much nicer it would be if we looked at our oddities as habits. We could sling at least some aspects of health care back into peoples' laps, where it belonged, if we really believed that man was born free.

Habits are essential in our survival kit so that we may proceed, after a period of learning, to get on with the business of living without conscious awareness of the complexity of the thousand and one actions that may well be carried out unthinkingly in the course of the day so that we may concentrate on the acquisition of fresh skills, fresh knowledge and fresh insights; that is to say, make full use of ourselves. Habits thus allow us to evolve but, paradoxically, only on condition of reviewing them constantly and that means at the expense of the sense of security that settled habits promote. No one likes to exchange security for anxiety—which is one of the reasons why it is so hard to kick a habit. But the dilemma has to be faced unless we are content to let our potential for a more meaningful existence perish by default.

Doctors, too, cultivate habits, and I would like to be allowed to look at a few random samples. 'Random samples' I hear myself say? Well, that is the first big deception: the choice is no more random than the one you exercised when ordering your dinner wine: what you fancied among what was available tempered by a quick recall as to whether it had been a good day for certificates. What follows, therefore, are by no means original contributions but acts of piracy—I enjoy stealing other peoples' thoughts.

Let me kick off with what one may consider a 'Good Habit'—to find out the truth about ourselves. Michael Balint caused some very searching enquiries into this subject and I am sure he would not have minded my saying that he had some illustrious predecessors. The chairman of the venerable Patients' Association who came up with the saying 'Physician heal thyself' got rather wide publicity by being allowed a line in the New Testament[1], and rightly so. Deep down it is the patient's cry for greater objectivity in relationships between doctor and patient, and I presume that it is also one of the most potent reasons why we have assembled under the Balint banner. But . . . what are our chances of succeeding? Let me give you an example.

A couple of hundred students were given an account of a child's behaviour which involved aggression. Pretty mild stuff by present standards such as throwing a stone at a dog, pinching little sister's arm when mum was not looking, dismembering beetles and similar occupations the delight of which still echoes in our memories. To each account was attached a photo, ostensibly of the child concerned but actually chosen according to physical attractiveness or otherwise.

The students then filled in a questionnaire giving their estimates that the child had done a comparable thing in the past or would do so again. They were to rate the undesirability of the behaviour, pronounce themselves on the punishment they thought appropriate, and assess the child for such traits as: good-bad, kind-cruel, or honest-dishonest.

The answers showed a definite bias in favour of the prettier children. These came out as less likely to repeat the act; they were considered more honest and less unpleasant than the unattractive children. The latter's behaviour was categorised as less desirable and the only gleam of hope for them was that the students did not suggest punishing them any more severely.[2]

I suspect that what goes for pretty children may well apply all along the line and if you agree I have made my point. If we can't achieve much in the way of objectivity and have thus little hope of healing ourselves, the question is: which is the minimum degree of health compatible with being a doctor?

If there be an answer, and I am not sure of it, we might want to look at what constitutes illness.

Habitually we doctors are very sure of ourselves and pronounce the verdict with little hesitation and in no uncertain manner. This is easy enough if someone has received an injury or, say, has malaria or cancer. But what about the mind? Can it be sick in any more precise fashion than a society, an economy, a joke? Yet by declaring a person to be sick, even by the mere fact of accepting him as a 'patient' we have with one stroke categorised, isolated and perhaps even stigmatised him among his fellow beings.

Mark you, he may have wanted nothing more passionately than to be 'treated' and be allowed to regress in your arms, but that is not the issue. What I am questioning is whether a person who functions inefficiently in a social context, has learned little about the complexities of life and has perhaps been lumbered with distorted experiences of personal relationships and who, as a consequence, shows behaviour and acts in a way that we find hard to accept, should be called ill? To do so may well mean that he forfeits his chances of growth and adjustment. To have colluded with him in being labelled a sick person may have the only effect of having procured for him the right to continue his sickness, to be considered incapable in a social setting, and to be needy of permanent support on all sorts of levels.

It may therefore be a measure of our own health to be able to say: 'what you are suffering from is your own, personal and unique way of compressing into a kind of bodily or mental shorthand the anguish of what it is to be alive. This is something I share with you, and perhaps I can help you to inject some reason for hope into this seemingly hopeless situation'.

By hope I mean an expectation of successful participation in social interactions. We doctors are, as Michael Balint constantly reminded us, a most powerful drug and only by remaining constantly aware that it begins to act in full force the moment we call a person a patient, or a behaviour or a sign an illness, can we stop falling into the trap of creating new classes of the sick instead of promoting better health. This does not mean that the people who come to see us do not need help; we are all students of life and some need personal instructors, a role which we may indeed be equipped to play quite well. But we must be clear in our minds that where no formal sickness exists there can be no formal cure. Which is like saying: if we need patients we shouldn't be doctors.

It is hard to believe but not long after I had committed this conundrum to paper I came across a report by a man called Rosenhan, a professor of Law and Psychology at Stanford University in California who is obviously a very worried man.[3]

He briefed a number of volunteers to get themselves admitted to a mental hospital, complaining that ethereal voices were saying 'thud' and 'hollow' to them but insisting that otherwise they felt perfectly well. They had also been told to drop the complaint immediately on being admitted, and they were to cooperate fully and intelligently and behave naturally in all situations that might arise. They were duly examined, interviewed and eventually discharged—every one of them with the diagnosis 'schizophrenia in remission'.

Rosenhan then decided to play it upside down. He told the hospital staff of the previous experiment and warned them that he would during the next few weeks send a number of phoney patients along and would they be on the look-out for them?

Of the next 193 patients admitted to that hospital, 41 were declared fakes by one or the other consultant, one of whom scored no less than 23 himself. In actual fact, no pseudo-patient had presented himself during the period in question.

This is disturbing enough but the real reason why I was keen to acquaint you with this splendid piece of research was that at least 1 in 3 of the 'real' patients discovered the 'fake-patients' to be phonies and reported that they had reason to believe that there were spies among them who had come to check up on the hospital —which earned them a smile and another mark-up in the rating of their delusional syndromes.

This ties up neatly with what a consultant at one of the London mental hospitals told me not long ago: 'Some of us may understand our patients, but all of them understand us far better'. He really meant it.

A habit that comes as natural to us as breathing is to tell patients to take medicines several times a

day at well defined intervals, and be very stern about it. Has it any rationale?

People talk of half-lives of drugs, blood levels, urinary excretion rates and tissue concentrations of chemicals about whose mode of action and point of insertion into the biochemical cosmos no hard facts are available. I find the whole system of drug administration both incredibly naive and highly dangerous. It is naive because we jump to conclusions about cause and effect with a nonchalance that would frighten a medicine man in darkest Africa to death. It is dangerous not only for the same reason, but also because we are beginning to learn that effects are exerted at a molecular level in limited receptor areas or systems, while we are pouring down our patients' throats millions upon millions of molecules of which only a limited number are required to bring about an effect. Not only does it make me think twice about the homoeopathic pharmacology, but I also wonder what happens to the excess amount of drugs which cannot find a home? Are we perhaps unknowingly relying on an evolutionary mechanism acquired to cope with just such events?

We live on materials which must be transformed to our individual specifications before they are allowed access to the inner man and we probably have acquired a vast reserve capacity of sampling and dealing with undesirables as we went nibbling at the jungle plants in times no less hazardous for our survival than the present. What happens, say, to amitryptiline before it affects the mood 10 days later? Where does that phenothiazine molecule in the urine come from months after the last dose? And is it not uncanny that examples of this kind are usually limited to psychotropic drugs? Could it be that if you assault that elusive master area in the brain, the thalamus, you'll find it protected better than Fort Knox? Maybe it lets pass only friends, and then only under unknown conditions, after prolonged scrutiny?

Speculations, of course . . . but I find the idea that we must respond to physiochemical manipulation without having a say in the matter quite unacceptable and in any case already disproved by the placebo effect.

To come back then to the 't.d.s. habit': should we be prepared to break it and ask our patients to take their medicines in relation to the good it does them? Obviously, there are untold situations in which this would be nonsense and it would be below your dignity to discuss them; but I have found a good few indications for such an approach provided one has built up a relationship with the patient which allows one to transform something which they do anyhow behind one's back into a form of open, adult and constructive cooperation.

In this context we might look into another habit that has come over us, i.e. to cure people. Until about 250 years ago the word was not used in the medical sense but lived up to its original meaning of 'to care', 'to take care of'.

People began to think of final solutions in a finite universe 250 years ago and the French revolution was just around the corner and it was then that the verb 'to cure' came to indicate being totally relieved of suffering. On the whole we have stopped believing that our problems are soluble, but as doctors we have not quite gone the way of the physicists, and there is a suspicion that we have become insensitive to the wider issues of the human condition in our restless search for cures. Remember the story of the schoolboy who said he could demonstrate that spiders could hear with their legs? He placed one in the middle of the table and said 'jump'. The spider jumped. He repeated the experiment and then cut off the spider's legs. Again he said 'jump' but the spider remained quite still. 'See', said the boy, 'you cut off a spider's legs and it goes stone deaf'. Perhaps one can only cure by some process of mutilation if it be true that most illness is a phenomenon of adaptation, but to put cure before thought can only lead to the logic of the schoolboy.

What we have to remember is that we all have learned our tricks long ago and that there are obvious limitations to unlearning one's earliest experiences and that to aim for such a goal in our patients may not only be unrealistic but harmful. Which does not mean that nothing should be done about clarifying such early impressions and their effects on later personality functioning. On the contrary, only by coming to terms with the unmodifiable aspects of one's personality can one discover and come to terms with oneself as a person. If we and our patients fail to accept that there is a limit to modifiability we risk trying to change what cannot be and fail to change what can.

Further we are in danger of equating treatment with cure, and as cure means modified behaviour in our patients, we are likely to imply in the treatment situation that the present behaviour is 'bad' and that the direction in which the therapist wishes the patient to move is 'good' or at least 'better'. But what is good and what is bad is defined by us whilst patient-centred therapy requires that patients should be assisted in defining their own goals, their own conceptions about

such matters. Which means that their aims may be at variance with the values of the therapist and in any sensible scheme of psychotherapeutic interaction there must be room for this con tingency.

This brings us to a habit we would like to discard but shall in all likelihood have to suffer: that of having to make decisions on unsure grounds with insufficient evidence. Increasing skills have landed us in some pretty situations. While criminals will now largely escape the death penalty in the Western world, patients are lining up by the thousand. Organ transplants, kidney machines, keeping badly deformed children alive, cytotoxic-cytostatic-immunosuppressant cocktails in germ-free prisons, termination of pregnancy 'to mention only the glamour subjects' are all variants of decisions about life and death with doctors as judges, juries and executioners.

What are we to do? We can't opt out, especially as a rather well informed public has passed the buck to us. Are we going to make dogmatic pronouncements, both as moralists and technicians, or is there perhaps a broader base on which to form partnerships with out patients and encourage them to decide what is theirs to choose and theirs to bear, and help them carry their heavy burden instead of assuming the role of an arbiter, albeit benevolent?

Since we really do not know what is right and what is wrong, ought we not to share the resulting impotence with our patients who approach us because they are precisely in the same straits? We ought not to feel ashamed to hang our heads and wipe the odd tear of frustration, anger and compassion from our eyes in full view. If we do we shall soon drown in the quicksands of moral philosophy and we can all point at some poor chap, God bless him, to whom this has happened.

I would like to give two quotations to spotlight, a habit of which we are rather more fond.

The first comes from a survey of work in a drug dependence clinic and goes like this: 'The first three years' work of a drug dependence outpatient clinic is discussed. 40 patients who succeeded in overcoming their drug habits are compared with a similar number still on drugs. No clear differences emerged which offered a prognostic guide'.[4]

The second reads: "What's the use of their having names" the Gnat said, "if they won't answer to them?" "No use to them", said Alice, "but it's useful to the people that name them, I suppose. If not why do things have names at all?"[5]

The making of a diagnosis, or the necessity to coordinate observable and inferential facts so as to enable one to prognosticate, and hence to enable one to conceive of a plan of action was one of Michael Balint's fundamental problems he set out to solve. He coined the term 'Overall Diagnosis' and thought that it might well result in a higher degree of predictability not only with regard to prognosis but especially as to the likely effects of interaction between doctor and patient, and so provide the doctor with well defined, realistic aims and a patient-centred technique of treatment.

He used the word diagnosis in its literal sense, meaning 'to know through and through', or 'from beginning to end'. He fought against labels and resolved to teach us to rely on observation, not theory. He also knew that when a phenomenon is assigned to a class, certain individual characteristics of that phenomenon are forever lost as no two class members are completely identical and thus he conceived of a person as continuously differing from himself over a period of time. Seen in this tremendous context the 'Overall Diagnosis', an intellectually unassailable concept, became a most painful exercise in defining the impossible, the elusive, the unbelievably complex: as some of us here to-night may well remember who, in two years of considerable toil and exertion, produced exactly nothing they found worth committing to posterity.

The reason, I feel now, is that we never realised that we were being asked to evolve the Art of the Impossible.

Diagnosis both articulates and restricts the range of assumptions we can make about a person. On the other hand, the mere fact that we have entered into the therapeutic situation reveals a belief in psychological growth which, because of the very nature of man, is individually undefinable and it would be illogical therefore to postulate a truly predictable relationship between the patient's current level of functioning and the effect of our intervention—all the more so as from every human encounter we emerge modified ourselves.

Not unexpectedly we have all somehow managed to navigate by dead reckoning. What I feel Michael in his teachings impressed on us most strongly was that we should not consider ourselves thereby unsinkable, nor that we ought to repeat learned responses and reject the patient if he did not dance to our choreography, and to point out that there were unlimited refinements to a technique of communication which would make us into better helpers, and that we must continue to probe. In short, what he said was: to be realistic, you must ask for the impossible.

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1. St. Luke, iii, 23.
2. Dion, K. (1973) *Journal of Personality and Social Psychology*, **24,** 207.
3. Rosenhan, D. L. (1973) *Science*, **179,** 250.
4. Oppenheim, G. B., Wright, J., Buchanan, J., and Biggs, L. (1973) *British Journal of Addiction to Alcohol and Other Drugs*, **68,** (37).
5. Carroll, L., *Through the Looking Glass.*

The real references are all unacknowledged and hopefully, unresented by their authors whose torches I am bearing.

This paper was read at the Annual General Meeting, 3 May 1973.

The Patient's Need from the Doctor

H. STEPHEN PASMORE

(*General Practitioner, London*)

The traditional scientific approach in medicine was concerned with history-taking, examination, investigation, diagnosis and treatment—in that order. This approach proved to be of the greatest value when the patient was suffering from some organic disease, but of little value when the patient's discomfort was due to emotional factors acting at a conscious or an unconscious level. A new approach had therefore to be made to study the emotional factors causing disease.

In the past there has been far too large a gap between doctors investigating and treating organic disease, and psychoanalysts, like Freud, investigating and treating emotional disorders. The gap has occasionally been bridged by such outstanding men as Wilfred Trotter, late surgeon to University College Hospital. In his address to the medical students at the Hospital in 1932 on 'Art and Science in Medicine', Trotter said that the first human faculty a good doctor should cultivate was the power of attention, 'of giving one's whole mind to the patient without the interposition of anything of oneself', for disease often told its secrets 'in a casual parenthesis'.

He also emphasized the fact that the ordinary patient went to his doctor for the relief of pain or some other discomfort, and not because he was 'in pursuit of the ideal of health', while the doctor, when confronted with the patient, wanted to discover the pathological condition present and control it if he could. Doctor and patient were thus 'to some degree at cross purposes from the first'.

This paper is concerned with the consideration of these cross-purposes and with the patient's need from the doctor rather than the doctor's need to make a diagnosis and treat the patient.

Although men like Trotter had been able to bridge the gap between the physical and mental aspects of disease, having themselves come into contact with the writings of Freud and others, they had little time to incorporate their new-found knowledge in the routine lectures they had to give their students to enable them to qualify as doctors. It was not until the founding of the Tavistock Clinic in 1920, followed by the development of the 'case discussion seminar' by Enid and Michael Balint in the Family Discussion Bureau at the Clinic in 1949, followed by similar seminars for general practitioners organised by Michael Balint in 1950 that the interest in 'the other part of medicine' was fully revived.

At Balint's seminars the general practitioners underwent a different form of training from the one they had received at their medical schools. Instead of being taught in the traditional way, they were asked to present their cases for discussion in the seminar. The main focus of attention was directed to the doctor)patient relationship, and it was the study of this relationship which enabled the doctors to make closer contact with their patients and help them to find a way out of the emotional problems that beset them.

No longer did the doctors think of disease in terms of isolated symptoms, they saw the dis-ease of disease in terms of relationships with other people. But in spite of their new awareness of the emotional disorders behind their patients' complaints, the doctors tended to revert to the use of the same techniques to diagnose and treat those disorders as they had learned to use in the diagnosis and treatment of organic disease. The result was that some of the doctors concerned found themselves becoming very efficient as detective-inspectors in making an overall diagnosis of their patients' problems, but no better able to help their patients deal with those problems.

In Trotter's words, some of the doctors tended to interpose too much of themselves by asking their patients too many questions related to their feelings, relationships and so on, and as a result spent too little time in listening carefully to what their patients were trying to say. These doctors tended to overlook the fact that many patients only wanted relief from some temporary discomfort rather than a blue-print for a new life based on the doctor's conception of what that new life should be. The doctors tended to forget that just as Balint had taught them by making them think for themselves, so it was their duty to help their patients find the solution to their

problems by making them think in the same way rather than imposing any of their own views on them.

The following story will illustrate how careful the doctor must be in conducting the first interview with his patient if he is to avoid getting at cross purposes with him.

Mr Parker, a businessman aged 35, married with two children, asked his doctor for a 'check-up' as he had felt tense and sleepless for a few months. He was persuaded to talk first about his tensions. Then, in answer to the doctor's questions, Mr Parker said that he had been given a slightly more responsible position in his firm during the last six months. He had always been conscientious and worked hard. His father was rather a weak man as was also his younger brother. His mother was the more dominant character in the family, and he was closer to her than to his father. His mother had kept him up to the mark and he worked hard to gain her approval. Mr Parker then spoke of his need to be appreciated in all fields and to receive love and affection. He agreed he turned up early in the office to gain the appreciation of the office staff. He expected his children to be as conscientious as he was. The doctor suggested that he must feel very insecure if that was how he had to behave.

The doctor sensed a lot of pent-up aggression during the interview and felt that Mr Parker was rather rigid in his ideas and unlikely to co-operate much in further talks. A second appointment was made for a week later. The doctor made a note of his overall diagnosis: 'An insecure man with a strong mother and a weak father. His pattern of life seemed to be related to his need to gain mother's affection so that he always had to be "a good boy and work hard"; but mother never gave him her full love—only appreciation when he had done well'.

This is a typical case where the doctor has sensed that the patient's symptoms, which were expressed as a need for a medical check-up, were due to emotional disturbance rather than physical disability. If the doctor had carried out a full check-up he would have been able to reassure Mr Parker that there was nothing physically wrong and Mr Parker would have felt better for a while though his tensions would have remained uninvestigated and untreated. But the doctor wanted to help the patient as a whole. He took a good history and was able to make a good overall diagnosis. The patient and doctor had apparently made a good start, but all the doctor's faults in handling the case were admirably summed up a few days later by the patient when he wrote to his doctor to cancel the second appointment, saying 'after our first meeting I felt like a car which had been sent for a check-up on brakes, lights and clutch; only to have all the upholstery taken out'.

The doctor, having learned how to recognize emotional disorder, made the mistake of combining the techniques for the investigation of organic disease with the techniques necessary for the diagnosis and treatment of emotional disorder. He tried to get all the information he could from the patient in order to make a proper overall diagnosis before attempting a course of psychotherapeutic talks. This was too much for the patient, who ran away.

If doctors are to avoid getting at cross purposes with their patients they must study their patients' needs in a different way. They must remember that though patients may readily submit their bodies for examination and treatment, they are far more reluctant to submit their minds to a similar procedure. They will only offer the doctor a tiny thread of their mind because they feel they must retain their own identity, for fear that if they give their doctors their whole minds they will lose control of themselves. It is this thread that the doctors must pick up and examine to find out the patient's needs.

At the first consultation the patient's need will be for the immediate relief of his symptoms, whether they appear as disturbed feelings such as anxiety or depression, or as somatic complaints such as backache or indigestion. At subsequent consultations the patient's needs will vary from an attempt to re-establish his own 'status quo' as soon as possible, to an attempt to discover with the doctor's help a new 'modus vivendi' over a longer period. The patient will only get the full benefit of the doctor's help if the thread he offers the doctor is not pulled too quickly. Only when the doctor has established an empathy with the patient will the latter allow him to unwind the thread a little more.

There is, of course, a danger of limiting the possibility of good psychotherapy through too much collusion between doctor and patient, in the sense that the doctor and patient will try to maintain a good image of each other. The word 'collusion' is here used in its sense of 'acting in secret concert with' or 'playing into one another's hands'. 'Collusion' may be considered good therapy as long as the doctor is aware of the collusion and feels that the patient's real need of him is for a sympathetic collusion rather than a deeper probe into the patient's inner world.

The second story illustrates some of these points:

Miss Spencer, a pleasant, competent, nice-looking woman of 65, had been on her doctor's

list for 20 years, and had only consulted him for minor complaints three or four times a year. She used to share her flat with her elderly and equally pleasant mother who had died some years previously. Before retiring, Miss Spencer had had a good post in the Civil Service and had now taken up an administrative job in a business organisation.

Miss Spencer asked to see her doctor for a few minutes for a minor problem, which turned out to be a recurrence of her cystitis. Previously she had suffered from cystitis which had been found to be associated with a benign polyp at the neck of the bladder which had been removed. The doctor, finding no albuminuria present, suspected her symptoms were due to some underlying stress, particularly as he had noted how upset she had been over her mother's death, over the possible redundancy in her job, and over her vaginal discharges and vague pelvic discomfort for which she attended a lady gynaecologist.

The doctor suggested to Miss Spencer that her irritable bladder must be due to some anxiety. Miss Spencer at first thought this a novel idea, but soon recalled that her symptoms started after her boss had left her nonplussed by reprimanding her in front of her clerks over some trivial matter she had overlooked. In the next two talks Miss Spencer was able to elaborate on the fears she had of not being able to 'hold her water in Committee', of the suppressed rage she often felt against her boss (a woman slightly younger than herself), her natural fear of not finding any other suitable employment at her age, and her upset at the way her boss had shown injustice and unfairness. The doctor suggested her fear of injustice was due to her feeling of insecurity, and Miss Spencer took this up by saying she had been very immature as a child and got bullied, and had greatly regretted not being able to talk to her parents when she was at a boarding school. She was an only child and had relied a lot on her parents. The bladder symptoms improved and there seemed no need for further talks.

The doctor would appear to have done much better work in this case than in the first one, for the patient not only came for further talks but seemed to have lost her bladder symptoms as a result of them. There was a clear collusion here between doctor and patient.

The doctor preferred not to find out why Miss Spencer had to be seen as such a good and competent person. He preferred not to talk about the stark realities of her life: her sexual frustrations, her failure to marry and have children, and her underlying aggression that must have existed towards her loving parents, from whom she was not strong enough to break away. The collusion in this case enabled the patient and doctor to think well of each other, and enabled the patient to be relieved of her immediate anxieties. The collusion, however, effectively prevented a deeper communication of the patient's basic anxieties, and though doubtless it was the correct treatment for Miss Spencer, aged 65, it would probably have been incorrect if she had been 30 or 40 years younger.

The patient's need from the doctor may be very great, though it is often difficult for the patient to express it clearly. In such cases the doctor can sense the patient's need better by using a different technique, the technique of imposing as little of himself into the conversation as possible, of becoming more receptive to the patient and of identifying more closely with his feelings; in other words, the technique of accepting the atmosphere created by the patient rather than imposing on him the traditional medical atmosphere of the hospital cross-examination.

The third story illustrates how the patient's need from the doctor can be better appreciated by the doctor, if he stays in the background and becomes more sensitive to the atmosphere created by the patient.

Mr Lawrence, a student, aged 22, left his college after obtaining a 3rd class degree. He knew the college doctor discussed psychological problems with the students, and so made an appointment to see him at his surgery 10 months later for a special talk. He had great difficulty in communicating his problem to the doctor, but without any prompting from him started by giving a history of mental illness in his family. He then spoke of his own difficulty in getting jobs and of some sex problems he had had with a girl of his acquaintance, and said he managed to subdue his anxieties by trying to think about something else.

The doctor asked him to define his problem more clearly if he could, and the student spoke of the 'obsessional way' in which he found himself applying for jobs, of how his father was in a mental hospital with a neurosis, and of how his father ran a small and precarious business, and wanted him either to take it over or go into one of the Services. He added that he was the eldest son in the family.

The doctor, who had noted that the student had not mentioned his mother, felt confused about the whole story and interpreted the confusion he felt as a symptom of the patient's emotional

disorder. He expressed sympathy with him over the difficult position in which he must find himself, as the eldest son trying to please his father and at the same time trying to become independent of him, and suggested that he needed further talks to help him overcome his problems. The student said he was unfortunately going to move into the country, so the doctor gave him an introductory letter to a local doctor.

Although there is no follow-up of this case the doctor felt he had used a better technique in not making any attempt to organise the interview or elicit details of the student's history by using the detective-inspector technique. The student had opened the conversation by mentioning the mental illness in his family without giving any details and the doctor deliberately refrained from asking him for the details at that moment. This was what Balint had meant by 'selective attention and selective neglect'.

The student next spoke of how he found himself applying for jobs in an obsessional way but again gave no details. He then touched on his sex problems in one sentence. The doctor felt sorry for him as he struggled to find the right words to express his disorder and realised that the confusion he felt about him was due to the student's projected confusion on to him. This was what Michael Balint had taught—how to use the doctor patient relationship as a diagnostic sign and how to identify with the patient for a few moments then withdraw and interpret what was felt, back to the patient.

There is little doubt that in this case the doctor gained more information about this previously unknown patient by *feeling* his confusion and conflict, than he would have done if he had first tried to find out what had led to that confusion and conflict. The doctor sensed the patient's needs in the first interview by getting into close contact with the patient's feelings—by 'tuning-in' to the patient as it were, and would have been able to give him considerable help if further talks could have been arranged.

The three cases quoted also demonstrate the different techniques available to the doctor when trying to help a patient with some emotional disorder. Although all three techniques can be used at some stage in one interview or in different interviews, there is a tendency for the doctor to pursue one or other technique for all his patients. The 'detective-inspector technique' and the 'collusive technique' may give very rewarding results at times, but the technique of 'tuning-in to the patient' is more likely to meet the patient's needs.

The patient's real need from the doctor in psychological illness will not be met by the doctor's prescription of a course of treatment based on the lines of inquiry traditionally used in the investigation and treatment of organic disease, because the patient's real need from the doctor is to be understood, to be respected, to be given insight, to be helped to regain the equilibrium he has lost, and to be enabled to regain confidence in himself so that he can rely on his own efforts to surmount his difficulties.

The patient's real need will only be met by the doctor if he abandons the traditional scientific method of enquiry and tries a psychological approach: an approach which will be considered equally scientific when all its ramifications become known.

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Patient-Centred Medicine

Edited by PHILIP HOPKINS

Regional Doctor Publications Ltd., London 1972 £3.50

It is never easy to put into print the proceedings of a conference in a form that is both readable and accurate. Dr Philip Hopkins has succeeded in this task admirably. The papers presented at the First International Conference have been trimmed of excessive verbiage while losing nothing in meaning. The papers are grouped, as at the Conference, into those concerned with the Doctor, with the Patient and his relationship to the doctor, and with the Illness. There is a short but moving 'In Memoriam' section in which colleagues from various countries described the impact of Michael Balint's personality and ideas on their work and outlook.

A thoughtful introductory paper, 'Changing perspectives in general practice', by Jack Norell, leads on to a dazzling journey through Western European and American presentations of the doctor at work in various settings, and at varied stages of his career, from pregraduate onwards.

The chef-d'oeuvre inevitably is the presentation of a Balint Seminar led by Enid Balint. This comes over in print remarkably well. Those who were present at the demonstration, and that includes the entire Conference membership of well over 400, will recall how vivid and exciting it was, with the work of the group spilling over into the audience itself. I do not think that much was lost in the group work by the stage setting; nor perhaps by the fact that it was a newly constituted group. Though many people nowadays have experience of group training, I think this demonstration was truly memorable.

In part two, the Patient, especially in his doctor/patient role, takes the stage in a suitably stimulating variety of situations and conditions. In part three, attention is focused on the Illness and its management, again with impressive international flavour.

The general style of the papers is clinical and non-academic. I say this in praise, not condemnation. They read well; the reader's interest will be held, and he will frequently recognise from his own experience clinical settings described in the papers. It may be a useful exercise for the reader to identify the 'distance' from Michael Balint of the individual contributors.

There is, unavoidably, a difference in the quality and value of the papers, and the problem this represents has been ducked by the editor. By presenting the papers in some sort of chronological sequence, based on the Conference programme, all appear to warrant equal attention. This, alas, is not and cannot be true. It is invidious to mention certain papers out of such riches, but Stephen Pasmore on 'The patient's use of the doctor', Cyril Gill on 'Types of interview', and Michael Courtenay on the 'Flash', are gems, and will find a place as minor classics in Balint annals. Perhaps editors will have to practise selective attention and selective neglect in the future.

What is the purpose of publishing medical conference proceedings in general?

First, it is a permanent record of the Conference.

Second, contributors have the reward of seeing their efforts in print.

Third, those who attend the Conference have the opportunity to refurbish their memories and impressions of the overall impact made on them at the time.

Fourth, to permit a wider circle of readers to capture something of the content and flavour of the proceedings. This is especially important when the work presented consists of an inseparable amalgam of patient and doctor, illness and therapy, and ongoing mutual experience; where teacher and taught are out of place, where dogmatic assertiveness and clear cut results rarely exist.

This, of course, happens to be the common lot of general practitioners especially, hence, so many have claimed Michael Balint as their own.

This volume allows general practitioners who did not have the good fortune to know Michael Balint in person, to get the feel of his work which has made such an impact on modern general practice.

Finally, Max Clyne is to be congratulated for his energy and skill for the part he played in organising the Conference itself, and Philip Hopkins as Editor (and publisher) is to be congratulated on having produced so promptly a volume so pleasing to the eye, to the touch, and to the purse. The Balint Society is fortunate to have had two such stalwarts on the scene.

I look forward with pleasurable anticipation to the Second International Conference in 1974.

AARON LASK

Book Reviews

Psychotherapeutic Techniques in Medicine By Michael and Enid Balint. Paperback Edition: Tavistock Publications, London, 1972.

The appearance of a paperback edition of this book, originally published 11 years ago is a useful reminder of what a treasure-chest it is. Only the other day when looking for the chapter on 'Examination by the patient', it was astonishing to find it did not occur in the original 'The doctor, his patient and the illness', so basic did the concept seem to be.

The book contains four largely independent parts. The first discusses the influence of the setting on psychotherapy; the second the problems and the place of psychotherapy in medicine; the third technical and more abstract issues; and the last part is a review of the situation at that time of the various Balint inspired training-cum-research initiatives.

The text is so full of riches that it is only possible to mention a few. The attention paid to the patient's contributions is startling to a doctor who only fully realised the implications ten years after the book originally came out. It is the coming together of doctor and patient in an evolving relationship which is so skilfully portrayed. The consideration of the patient's angle, and the psychotherapy *of* the doctor, are seen as the twin foundations of a dynamic structure in which the doctor is a teacher in a continuing relationship, so that eventually a short and dramatic contact may have a fundamental influence on a patient's life and illness.

The important aspect of *identification* is discerned as the basis of all emotional understanding. 'To identify, the observer must be in tune to such an extent that for a brief time, perhaps only for a few moments, he may feel as if he were himself the person observed. Thus if the identification succeeds, observer and observed have a mutual experience.' This might have been written in connection with one of the Balint's later seminars which investigated the so-called 'flash', and it is this uncanny vision of the Balints later seminars which investigated the so-called which marks their work, not to mention their patience in allowing the general practitioners to catch up a decade later!

On the same plane is the summing up at the end of the chapter on 'Enabling people to understand themselves.' This is applied to the doctors, too, as the therapist is exhorted to 'have the courage to be himself and be willing to accept as much of his own peculiarities, weaknesses and strengths, skills and limitations, as he is able.'

Last but not least, the enormous advantages for doctors who can use both psychotherapy and physical examination are examined with a view to closing the gap between autogenous and iatrogenous illness still further.

MICHAEL COURTENAY

Reading Between the Lines.
Doctor - Patient Communication.
By Lucille Blum

This is a very readable book by an American psychoanalyst, who teaches doctors and dentists, and clearly understands their problems. She gives a brief outline of developmental psychology, human failures and defences, with particular reference to the patient's approach to the doctor, and the doctor's reaction.

The book outlines a 'tuning-in' to the patient and identification with him, yet with sufficient detachment to be objective and therapeutic. Doctor and patient together choose a physical or a psychosomatic approach. The doctor needs to understand himself and avoid the pitfall of playing God and other self-gratifications. The latent meaning of behaviour, gestures and phrases is discussed in the context of psychosomatic illness, hysteria, and anxiety.

However, the detailed discussion of illness is avoided which is a pity, because the patient's complaint with all its association, is by no means the centre of attention. The reader is encouraged to explore his personality and reactions, but seminars to help in this process are not suggested. The book is aimed at the right target, but it is a pity that it was not written in collaboration with a doctor, using the kind of relationship that is prescribed for the doctor and patient.

CYRIL GILL

Enfants et Adolescents Fatigués
By Pierre Bernachon. (Pp. 269) Editions Universitaires, Paris: 1967.

Dr Bernachon is a paediatrician, a member of the French Society of Psychosomatic Medicine,

and President of the French Balint Society. He continues to do some general medicine in order to have a wider view of the problems of children and adolescents.

He starts his book with a discussion of the difficulties of defining 'fatigue', but emphasises the importance of taking the complaint seriously even if there is no agreed definition.

Underlining the fact that 'fatigue' is not a diagnosis but a symptom, he goes on to discuss various situations in which the symptom is present. He begins with the various stages of development in children, pointing out that fatigue is often a non-specific reaction to a parent or teacher pushing a child to do something he has not yet reached the developmental stage of being able to do.

There are sections on the physiology of fatigue, clinical examination, and a review of organic and nervous conditions in which fatigue can be a symptom.

Finally he deals with social factors relating to fatigue, at home and in school, studying and playing, eating and sleeping, and with the prevention and treatment of fatigue.

Other sources are cited but there are no detailed references or bibliography. There is no index, but a contents list covers 9 sections with 87 sub-sections.

While emphasising the need for a specific medical diagnosis where possible, the author warns that to stop at this diagnosis can sometimes result in not noticing that an 'offer' is being made to consider some other aspect of this situation.

Since fatigue is often a reaction to an intolerable situation, the treatment section is concerned to a large extent with manipulating the environment of the patient, for instance, the over-demanding or over-protecting parent or teacher. Giving a tranquilliser to the mother rather than to the patient is now widely accepted here (by doctors): the suggestion that for prospective teachers a psychological test is no less important than a chest x-ray is perhaps more novel, but not less relevant.

'Rest' is the last item to be dealt with under treatment of fatigue, and with unexpected brevity, for Dr Bernachon explains that the prescription of 'rest' is too often only a palliative, a way of avoiding a problem.

This book is a welcome reminder that on the Continent the Balint Societies are not confined to general practitioners and psychiatrists, and of how much richer medicine would be if here too paediatricians, chest physicians, gynaecologists and even general surgeons shared the outlook, aims and activities of the Balint Society.

L. J. Ison

Opinion from Canada

". . . this book should be read by all residents in family practice and it would certainly be a good book to have on the reading list of senior medical students interested in family practice. Any family physician who feels he is not getting through to his patients' psychological problems and needs, would benefit from reading it. It opens a new area of practice and points the way to resource data in it extensive bibliography."
Canadian Family Physician, July 1973.

President's Report

(Given at the Annual General Meeting of the Balint Society, 3 May, 1973)

I look back over the year with pleasure and regret. All members of Council have worked hard and I am most appreciative and grateful to them. Our chief aim has been to further the aim gf the Society to provide training facilities for oeneral practitioners in Balint groups both in London and outside, and we have made progress as I shall relate. On the other hand I am aware that members, and especially associate members have not been kept informed of the work of the Society in the way we should have liked, notably because the second issue of the Journal was delayed due to difficulties over the financing of this expensive item. This hiatus has been ameliorated by the appearance of *Patient-Centred Medicine*, which is the Report on the First International Balint Conference, edited by Philip Hopkins and this in my opinion is the finest presentation of the proceedings of a conference that I have ever seen, and he is to be warmly congratulated.

With regard to work on training, a sub-committee on training has been established with a membership of the President, Enid Balint, Dr T. F. Main, Dr J Carne, Dr M. Clyne and Dr J. Pasmore. This deals with the question as to who should be accredited as leaders. As a first step it has been agreed that only psychoanalysts trained in the Balint method should lead seminars single-handed, though it is open to them to have co-leaders who may be general practitioners. Enid Balint leads a new group at University College hospital with Dr Cyril Gill, Dr Terry Lear leads a group in Northampton, and Dr Marie Singer leads a group in Cambridge. A number of members of the Society have been accepted as co-leaders as they have groups in view, but it was thought wise to insist that there should be two co-leaders in a seminar led by general practitioners. It is also a requirement that such leaders should be members of the Workshop for leader-doctors led by Enid Balint which has been meeting monthly since last October.

There is an initiative in Nottingham among general practitioners there to establish a Balint seminar which would be led by two general practitioner co-leaders, but approval by the local Postgraduate Dean has yet to be given and correspondence with him has not been altogether reassuring. In view of this we have set up an Advisory Panel in case Deans wish to ask for credentials of recommended leader-doctors. Enid Balint, Dr T. F. Main, Dr R. Tredgold, Professor D. Pond, Dr H. Wolff and Professor A. Crisp have agreed to serve on the panel, the President being a member *ex officio*. So although we have not yet established the first general practitioner led Balint seminar working outside London, we hope this will become a reality during the current year.

In this year of the Common Market we have also established an Anglo-French seminar under the leadership of Enid Balint, meeting in London some five times a year and having bi-lingual transcripts. If you find seminar work testing in itself I can assure you working in a bi-lingual seminar is an even more stretching experience !

The preparatory work for the Second International Balint Conference in Brussels in May 1974 is going ahead, and Drs Clyne and Mayer, who are the permanent members, have consulted the British members of the International Steering Committee and one of them hopes to attend the next planning meeting in Brussels. The initial work was started last November in Paris when the Secretary and myself attended as well as the permanent members of the International Secretariat. Enid Balint is to be the President d'Honneur of the Conference which will deal with Balint Training.

Lastly some Japanese doctors, including the professor who translated *The Doctor, his Patient and the Illness* into Japanese have been in touch asking to be a branch of the British Balint Society. While we thought this an unmanageable method of association, we have written warmly suggesting that they become associate members and have promised to keep them in touch with the international developments.

There seems no doubt that the work grows.

M. J. F. COURTENAY

Secretary's Report

(Given at the Annual General Meeting of Balint Society, 3rd May, 1973.)

The Balint Society has continued to flourish: there were now 89 members, of whom 19 were associates.

There had been four meetings, all well attended: Dr Freeling and Dr Marinker spoke on 'The Training of Post-Graduate Medical Students', Dr Erica Jones and Dr Clyne read papers on 'The Schoolgirl and the Pill'; and Dr Carne read a paper on 'Opening Gambits in General Practice', which represented the findings of an unfinished research project of the Tuesday seminar led by Enid Balint.

In the light of the decision made at the last Annual General Meeting on the teaching function of the Society, the Council has set up a Steering Committee to study the problem of training methods.

Another highlight of the year was the meeting in Paris last November of the French Balint Groups which was attended by eleven members of the Society. At this meeting it was agreed to hold the Second International Conference of Balint Groups in Brussels in May 1974 on the theme of Balint training.

Other activities of the Society included the setting up of a Balint Memorial Lecture Fund, which was proposed at the Annual General Meeting last year by the retiring President, Dr Philip Hopkins, who started it off with a generous contribution.

Many tributes have been paid to Philip Hopkins for his excellent editorship and production of the book *Patient-centred Medicine*, which comprised the papers read at the First International Conference organised by the Society last year at the Royal College of Physicians. So far, 643 copies have been sold.

H. S. Pasmore

Future Programme

Thursday, 18th October, 1973 at 8.00 pm.

At the Royal College of General Practitioners, 14 Princes Gate, London S.W.7. Tel. 01-584 6262 'Referrals: their purpose and results', Dr A. M. H. Hall-Smith and members of Dr Marie Singer's Seminar at Cambridge.

Monday, 3rd December, 1973 at 8.30 p.m.

At the Royal Society of Medicine, 1 Wimpole Street, W.1. Tel. 01-580 2070.

The First Balint Memorial Lecture, by Enid Balin The First Balint Memorial Lecture, by Enid Balint.

Tuesday, 19th March, 1974 at 8.00 p.m.

At the Royal College of General Practitioners. 'The Emotional Aspects of Vasectomy', Dr Geraldine Howard.

Thursday, 13th June, 1974 at 8.30 p.m.

At the Royal Society of Medicine.
Annual General Meeting, followed by a report by Dr Philip Hopkins on the second International Conference of Balint Groups at Brussels, on 'Balint Training'. The meeting will be preceded by dinner at 7.30 p.m.) Details to be announced later).

Second International Conference

The Second International Balint Conference will be held in Belgium from Friday, 24th May to Sunday, 26th May 1974 at the Palais des Congres in the centre of Brussels, on the theme 'Balint Training and its place in the Psychological Training of the Physician'.

Applications to attend the Congress should be addressed to the Secretary of the Congress, Dr R. Van Laetham, 42 Rue des Bollandistes, 1040 Brussels, Belgium. (Congress fee approximately £20).

Please contact Dr Max Clyne, 150 Lady Margaret Road, Southall, Middlesex regarding a possible charter flight.

Treasurer's Report

(*Given at the Annual General Meeting of the Balint Society, 3rd May, 1973.*)

The accounts show gratifying progress towards a degree of financial stability in the Society's affairs It is not the intention of Council to accumulate funds in the usual sense, but to use the money available in active pursuit of the aims of the Society. It will be noted that the expenses incurred are almost wholly in the field of communication: secretarial, clerical, postage, and a contribution (investment) towards the cost of production of the book of the conference, "Patient-Centred Medicine" on very favourable terms.

The donation of £60 to help set up the International Secretariat of Balint Societies is self-explanatory. Larger contributions were made by some of the continental Balint Societies. An immediate sequel is the planning of the Second International Conference of Balint Societies in the spring of 1974.

The Society has acted as Banker to two groups: an experimental workshop of leaders and future leaders of Balint groups led by Mrs Enid Balint, with Dr Tom Main as co-leader; and also to an Anglo-French group of several veteran Balint groupers (if that is a permissible expression), several Parisian general practitioner paediatricians led by Mrs Enid Balint, with Madame Raimbault as co-leader. It is hoped that sufficient funds will be made available so that there will be no charge to the Society.

Generous contributions from Drs P. Hopkins, M. Clyne and D. G. Wilson have got the Michael Balint Memorial Lecture Fund off to a good start. The Treasurer will always be happy to receive further contributions.

On a more mundane note, it will help greatly if those members who have not signed Bankers Orders for their subscriptions will kindly do so. The Society is registered as a charity; covenant forms are available for recovery of income tax to the benefit of the Society: new covenanters are always welcome.

Lastly, a cautionary note. One member was found to be paying the annual subscriptions monthly, his bank's computer was suffering from repetition compulsion. All members would be wise to check their bank accounts most carefully.

AARON LASK

Hon. Treasurer.

The Balint Society

Income and Expenditure Account for the Year Ended 31st March, 1973

Secretarial Expenses	£156·40	Under-provision for Accrued Items for International Conference 1972	49·06
Dotation to International Secretariat	60·00	Surplus for the year carried to General Fund	92·80
Currency Loss	62		£141·86
Hire of Hall	8·35		
Bank Charges	10·27		
Stationery	10·88		
Travelling Expenses	25·00		
Workshop Expenses	58·01	Subscriptions	£360·00
Anglo/French Experimental Group Transcripts	50·00	Workshop Donations	58·00
Books Sent to Sir Keith Joseph	6·05	Interest	59·44
		Publisher's Returns re Sale of 'Patient-Centred Medicine'	50·00
	385·58		£527·44
Surplus for the year before deducting non-recurring items c/d	141·86	Surplus for the year before deducting non-recurring items b/d	141·86
	£527·44		£141·86

The Balint Society

Balance Sheet as at 31st March, 1973

General Fund		*Cash at Bank*	
Balance 1st April, 1972	£819·09	Deposit Account	£494·89
Surplus for the year	92·80	Current Account	10·00
	£911·89		£504·89
Memorial Lecture Fund	210·00		
	1,121·89		
Creditors	25·00	Capitalized Publishing Costs of Book	642·00
	£1,146·89		£1,146·89

Income and Expenditure Account for the Year Ended 31st March, 1973

Balance Sheet as at 31st March, 1973

In my opinion and to the best of my information and according to the explanations given to me the said accounts give the information required and the Balance Sheet gives a true and fair view of the state of the Society's affairs as at 31st March, 1973 and the Income and Expenditure Account gives a true and fair view of the surplus for the year ended that date.

HENRYK DRYSCH,
44 Manor Court Road, W.7.

Extract from the Rules of the Society

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 BalintItype 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 wirting 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 recieve 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.

The Balint Society motif kindly designed by Mr. Victor Pasmore, C.B.E.
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