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OF
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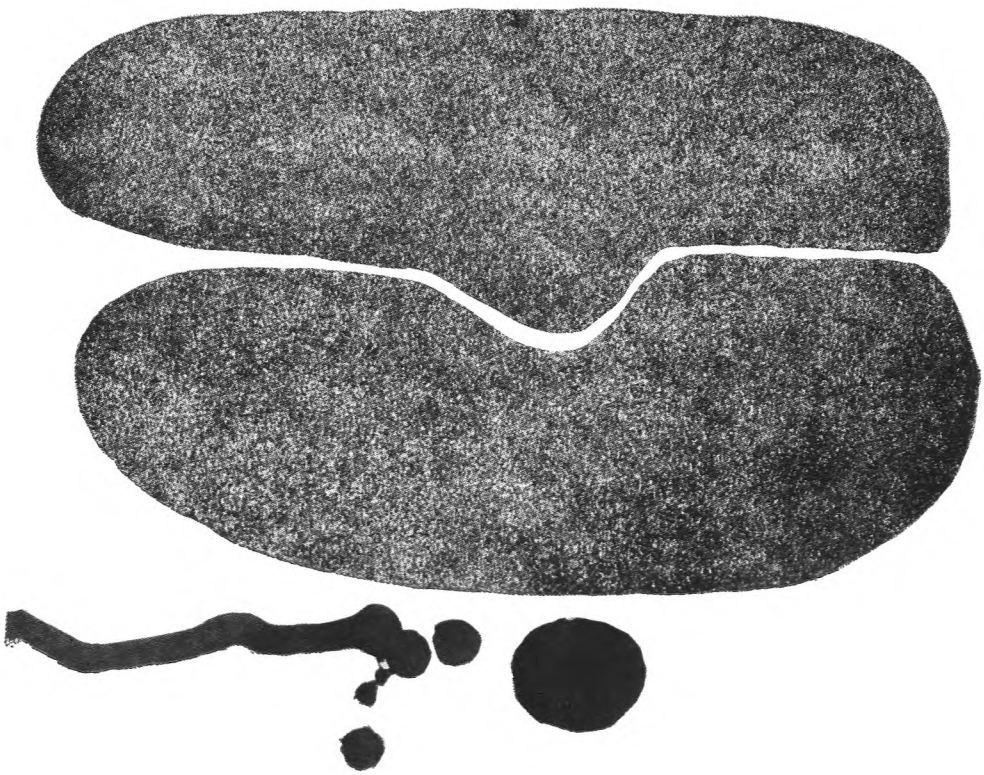

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JOURNAL OF THE BALINT SOCIETY

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Enid Balint, B.Sc.(Econ.)Hons.

Editorial

Both this Journal and our Scientific Meetings have now moved beyond the experimental stage: this is the third issue of the Journal; our Society is well into its fourth session of Scientific Meetings and, in December, 1973, Mrs. Enid Balint gave the First Michael Balint Memorial Lecture before a large appreciative audience in the Barnes Hall of the Royal Society of Medicine in London. We have certainly gone some way towards what we wanted to achieve.

A short while ago we found some old typed reports of our very first meetings with Michael Balint in 1951, starting off with Michael Balint asking: 'How did people get here? What kind of work are they doing?' and continuing with some of his questions and terse remarks that took us a long time to ingest, digest, and utilise, eg.

'You are leaving out the missionary job of the doctor, that is, teaching the patient to be ill.'

'What is a complete physical examination?'

'What is relevant?'

'But *whatever* you do to patients means something!'

'The doctor should be led by the patient's resources.'

We are still struggling with the answers to some of the questions, and with further elucidation of the results of some of our discussions two decades ago. We are building on what we started then. We have certainly gained a greater understanding of many aspects of the doctor/patient relationship, only to be confronted by new problems. This is as it should be with any scientific endeavour. Neither the method, nor the content will ever remain constant; if they did we would know that we had become fossilised.

So we shall go on arguing and discussing. The next major forum for discussion will be the Second International Conference at Brussels from 24th to 26th May, 1974. There we are going to discuss the training methods evolved by Michael and Enid Balint and their place in the training of the doctor. Is there a place for Balint Seminars in the training of doctors? Should this kind of training, the seminar, be ever-lasting? Should it be an experience for two years, then to be left for ever? Should there be 'refresher seminars?' Are new kinds of seminars possible, desirable, and effective, eg seminars held only once a month, once a quarter, occasional weekend seminars? Or seminars with members other than general practitioners, seminars with a teaching content, seminars led by non-psychoanalytical psychiatrists or GPs?

Our Society would have been an excellent place for the discussion of such questions, and for experimental work in the field of seminar training, seminar discussion, seminar leadership. Unfortunately, members have shown very little interest, if any, in the formation of small working groups to discuss such problems.

There is a real danger that we might become a society of talkers and not doers. This would be quite contrary to our avowed aims. It is true, some of our members are leading seminars, others are attending seminars, but the idea of small research seminars, dealing with specific topics for a limited time, has simply not taken roots, and no such research seminars have come off the ground.

It is good to see that the number of members of our Society is still increasing. There are requests for copies of our Journal from university libraries, both here and abroad. There is a great deal of interest in our work. It is up to us, by leading, training and research, to show that our Society is the pivot and central force of this work, and members ought to give serious consideration to extending our work from Scientific Meetings to study groups in the form of seminars, where the various aspects of its further development could be investigated. The Editors would like to hear members' views.

The Editors 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.

Manuscripts and communications for publication in the Journal should be forwarded to Dr Philip Hopkins.

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

Enid Balint

The research seminars jointly led by Enid and Michael Balint dealt with subjects that unavoidably and inextricably lay in both the professional and personal domains of the participants. The methods used for our research equally unavoidably touched highly sensitive spots in the members of the seminars. This might easily have led to a flattening of the level of work, or even to the premature termination of the group work had it not been for the complementary qualities and characteristics of the two leaders.

Michael—in spite of his humanity and humility —sometimes seemed to overreach himself in making his point with assertive logic and scientific precision, which made him appear cold, which he was not. Enid would intervene on such occasions with a womanly warmth that brought Michael (and us) down to earth again, and to a reappraisal that would provide our group—quarrelsome and argumentative at times—with a deep sense of security.

It is quite impossible and really not necessary to disentangle the respective contributions of Michael and Enid in our joint work. The Balint Society recognised this by making both Enid and Michael their first honorary members. Enid had been taking part in Michael's thinking and planning ever since they had been together.

Enid initiated the Family Discussion Bureau (now the Institute of Marital Study) in 1947. The Bureau was set up under the auspices of the Family Welfare Association to undertake research into the causes of marital breakdown and to develop a therapeutic approach to this problem. The holocaust of theWar had released overpowering emotions, caused physical suffering, and breakdowns and disturbances of human relationships. People had become more cognisant and apperceptive of this, but remedies had not been properly developed and helpers were few. The Balints' Seminars in the FDB in this situation arose out of an effort to train case workers and to understand and solve the problems.

From 1949 to 1952 Enid served on the Marriage Guidance Training Board that had been set up by the Home Office, and in 1954 became Casework Consultant to the Institute of Marital Studies at the Tavistock Institute of Human Relations, a position she still holds at present.

Michael meanwhile had translated the seminar work with the FDB into group work with general practitioners, a task in which Enid joined him later. Enid took on her own general practitioner training and research seminars in 1962. She and Michael had been jointly leading a research seminar, which she took over as sole leader on Michael's death. The results of this work have recently been published under the title *Six Minutes for the Patient* and is reviewed in this issue (page 25).

Enid was born in London, bred at Cheltenham Ladies College, and groomed at the London School of Economics, became a psychoanalyst and has produced important work in her own professional field. A large psychoanalytical practice and additional tasks arising from the esteem of her professional brethren, who have elected her Chairman of the Admissions Committee of the British Psychoanalytical Society and the Institute of Psychoanalysis, have not prevented her from continuing with her training work for general practitioners. Enid is an extremely busy woman, frequently travelling abroad to lecture, to teach, and to train.

In 1957 she was appointed Visiting Associate Professor of Research in the Behavioural Sciences, Department of Psychiatry, College of Medicine, University of Cincinnati, USA, and in 1971 she was appointed Visiting Professor of Psychoanalysis at the same University.

Enid Balint is an outstanding psychoanalyst and has published very important work in this field.* The general practice of medicine and our Society are very lucky that she also has devoted much of her skills, time, and energy to the problems of our field. Medicine has gained a great deal from her, and it is only becoming that we should express our thanks and appreciation to her.

M. B. CLYNE

*(Enid Balint's publications will be listed in a future issue. Ed.)

Michael Balint: The Development of his Ideas on the Use of the Drug 'Doctor'

Michael Balint Memorial Lecture given by Enid Balint on 3rd December 1973

Not every women has the privilege of being invited to speak in honour of her husband at the Royal Society of Medicine not quite three years after his death. Ever since I received the invitation, I have, naturally enough, been debating about what to say: how best should I try to do him justice, to do proper credit to him as a man, a scientist and a colleague.

I would have liked to have started by telling you about how his ideas were born and grew (many on holidays, many at his desk at 7 Park Square West, or on walks in Regent's Park and on Hampstead Heath), but I have chosen to discuss how Michael used himself, and in what dosage he was available. In thinking about how he used himself, I have to consider the two fields in which he worked. I do not think he *applied* psychoanalytic theory and technique to general medicine or *vice versa*, nor is it important which was his first love. Rather it was his way of thinking and the way he related to people which led him quite logically from one field to the other—so that he allowed himself to be *used* in the two fields which most interested him.

He was quite remarkably available—'useable'. For instance, if anyone, however young and seemingly unimportant and insignificant, wrote to him and asked him a question, or asked his opinion about some work he, the writer, was doing, Michael would invariably compose a long and careful letter in reply, and/or ask the writer to come and see him to discuss the matter. Sometimes I was impatient of these interruptions, because there was always so much to do, and I felt that the heavy correspondence which resulted from this kind of availability was something which he could ill afford and which *could* be avoided and therefore should be.

Naturally, my husband took no notice of my interference and carried on as before, which was clearly the right thing to do, because not only did he help to enrich the people who consulted him, but his own ideas and own way of thinking were also enriched by getting to know large numbers and varied kinds of person, and varied ways of thinking. His ideas and enjoyment of life were enhanced by having different kinds of audiences, different kinds of people to discuss them with, and he certainly enhanced the ideas and concepts of the people who consulted him.

Balint's work both as a psychoanalyst and as a leader of general practitioner seminars required that he should form hypotheses and concepts. These were needed if work was to proceed. He did not use his work to prove that his ideas and concepts and hypotheses were right; but created his concepts to enable the work to continue. Neither did he ever try to prove that his ideas and concepts were right in one field by applying them to another. His driving force came from the continually exciting discoveries which arose out of the study of human relations in the different settings of his choice. He never ceased to be amazed by the events of each day in his clinical practice.

It is our task now, after his death, to examine his concepts. We must examine, in particular, the connection between the different concepts he created during the study of general practice, and during his work as a psychoanalyst,[1] and to see the connection, the similarities, or sometimes even the inconsistencies, between the two. His thinking was largely consistent, and the relationship between the theories formed in one setting and the theories formed in the other are important when taken together. However, Balint himself was more interested in studying the minute, but all important, problems which faced him day by day in his clinical work, and in his work with general practitioners, than in trying to study his own ideas and the consistency of his theories. Like Freud, he could sometimes contradict himself and go ahead with ideas irrespective of whether or not he had taken a different view of the same problem on the last occasion. He was not frightened of being found inconsistent. He studied his relationships with his patients and why he was in difficulties or why he had succeeded at different times. He was not interested in trying to fit these observations into theories unless like

any other scientist, he needed them in order to continue his work. Furthermore, having formulated the theories in order to continue his work, he did not, although we often thought that he should, try to see in what way the different ideas fed one into the other.

In starting to study human relationships, as he did in the 1930s, he soon realised that some patients need to go back (regress) and make a fresh start in their analyses. To make, as he called it, a New Beginning. He held to this idea with different emphases throughout his working life, and yet was interested in therapy where no 'new beginning' was possible, but where disaster may be forestalled and where there is an opportunity to trace the development of the illnesses analysts try to cure, ie by general practitioners.

Clearly, other lecturers in other years will concentrate on one or other aspect of Balint's work. I must do the same or I will not do justice to any theme, or to the greatness and simplicity of his ideas, or to his particular form of genius. I have therefore decided to concentrate on one seemingly narrow topic delineated by Balint in *The Doctor, His Patient and the Illness*. In the first Introductory Chapter to this book Balint said that by far the most frequently used drug in general practice was the doctor himself. He went on to say that, 'no guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and his maintenance dose should be and so on.'

He then said that when at the first seminar this stage of affairs was realised the doctors decided that one of their aims, perhaps their chief aim, should be to start devising a new pharmacology. That is to say, to describe in what doses the doctor himself should be prescribed, the side effects, etc. It has perhaps been our aim ever since. Even the most experienced Balint trained doctors know that we still have only a partial answer to the question as to the dosage in which the doctor should prescribe himself, and it would not be an exaggeration to say that the history of the last 23 years' work could be described in terms of attempts to solve—or different approaches to—this problem.

Very early in the work Balint spoke about the need for a more comprehensive, deeper diagnosis of each patient than is normally thought to be necessary. By that he meant a diagnosis which is 'not content with comprehending all the physical signs and symptoms, but tries to evaluate the pertinence of the so-called 'neurotic' symptoms.' Later he called this kind of diagnosis the *overall diagnosis*, a concept which led us into some difficulties in terms of 'dosage'—ie in terms of the amount of time a doctor could, or should give to each patient. It was only later that we started to study, not only the dosage in terms of the *time* a doctor could or should give to each patient, but also in terms of the *intensity* of such a dosage.

The term, 'overall diagnosis' has been defined over the years in many different ways. In 1968 we spoke about what we had come to call 'patient-centred medicine',[2, 3] where in addition to trying to discover a localizable illness, or illnesses, the doctor also has to examine the whole person in order to form an 'overall diagnosis.' This, we thought, should include everything that the doctor knows and understands about his patient. The patient has to be understood as a unique human being. The illness, which can be described in terms of a 'traditional diagnosis', is either an incident like a broken leg, or a part like accident-proneness which makes better sense if understood in terms of the whole.

I must digress here before continuing to discuss the idea of dosage, and set out some of Balint's basic ideas on technique, most of which were already clearly stated in his first book, and which were reformulated several times later. One cannot decide on dosage or therapy unless a proper diagnosis—an overall diagnosis—has been made. Diagnosis must come first. The basic ideas were as follows:—

(a) There is a difference between the techniques needed in a psychiatric interview and the techniques needed in general practice. Each technique depends on—arises out of—its setting.
(b) 'He who asks questions will get answers—though hardly anything else'. It follows, therefore, that it is not useful to ask patients questions except, perhaps, if some area chosen by the patient needs enlarging on, or clarifying.
(c) Instead, the doctor must be prepared to listen in an interested attentive frame of mind and hear what the patient says and does not say, even when the story emerges in an unorganised way.
(d) Everything the patient says is of interest and may be of importance.
(e) One of the characteristics of these techtechniques are what we called 'selective attention' and 'selective neglect.' Although theoretically the doctor must leave 'no stone unturned' and listen to everything, he has to be able to use his observations so successfully that in due course he can infer unfailingly which 'stone had to be turned up' to provide the necessary clues, while never forgetting that he has chosen certain 'stones' and neglected others.

(f) Negative findings are as important as positive ones, ie if a patient does not mention his mother this may be as important a part of the overall diagnosis than if he does.

This kind of thinking over the years led the doctors to concentrate more and more time on listening and thus on building up a total picture of a patient in long interviews. In due course when a case was presented in a seminar for discussion, the doctor was ashamed or embarrassed unless he knew all the relevant data in which the seminar doctors might be interested about his patient. Not only (or even mainly) about the patient's childhood (we never fell into the trap of thinking that details about early childhood experiences could, in our kind of work (unlike in psychoanalysis) help us a great deal in the kind of therapy we were trying to develop). The details which we were listening for largely concerned the patient's current life situations—his relationships with important people (including his doctor) what had gone wrong, how and why.

In order to focus on these questions we devised over the years very many different forms on which our doctors were asked to record the interviews which they proposed to present to the seminar. The forms were really questions and gave some order to our thinking.[4] These forms, which disciplined our way of thinking, were important, but now we found ourselves wondering whether the discussions which arose out of them invariably helped us to devise a therapy; to decide, for instance, what dosage was needed and with what intensity.

Earlier we had asked the question (rather Stephen Pasmore had asked *us* this question) as to whether we were becoming detective inspectors and not doctors? Fact finders and not therapists? We wondered whether we were, in fact, causing a split in our doctors by trying to teach them to be minor psychotherapists and not general practitioners. If only a selected few patients were being helped by the doctors who attended our seminars we were losing sight of our original aim which was to study general practice and devise techniques to help the doctors understand and help all their patients better. We had no intention of turning them into psychotherapists. If they wished to become psychotherapists they could very well leave general practice and take the necessary training. But had we, in fact, lost sight of our early question about the amount of time each patient needed, ie the dose in which a doctor should give himself?

We decided then that the new skills that we had to develop lay in the way that the doctor allows the patient to use him rather than in the way that the doctor responds to the patient by his interpretations and theories. The model of this, was Michael himself. True, we could only assess this on the basis of a reliable diagnosis, but what kind of therapy should follow and how should the diagnosis be arrived at?

Over the years our doctors had become interested in obscure and unexpected areas of human relationships. This made our seminars, as it still does, of continual interest to us all. No-one wanted to give up anything that had been gained over years of hard work—but we were now all prepared to take a fresh look at what we had previously taken for granted.

Michael had a genius for being interested in and for inspiring others, for taking fresh looks, and taking nothing for granted. This extended far beyond medicine and lured him into the most unexpected fields. So that if an expert on any subject came to our house and started talking about his speciality, he was often astonished to find himself being asked questions, or by having *his* opinion questioned by someone who seemed to him to be an expert in quite a different field. Soon, however, it turned out that Michael knew a great deal about the other expert's expertise, and his challenging remarks were sometimes received with horror and sometimes with profound pleasure.

Whenever we went away on holidays together, Michael always knew a great deal about what we were going to see, and where we were going. This did not curtail his curiosity so that we always found out something more, and we discovered it in the kind of way which is unforgettable. Our holidays together, therefore, often seemed more like research projects or archaeological digs than anything else and this, of course, was both exciting and delightful. During holidays we also discussed whatever papers Michael or I were working on at the time and usually took them many stages further. You must not get the idea that we did not relax and enjoy our holidays. Quite the reverse, but I just had the opportunity of having my own interest awakened in subjects which, had it not been for Michael, I would just not have noticed. So it was in the seminars.

I have to digress again before returning to my main theme and to Balint's ideas about the adequate therapy which has to be planned for patients, (a) by building up an overall diagnosis, or what he called at that time, a comprehensive diagnosis, and (b) by planning the therapy. In his first book for general practitioners, while discussing this topic, Balint used a concept which later became of great importance to psychoanalysts. This term, *The Basic Fault*, eleven years

later became the title of the last book he published for psychoanalysts.[5]

What he said about this subject in *The Doctor, His Patient and the Illness*, is pertinent to my subject because it sets limits to the kind of diagnosis and therapy (therefore the dosage) which Balint, at that time, thought must be set by general practitioners. Incidentally, I do not think he ever returned to this subject of limit setting again. He disliked this attitude to work, but I shall have to return to it later myself.

After examining some cases and discussing their treatment: for instance, the case of a mother and daughter where the 'cure' for the daughter's illness was to get away from her mother,[6] ie when the symptoms were cured, Balint said, 'the longer the period of observation the more the impression grows that an illness is almost as much a character quality of the patient as the shape of his head, his height, or the colour of his eyes.' 'What', he said 'is primary; a chronic illness or a certain kind of personality? Do sour people eventually get peptic ulcers or does a peptic ulcer eventually make people sour?' This way of thinking, says Balint, was developed by Groddeck, Ferenczi and Jeliffe, and has produced what is now called psychosomatic mecidine.

There is no doubt that Balint took their thinking much further in many ways; mainly, probably, by developing the concept of the basic fault. He saw the basic fault 'as a part of the biological structure of the individual involving in varying degrees both his mind and his body.' 'This', he thought, 'is caused by a considerable discrepancy between the needs of an individual... in his early formative years or possibly months... the consequences of which are only partly reversible.' This, published in 1957, after Balint had already spent 25 years of his life as a psychoanalyst studying this important and elusive period of a patient's life and thirteen years before the book was published. He spent the rest of his life, right up to the end of 1970 when he died, even after the book, *The Basic Fault* which discussed it at some length, was published, studying and reflecting about this theme and studying the techniques which are used by psychoanalysts in their attempts to reach the fault which arises in the early stages of human life. By the way, it is interesting to observe that the term 'basic fault' which we took many months to devise, was borrowed in the end more from geology than biology.

In *The Doctor, His Patient and the Illness* Balint pointed out that although general practitioners could not *reverse* the results of the faults, or reach them in therapy, they are in the unique position to *study* them, as they alone have the opportunity to see the development of the faults even before the patient becomes overtly ill. Incidentally, he thought that analysts could also not cure or remove the 'fault', but they could, in favourable circumstances, help to heal the scars caused by the earlier failures in care.

However, general practitioners may be able to intervene before the basic fault changes from being mainly a feeling of unease and discontent, and when the patient starts 'complaining', and then later complaining of some illness which later still becomes what Balint called an 'organised illness' with a name and an often available organised treatment. That is to say, when the patient becomes overtly ill. The general practitioner may be able to intervene and prevent the 'fault' becoming organised into an illness.

Let us now reconsider how an overall diagnosis is arrived at on which the therapy has to be based. Balint made it clear then that although the overall diagnosis has of necessity to exclude an investigation into the area of the basic fault, ie the earliest relationships and how they are experienced by patients, it *is* concerned with a comprehensive examination of the current life of the patient as well as his 'traditional' organised illnesses. This led us to return to the question of what a *general practitioner* is supposed to do about it? (Balint at that time said, 'what kind of psychotherapy should he do?' but he later dropped this word and called it 'medicine', ie he included into the ordinary treatment a general practitioner should, and could, give to all his patients what he originally called general practitioner psychotherapy.)

He said that most illnesses that fall outside the usual physical, traditional diagnosis were treated by reassurance, advice and pills, and although he maintained that he had no quarrel with such treatment, he insisted that it could not be given unless based on a proper diagnosis. How, indeed, can a doctor reassure, or give advice unless he understands what needs reassurance and advice, unless he understands the whole problem, or indeed, the whole person, not only part of him (perhaps a symptom) which offers itself for treatment, ie unless he understands and realises he cannot understand the illness as a part or one aspect of the patient. The patient has to be examined—but the area (as he called it) of the basic fault has to be excluded from the examination. This led to the long interviews I have already mentioned.

It was, in fact, only during the last few years of Balint's life that we turned our attention with great difficulty and resistances to study the

medicine (psychotherapy—call it what you will) which is *only* carried out in the normal 'six minutes' given to the patient in 'surgery hours', to find out whether an overall diagnosis, and the treatment based on it, can both sometimes be *best* carried out in these brief encounters in the surgery rather than in 'long interviews'; and if so, which patients, or what illnesses, are best treated in this way.

We had always realised that the diagnostic stage of therapy was part of the therapy itself and not necessarily a preparation for it, but what had not been given enough attention was whether such a diagnostic period was necessarily done in 'long interviews'; could it perhaps grow up over a series of short interviews made during ordinary surgery hours? This study was Balint's last planned research project but was unfinished by him. He contributed the first chapter to the book which was finished by the group which studied the problems which he and I led together; most of the thinking which is contained in it took place during his life-time.

Can I now restate the position as I see it today?

Is it possible to acquire a sufficiently reliable overall diagnosis and not lose the wood for the trees, by amassing unnecessary details, in the routine work of general practice, during the ordinary routine of the surgery consultations?

You might think that if we are deciding that satisfactory work can be done in this way we are advocating a repetition of the discrepancy which Balint describes as leading to a basic fault in the early years of life. Namely, too great a discrepancy between the needs of the patient and the provision of the environment, ie too small a dosage of the doctor. You might say that if we think that a human being can be helped enough in six minutes, whatever his illness, surely we are callously advocating the repetition of the earlier trauma and rationalising our decision because doctors have, in fact, not enough time to give long interviews to all their patients.

Patients often come to their doctors hoping they will take away their pain, but they may also be dimly aware of the origin of their pain in the area of the overall diagnosis, and half hope for a relationship which will help this. They may also dimly hope for a 'magic' cure which will cause no painful effort. It is the general practitioner's job to recognise and understand the 'pain' so that the relationship between them can be useful, and to avoid collusive 'magic' (such as powerful doctor and grateful dependent patient), and an organisation into illnesses which can be treated but which leaves the original pain untreated.

Patients thus come to their doctors when they have some hope that the doctor will find out or 'recognise' what they need; where the pain lies? What is wrong? Maybe they come with a sore throat and they want the doctor to take *this symptom* seriously and treat it; maybe they want the doctor to take this sore throat only as a ticket of entry so that they can discuss some more imperative anxiety about which they are only vaguely aware. Maybe they hope the doctor will spend some time with them; maybe they do not. Maybe they even hope to be referred to a psychoanalyst! Maybe they hope that the general practitioner himself will be a psychoanalyst although they may not spell this out. But I think that this is rarely the case.

The general practitioner's personality, his profession, is unique, a vital part of our society, but it must be circumscribed, as is every profession, and patients need to know that they have doctors who are neither magicians, nor prescription writers nor psychoanalysts, but who have a well defined function unique to themselves.

For me, Balint's work stands or falls by whether each general practitioner can realise what his function is (that, as one French doctor wrote to me, each doctor can know in his heart how he wants to spend his life as a doctor). If the doctor knows how he wants to spend his professional life, I think his patients will be satisfied too, will know how they want to be patients, and will not hope for what the doctor cannot give, any more than they would expect any other professional to have the expertise of another.

If a patient gets what he needs from a general practitioner (and a general practitioner gives what he needs to his patients) then, I think, there is satisfaction and health, and not a discrepancy between need and provision of need. The patient comes to the doctor hoping to be helped to 'feel better.' His vague ideas about what is causing the pain are brought to the doctor in the hope that the doctor will *want* to know about it, will be devoted and interested, not magical and mysterious.

People can often be satisfied with what seems very little to an outside observer. But if what they need is ignored and something else is given, or their need is organised out of existence by reassurance based on a misunderstanding, or on a professional distance of the wrong kind based on fear in the doctor, then the hope for help will waver and the patient will be left alone, and the world of medicine will have let him down. My husband's work, I think, is a great contribution in the prevention of this disaster. It introduces into medicine the skills which the doctor needs.

So that doctors can remain doctors. So that there need not be too much discrepancy between a need and the provision made to meet it.

I need now to return here to the idea of the intensity of the contact which a patient needs from his doctor in addition to the amount of time. Although we have worked with this idea for some years, I do not think it was until the final stages of our work which resulted in our description of what we called the 'flash' technique, that we studied it in detail. This technique is described in some detail in our book, *Six Minutes for the Patient*.[4]

We discovered that in some short interviews, instead of trying to solve exciting puzzles and problems, the doctor was now expected to 'tune in' so exactly to the patient's wave-length of communications that he would be able to respond to them fairly faultlessly. My husband, in his chapter in this book, said that this state of being 'tuned in' must be kept up for the whole length of the interview so that the doctor and the patient might be able to talk to each other without much danger of misunderstanding. He said another way of describing the same experiences was of two minds clicking in with each other; we came to call this 'clicking in'—an experience of a 'flash'. We found that this 'flash' might either happen in the patient or in the doctor, or, which proved to have the best therapeutic prospect, simultaneously in both of them.

My husband went on to say that in trying to describe this technique it is perhaps best to contrast it with the old method in which the doctor had the privilege and responsibility of understanding what the patient tried to convey to him, so as to recognise all the omissions and distortions in it, using his knowledge to solve them, and with his skill to enable the patient to produce the right associations which would prove that his solutions were, on the whole, correct. This role, we thought, was one of a leader, of a superior.

In the new technique, where greater intensity is needed, the therapist's role is to 'tune in', to follow the patient's lead, to allow the patient to use the therapist, and is a less glamorous, much more modest role. The dosage is apparently less, the intensity greater. We found also that although these interviews, often very short, were very intense and the doctor felt tired, even disturbed and tense after them, and the contact did not lead to a dependent relationship between the doctor and the patient.

As I said in my chapter in the book, the 'therapy', we think, lies in the peculiar intense flash of understanding between the doctor and patient in the setting where an on-going contact is possible, and where neither the doctor nor the patient gives up his self esteem. False self esteem is replaced by something new and solid and mutual between doctor and patient. The patient functions better, with more satisfaction: one could say, he becomes more 'full of himself' accepting, though not necessarily condoning, his failures, weaknesses and strength.

Can I illustrate this from another field? For instance, from the field of the family; and of the relationship of a mother with her child. In my experience some mothers measure the value of their relationship with their children in terms of time. People say this is a very good mother; she spends all her time with the children. Whereas another, who spends less time, is thought to be less good. I think this is a very uncertain criterion. The goodness or badness of a mother/child relationship depends more on what happens when the two people are together than on the time that is spent. This may not be true always. Seriously ill children may need their mothers all the time, and all children will need their mothers for long periods sometimes.

Then again, what about regressed children or adults? A ten-year-old suddenly behaves like a six-year-old and needs special understanding or care. Or a man of fifty becomes insecure and withdrawn and cannot work. I do not think, even here, it is always time that is needed; but understanding, recognition that the distressed person is someone of importance, unique, not just a nuisance who has lost his identity, but that unexpected thoughts may be troubling him. He needs to be noticed, but not have people give themselves up to him so that he becomes dependent and lost; in a nightmare.

Balint suggests that the same is true with patients. They sometimes need something special, but it is not only time. If it is time, then only time will do, but perhaps such patients cannot be treated by the general practitioner as the time, as well as the kind of understanding and skill that is needed, is not found in that setting. Then the general practitioner has honestly to fail his patient, or is it failure? Even if it is, it is to my way of thinking, not a disaster. It is surely better to say to a patient that he cannot be helped, than to pretend that he can and carry on. The disaster lies in dishonesty and pretence, because then the patient feels ignored, not taken seriously.

However, in my experience over 23 years, more people can be helped by doctors who like their work and know what they are there for, than by any other profession in the world.

I promised to give some hunches about the kind of patient who can best be helped by short

interviews. I would like to suggest that all patients may at some time in their lives only tolerate or need short interviews. The ones who need the short interviews need a brief, intense understanding which can sometimes be given by a 'flash.' These are, I think, the people who function well enough on their own, who fear dependence, who perhaps do not want to 'confess' to something they feel to be shameful, but who need a doctor whom they can trust not to intrude, but who nonetheless is interested and briefly involved and does not withdraw and becomes offended because no more is wanted now.

These patients say, 'help me with this, but don't expect me to tell you more', even when they do not know what 'this' is (so an overall diagnosis is relevant here too.) 'Keep off but tell me why this hurts, why I feel this pain?' The doctor may not be able to help *without* a thorough 'long examination' but he may be able to cope if his observations are keen enough during short interviews.

Other patients who want a long time with their doctor may want to tell even less, but talk more—they can be just as secretive. They need a long time and can only be helped if given a long time—the 'ancient mariner' variety—but the long interview itself is sometimes used as a defence against real 'engagement'. But it is difficult to say which patient needs or receives more from his doctor. When I say which patient I mean which patient *at which time*. A patient who needs a short interview at one moment may possibly need a long one at another and *vice versa*. Perhaps in any case in practice, patients get long interviews only when their needs happen to strike a response in the doctor.

What of the future? Are general practitioners still coming forward for seminars which help them to listen in the way that I have described, to go through a process of unlearning, to make an overall diagnosis to do therapy in the ordinary surgery hours based on an overall diagnosis, to have hunches, or even 'flashes', etc, or has there been so much written about this kind of thing over the last 20 years, will they now be content to read what there is to be read, and to carry on by themselves without too much discomfort?

Certainly, it would be very strange if the medical scene were the same at the end of 1973 as it was in 1950. In what way, then, has it changed? Cyril Gilkand I have recently, a year ago, started a new seminar for general practitioners at University College Hospital. Before starting I was very eager to find out in what way the new group would differ from the earlier ones as I remember them when we started in the 50s. Are there any differences, in fact? Or is everything just the same as it was at the beginning?

It is difficult to answer these questions, but I want to try because I think it is relevant to the planning of future groups. In order to make the best use of the doctor's time and of the group leader's time, ie to arrange the right dosage of doctors and leaders of groups' time. Can leaders best be used in the same kind of group we started in 1950 or should they turn their attention to other forms of training?

Some highly trained general practitioners, as well as trained psychoanalysts, are now leading groups, and that training seminars, 'Balint groups', are becoming an integral part of some postgraduate vocational training schemes, so that some newly qualified doctors are getting training, and there is a chance surely that in another few years time there will be many doctors who, not only have read the books, but have also acquired the necessary skills early in their careers.

In my experience, reading certainly does help doctors to start and move in a new direction. I doubt, however, whether it does help them to have the sensitivity and the ability to make relevant observations which are required if they are to change in their relationship with their patients, and are to become aware of the different aspects of their patients which need examination, ie to acquire new skills. The younger doctors who have read a great deal still cannot, by themselves, be aware of their blind spots; of the variety of responses open to them; they cannot know how to listen in order to arrive at a new understanding of the patient's illness. Many doctors, however, are reluctant to embark on a long training and hope that a knowledge of the literature will be enough.

I doubt if this is true, although it would be nice to think it were. I am not only occupied with the training of general practitioners, but also with the training of psychoanalysts and I am continually surprised how the student psychoanalysts who come to me for training and for supervision, who are usually well seasoned doctors and probably trained psychiatrists as well, find it difficult to understand their patients' communications.When I started supervising, I thought it was impossible that such well trained and experienced doctors who had read so much Freud and had attended lectures and seminars, would not understand what seemed to the experienced analyst very simple communications, and which an experienced analyst would find relatively easy to interpret to the patient.

Clearly, one has to bear in mind that it is always easy to understand somebody else's

material and always difficult to understand what comes to one direct from a patient. But even taking that into account I have been persuaded over the years that nothing takes the place of clinical experience and that clinical experience on its own does not lead to further understanding unless there is some training of the kind initiated by Balint.

May I therefore end on a mixed note of optimism and pessimism? My optimism is based on the break-through made by Michael Balint in the fifties, and the effect his ideas have had on the whole way in which medicine is now understood. By this I do not mean that no one had thought of whole person medicine before he started to write about it, or that the ideas of dosage or overall diagnosis had not been in people's minds before. However, it was Balint who put these ideas together, who conceptualised them; who continued to use his imagination and knowledge in a creative way right up until his death, and whose influence is bound to increase rather than diminish as the years go by.

My pessimism is rather based on my own experience about the length of time it takes a doctor to use his knowledge and understanding in a therapeutic way. I still cannot see that there are any short cuts in the learning of a skill. It seems to take doctors a long time to acquire skills, to find that their competence with their patients matches up at all to their understanding of their patients' needs.

I do not know how a solution to this can be found; all I can hope for is that doctors and others working in similar fields will have the patience to wait and to realise that although it may take a long time to acquire new skills and become 'better doctors' in the sense in which my husband wrote about it, still in the end the new skills *are* acquired and on the way the doctors themselves, working in the kind of groups which we continue to run, find their professional life, even if sometimes more baffling and disappointing, more exciting and challenging than they had before the name of Michael Balint had become known to them.

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Referrals: their Purpose and Results

Presented by A. M. HALL-SMITH,

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The first meeting of the Balint Society's 1973-4 programme, on 18 October 1973, took the form of a paper by the nine members of the third-year Seminar working under the auspices of the Cambridge University Postgraduate Medical School with Dr Marie Singer as leader.*

The origin of the Seminars at Cambridge has a particular interest for members of the Balint Society. It stems from the residence there of two persons with Balint connections. In 1967, Dr C. T. M. Wilson, who had attended one of Michael Balint's GP symposiums, approached Dr Marie Singer, an associate member of the Society, to ask whether she would lead a seminar for general practitioners in Cambridge. She was already assisting with seminars at the Tavistock Centre, in addition to conducting her psychoanalytic practice, and lecturing in Experimental Psychology at Cambridge.

Dr Wilson brought together a group of GPs prepared to meet weekly on a private-fee-paying basis and, in January 1969, the first Cambridge General Practitioner Seminar began. Its members were: Drs E. V. Bevan, Roger Cole, David and Shirley Emerson, Keith Hallam, J. P. Recordon, and C. T. M. Wilson. Now in its sixth year, the group has continued with few changes, the entry of Dr David Jennens, and the departure of Drs Hallam and Cole.

In 1970 the Cambridge University Postgraduate Medical School took the Seminar into its curriculum under the name of Courses on Psychological Aspects of General Medical Practice, with the financial support of the National Health Service.

A second seminar also began its sessions, and is now in its fourth year; a third is in its second year; and a fourth began its first year in 1973 in the Suffolk/Norfolk area.

All the seminars are led by Dr Singer, and it is thanks to Dr Singer that Cambridge is unique among universities in having included seminars for general practitioners in its postgraduate curriculum.

The group had, in its third year, 1972-3, investigated Referrals and, to that end, had individually kept a record of all referral over a six-month period.

Dr Hall-Smith outlined the progress of their research, and called upon the members to describe some illustrative cases, 14 in all from their practices.

They are here printed in full, with Dr Hall-Smith's introductions and comments, followed by a transcript of the general discussion succeeding, and to round off the presentation, a report of the group's own discussion—autopsy—held on its home ground at the beginning of its fourth year—EDITOR.

We asked ourselves why we made a referral, and what was the consequence, trying to observe what it did to or for the doctor/patient relationship. The research was carried out by a group of nine general practitioners and Dr Singer. Men and women were equally numbered. Our practices varied: one had a remote village practice, two came from large groups in market towns, and the rest worked in Cambridge. Each doctor kept a record of all his referrals to consultants over a six-month period, a total for the group of something over 1100.

In our weekly two-hour sessions, usually half an hour was given to the subject, and much of it was spent teasing out a definition of our categories, shown in the Table, with the percentage of cases falling in each, together with the breakdown according to age.

Age groups

These were chosen to correspond to the developmental stages in life's journey:

0- 5 the dependent infant
6-12 the latent child
13-25 puberty, through adolescence, to the end of wild-oat sowing
26-50 the married years: settling down, reproducing, and watching with awe and trepidation as the children fledge
51-65 the reflective years, embracing the climacteric
66+ increasing old age and infirmity.

Group 1: Reasons for referral

Group I was subdivided into five categories, the first of which, *A*, contained those referred for *Treatment*. These were broken down according to their consultant destination:

**Drs S. Blaxland, P. A. Eckstein, Elizabeth Jonason, Mary Wyn Parry, B. B. Reiss, Barbara Sandell, Monica Shutter, O. A. Sills, and A. M. Hall-Smith.*

A1 SURGICAL. The biggest group of all referrals, mostly for the surgeon's technical expertise, through outpatients, rather than as emergencies. All patients referred to an FRCS are included here, as otherwise it is difficult to know where to score some ear, eye and orthopaedic referrals where actual surgery is improbable.

A2 MEDICAL. The next largest group, where investigation and accurate diagnosis may not have been as straightforward as in surgical cases before referral, but all these patients were referred ultimately for the physician's treatment.

A3 OBSTETRIC. A small group, reflecting both a low number of births in a six-month period and the fact that we had few patients who needed referral during the period of antenatal care.

A4 TERMINATION OF PREGNANCY. We decided to make a separate group of these, both because they are a significant feature in all of our practices and because in our seminar some reservations became evident in many of us as to the wisdom of too ready an acquiescence with this request.

Mrs A: Termination On and Off

Mrs A, her husband, son and daughter had been patients for about 5 years. None of them had at any time consulted me for anything significant. The family had moved down from the North at the suggestion of Mrs A's mother, who had organised the houses and the husband's job.

In August 1971 Mrs A, aged 36, attended the surgery with her husband, requesting a termination of pregnancy. Both were infant teachers but Mr A had to resign on account of unsuitability, and his wife was in fact the breadwinner. I was not sure what Mr A did by day, but he spent most nights Scottish-dancing with a young lady. One evening, on returning home from his dancing, he seduced his wife and pregnancy resulted. This had been the first intercourse for years. Both agreed on termination which was carried out.

Towards the end of September Mrs A became depressed, unhappy, aggressive and guilty. Her husband had meanwhile found a job and was able to support his family. I was accused of the abortion and felt insecure and inadequate to deal with her. I referred her to a consultant psychiatrist.

For the next 9 months Mrs A saw the psychiatrist and his social worker, and me and my partners, especially one lady doctor.

In June 1972 Mrs A presented once again for termination. I refused but asked my partners, the psychiatrist, and, eventually, a gynaecologist to see her. A termination was agreed upon by the various parties concerned and everything was arranged. The day before the operation Mrs A changed her mind and decided to continue with the pregnancy. Over the next two weeks she changed her mind four times.

Miss A, aged 16, on learning about her mother's request for a termination was shocked, and threatened never to speak to her again if she proceeded with the wicked plan. The pregnancy continued, and Mrs A continued seeing the psychiatrist, the social worker, and the doctors.

There had been some doubt in my mind as to the original termination because Mrs A had not received anything from her husband for five years: no washing-machine, no holidays, no outings, not even birthday presents; in fact, this pregnancy was the first thing he had given her. The seminar also felt that a seduction or rape of this woman was physically unlikely.

I now feel that the psychiatric referral should never have taken place—it was a doctor's escape referral. This woman seduced and terminated all her contacts, whether husband, doctor or psychiatrist.

Table showing Summary of all patients referred during a six-month period

Group I Reason for referral	%
A TREATMENT	
1 Surgical ... ... (incl. Gynae. 10.5%)	47.9
2 Medical	24.9
3 Obstetric	2.0
4 Termination	1.6
5 Prosthetic	3.7
6 Psychiatric	4.2
B DIAGNOSTIC INVESTIGATION...	13.5
C DOCTOR'S REASSURANCE ...	6.8
D DOCTOR'S ESCAPE	2.4
E PATIENT'S REQUEST	
1 For Reassurance	2.8
2 For Other Resources	6.0
3 For Escape	0.2

Group II Nature of referral	
A EMERGENCY HANDOVER ...	12.6
B COMPLETE HANDOVER ...	31.1
C ADVICE AND RESUMPTION OF CARE	33.0
D CONTINUING CARE SHARED	
1 In Co-operation	17.2
2 In Competition	1.7

Group III Results of referral	
A FOR PATIENT	%
1 Cure	34.0
2 Improvement	38.0
3 No change	19.0
4 Deterioration	4.0
5 Death	5.0
B FOR DOCTOR (SKILLS)	
1 In Diagnosis	4.8
2 In Treatment	3.1
C FOR DOCTOR/PATIENT RELATIONSHIP	
1 Relationship altered	4.6
2 Insight on patient	7.3

Age in Years	%
0— 5	5
6—12	6
13—25	17
26—50	32
51—65	24
66 and over	16

A5 PROSTHETIC. This group comprised all patients sent on a journey to a colleague to obtain something, such as a belt, a hearing aid, or a loop. Statistically, one may take the loop as an instance of a referral which might be scored both here under A and also under E2, that is, at the patient's request. Thus, the totals in Group I therefore add up to more than 100%.

A6 PSYCHIATRIC. Most of us have found that since joining the seminar we refer fewer patients each year. Perhaps the fact that five of us work in close association with psychiatric departments as clinical assistants may contribute to this sense of realism, not to say scepticism; despite this, we appear with no privileges when it comes to obtaining an acute psychiatric admission. We feel sore about this, as we believe that psychiatric hospitals should readily accept a patient with the psychiatric equivalent of renal colic, and not ask him and his attendant to endure the acute pain at home while its cause is slowly elucidated.

Mrs B: Psychiatric Emergency

Mrs B, aged 35, had had several psychotic episodes, including one when she was a student in the United States, where she had grown up. She had been advised against having children but, in view of her anxiety to have them, had been allowed to go through two pregnancies with help. Her elder child was now aged 2½ years and the younger 4½ months. I had attended her the previous week for one or two physical complaints, and had realised that she was going through a difficult phase but not that a crisis was likely to occur so soon.

The imminence of the crisis came to my knowledge when I happened to meet a consultant psychiatrist at the hospital. He told me that Mrs B had been in touch with him over the previous 24 hours, and had also been making telephone calls to other people such as social workers and family planning doctors. She had made an appointment with me for contraceptive advice, but had failed to keep it. The consultant said she was likely to break down and went on to discuss the possibilities of residential care for the children. But he had made no attempt to warn me. I realised a crisis might be coming and there would be difficulty in dealing with the patient.

When I saw Mrs B at home before 6 o'clock that evening, it was apparent that she was becoming psychotic again, and I feared for the safety of the children. Her husband was clearly unable to cope with the situation and had reached breaking-point himself. I left, telephoned the hospital to try and get her admitted with the baby, from whom she would not be parted. The hospital gave no help and merely offered an appointment next day.

I returned to Mrs B and gave her sedation, and instructed her husband to contact me if the situation worsened. This he did between 10 and 11 p.m.

I found the patient disorientated and very protective of her children, refusing to let me touch or see them, or indeed, to let anyone go near them. Her husband was also fearful for their safety. The situation was not helped by the arrival of Mrs B's father from the United States, for he clearly had little insight and could make no helpful suggestions nor exert any influence on his daughter.

After I had been in the house for some time, there fortunately arrived the psychiatrist wife of a professional acquaintance: she was accepted by the patient as a grandmother figure and allowed to help with the children. After much persuasion and patience I took husband and wife in my car to the psychiatric hospital, and eventually she was admitted, despite the dislike she showed for the apparently unprofessional interest and uncommunicativeness of the receiving doctor.

It seemed to me that, if the consultant had telephoned and told me what he did on our chance meeting, the situation could have been organised before it reached crisis point, and he could have given more help to this end. Moreover, he was a deputy for the patient's own consultant, who had written warning me of her deterioration. This letter reached me only a few days after the crisis!

We now come to those referred for reasons other than for treatment.

B Diagnostic investigation

This implies that we know fairly clearly either what is wrong, but need consultant help in checking our diagnosis, or that further investigation is required by the hospital service before any diagnosis can be made. We have excluded referrals for pathological tests and simple X-rays, but have included radiology where the consultant met the patient, as for barium studies.

C Doctor's reassurance

Nearly the same as B, only seen more in terms of the general practitioner's confidence. Things can misfire here either when the consultant is not briefed that the GP is asking for reinforcement, or when the consultant fails to perceive his cue. Here is a cautionary tale.

Mrs C: The Long and Short of It

Mrs C was the 52-year-old wife of a parson who had had to retire from his parish before the usual age on health grounds. The couple visited me when they arrived in the locality on the recommendation of a fellow parson. They expressed a desire to register but qualified this by saying that they did not live in the immediate vicinity and were selling their car. In addition, they had required a lot of medical attention and thought that any doctor who took them on should know this. I had mixed feelings and suggested they try a doctor nearer home but offered to accept them if the other doctor could not. In the event, the other doctor could not take them, making the excuse that he had too many undergraduates to look after.

The symptoms Mrs C brought to me were a generalised aching in the joints, and also intermittent terrible tiredness. She had had a number of referrals for abdominal pain by her previous doctor (of whom she spoke disparagingly); cholecystectomy was contemplated, but decided against by the surgeon. She has also been seen by a number of consultant physicians and a psychiatrist in earlier life.

Because of the joint pain a consultant physician in one recent letter had suggested a trial of Librium

and that, if this did not work, then she had palindromic rheumatism. She had latched on to this term and seemed very pleased with the sound of it.

After thoroughly examining her and doing a number of investigations, all of which proved negative, I doubted whether she had palindromic rheumatism, or indeed any other kind of rheumatism. Although naturally somewhat cautious, I concluded that most of her problems were of a psychological kind. However, in order to be doubly sure, I wrote a very long letter to a consultant physician with a special interest in rheumatic disorders, and also a wide medical horizon. I received in return a shorter letter which was rather inconclusive; the patient later told me that the consultant, on seeing my letter, had remarked 'That's far too long, I'm not going to read all that.' However, I had little reason to think that he did not read my letter. This is an example of the doctor's need for reassurance, which in this case, was not forthcoming. Perhaps I was hoping for too much. Later the patient decided to change her doctor.

D Doctor's Escape

None of us are so saintly that we do not make a referral to obtain relief from a heavy chain of fruitless and demanding consultations. Scores varied: obviously some of us were more ready to admit to ducking out than others. Escape stories do not always achieve a successful escape for the doctor, however.

Mrs D: No Escape

I have a patient, Mrs D, aged 64, who is the proprietress of a small hotel. She does the bulk of the cooking and is a very meticulous, conscientious and hard-working person. She finds it impossible to find time to attend the surgery: all my attendances are in the nature of emergency calls. I am personally singled out from my partners, and the hotel also besieges me on my private number. When I attend, on these emergency calls, Mrs D emerges from the kitchen, where she has been hard at work!

Almost invariably the agony is of a hysterical nature. I treat her by letting her pour out her latest feelings about her husband, the chef, or the servant girls. When she has finished this release of her aggressive feelings, accompanied by wringing of hands, hyperextension movements of the neck and waving of the arms, she has forgotten the reason for asking for a visit. She then endeavours to placate me by inviting me to stay for dinner, or to come any other time I like for dinner and to bring my family. I have tried this, and found it quite impossible to know when I am paying for dinner and when I am a guest. It is very expensive to find out.

One night I received one of these emergency calls. There was extreme pain in the neck and shoulder, and pain down the arms; Mrs D had had a very recent full review by a cardiologist; her neck had been X-rayed and shown to exhibit many diminished disc spaces; but in spite of the pain, she was voluntarily carrying out full arm and neck movements. In my heart of hearts I knew that I should sit and listen, but on this occasion I felt too weary. So I said to her: 'What about the gorilla?' This was her name for her physiotherapist, but she did not want to see the gorilla. Then I suggested an excellent local orthopaedic surgeon, who I thought would deal with her both thoughtfully and dramatically.

Consequently, I arranged for Mrs D to be seen next morning by the orthopaedic surgeon, who gave her injections and threw her about in a most impressive manner! (this, of course, was her interpretation of the interview).

The doctor's escape has not lasted for long; the orthopaedic surgeon went on to prescribe corsets and collars which are never worn. The orthopaedic surgeon is blamed because they are of no avail and Mrs D refuses to see him any more. I had the whole trouble poured out at the subsequent visit, and realised my shortcomings at the time of the emergency call.

This patient is on my National Health Service list, but attends the consultants and physiotherapists privately. I find that 'doctor's escape' occurs more often when the patient is insured or has money to pay for quick consultations. In fact, there is often no escape.

E At the Patient's Request

We made three subdivisions here: (1) for the patient's reassurance; (2) for direction to other resources; (3), for the patient's escape.

E1 THE NEED FOR REASSURANCE. Many patients, quite reasonably, still ask for a second opinion. We found that it was always granted, but usually after exploration with the patient of the reason for asking.

E2 THE DIRECTION TO OTHER RESOURCES. We have already mentioned that this group includes those anxious to be relieved of, or prevented from, achieving unwanted pregnancies. Both sexes are represented here, as vasectomies are included.

Also here are scored private referrals for luxury services not usually sought on the NHS at that stage of an illness.

Eve: Two Noses

Eve had approached me alone and shy, at 16½, to ask if plastic surgery could be used to correct the shape of her nose, which displeased her. I did not feel that her nose was in any way disfiguring, and became most alarmed at the thought of employing a surgeon to relieve adolescent stress. I suggested she return with her parents to talk it over. Shortly after, the father, a prospering businessman, rang up (interrupting a consultation) and I countered the father's straightforward support of his daughter's request by saying such things were not usual in Britain (implying not really proper), and made a plea for the whole family to rethink the matter carefully.

After a year of silence, the father again rang up (again interrupting a consultation) and said due thought *had* been given, and their decision was to pursue their request. I again felt alarmed, and this time angry at being hustled, particularly on the telephone, and implied to the father that he was using a business man's methods in the field of adolescent

psychology, and I made my disapproval clear. The father, nettled, soon appeared in surgery, protesting his straightforward anxiety to help his daughter achieve peace of mind, and reminding me that they had consistently obeyed my advice, and would prefer to continue the referral *with* my co-operation.

I felt held to ransom, and took the advice of a colleague in selecting a plastic surgeon for a private consultation, and wrote a long and earnest letter of referral, underlining my alarm at the proposal. I fully expected the support of the surgeon, and was somewhat shattered to be thanked for my 'exhaustive and helpful' letter, and to learn that he felt rhinoplasty was much to be recommended. On reading my referral letter to our group, I began to perceive how I had overstated my case. The *coup de grâce* was at the end of the surgeon's reply for, at the referral interview, the girl's mother had expressed displeasure at the shape of her *own* nose, and the surgeon had added a PS. that she had just rung his secretary and asked to be admitted for a similar operation at the same time!

Feeling the moment inopportune to approach the father with an abstract account of mother and daughter competing against each other for his affection and bank balance, I held a shocked silence, but this was mollified when Eve came into surgery with shining eyes and thanked me warmly for the referral I had made. I did not mention the mother's proposed accompaniment, nor did the patient. As she left, I said I looked forward to seeing the new Eve.

I received post-operative reports from a satisfied surgeon, and hoped for a sight of my newly modelled patients. In this I was disappointed. Eve went up to university without reappearing, and her mother, although I twice asked her to attend in person, rather than on the telephone, to discuss health matters relating to other members of the family, failed to appear, but took one of the problems to a partner.

The surgeon, in his six-month follow-up letter, wrote saying that the noses had settled down well, but noted sadly that each patient seemed more enthusiastic about the other one's result. I permitted myself a wry grin!

E3 ESCAPE. Scores are low, because escape is often to a partner, or through an unkept appointment, and not so often through a referral achieved with this ulterior motive. However, an improbable escape story on the part of a harassed husband follows:

Mr F: Marital Jealousy

This harassed husband, Mr F, is a 48-year-old man who first presented as a telephone call from another general practitioner in the town who said that the man had been advised to consult him by the local Marriage Advisory Council because of excessive penile erections. The general practitioner thought that perhaps the man might have prostatic enlargement, which might be the cause of his symptom.

I saw Mr F shortly afterwards. It appeared that his excessive erections during sleep were infuriating his wife. He wanted to be referred to somebody who could relieve him of his symptom but agreed to investigation first. Despite negative tests it was clear that he felt there was something physically wrong, and, largely for this reason, I referred him to a consultant with a special interest in endocrinology and psychosexual disorders.

The consultant's investigation showed a normal hormone pattern and no physical abnormality. He later saw both husband and wife, and concluding that she was grossly depressed, advised anti-depressants for her. He also spoke in a jocular way about middle-aged men and their heightened sexual desires. She came to see me afterwards and made it obvious that the consultant's attitude towards her husband's sexuality and his suggestions that there was something wrong with her, had served to infuriate her the more; she refused his recommended treatment. This made the husband even more desperate, and he asked for further referral. I referred him to a consultant psychiatrist, but he was seen in the first place by a general practitioner clinical assistant, who also concluded that the problem was mainly in the wife. He suggested sedation for the husband, and possibly for the wife, to take some of the heat out of the situation. The mild sedation and reassurance proved of only slight value.

As the history unfolded itself in the course of these interviews, it appeared that the wife, who did not sleep well anyhow, was waking at night to find her husband with an erection and, according to her, making movements as in sexual intercourse. She concluded he was dreaming about other women and having a good time with them, she would wake him up in a fury and he would have to get out of bed, and that was the end of sleep for the night. It was an almost nightly occurrence.

After a further period of time, I referred Mr F back to the consultant psychiatrist, who, on this occasion, took the matter over himself. His approach was to try and elucidate objectively what exactly was happening. He referred Mr F to a psychiatric colleague and a plan was evolved for Mr F to be sent to a distant centre to have simultaneous measurements of penile turgidity during sleep, and of the dream pattern as measured by rapid eye movement. This remarkable plan never got off the drawing-board, but not without both husband and wife getting excited about the prospect of a resolution of their problem. The failure of the plan was a great disappointment.

Later the consultant referred the patient again to his psychiatric colleague, who had been doing research on a drug to reduce sexual function without resort to hormonal treatment. Once again the plan failed, as the drug was not available for general use.

This is an escape story—on the part of general practitioner, psychiatrist and patient. They were all fleeing from this very angry, jealous woman, and the matter rests in very much the same unhappy state after two years.

Group II: Nature of Referral

A Emergency handover

A clear definition and, incidentally, carrying with it no choice of consultant. The other groups become more difficult to define.

B Complete handover

The definition proved contentious. Most agreed that referral for a hernia repair, even if one subsequently signed certificates, was in effect a complete handover. Coronary convalescence

after return home was less certain, and most psychiatric cases would by their very nature, as family affairs, be in one of the two subsequent groups.

C *Advice and resumption of care*

These patients, like those scored under B in Group I, made a trip to a consultant to reinforce the general practitioner's hypothesis, or to get technical advice on management. Consultants did not always see it so simply, and the next case illustrates the complications that can occur for the general practitioner in a seemingly simple referral.

Mrs G: The Simple Complicated

Mrs G, aged 79, was referred to a physician for diagnostic investigation as a possible case of myxoedema. The physician, after finding that thyroid function tests were within the normal range, reported that he had referred Mrs G to a psychiatrist with a diagnosis of depression. On calling at Mrs G's home, I found her dissatisfied by her consultation and very puzzled and unwilling to see yet another consultant. Since, in my opinion, Mrs G did not show any classical depressive symptoms despite the strain of painful joints and living alone, I cancelled the psychiatric appointment and explained my reasons to the consultant physician, who did not acknowledge the letter. In the event, Mrs G has been much happier.

We discussed this referral in our group. Should the consultant physician have referred Mrs G direct to a psychiatrist (with his own diagnosis) instead of back to the general practitioner? In doing so, did he consider the patient's reaction or the patient/doctor relationship? Mrs G had been referred solely for an answer to a diagnostic query. Since I was interested enough in the case to investigate further, was it not proper for him to report both his negative finding and his positive diagnosis and leave me to consider the situation and take further action?

It was acknowledged that the consultant may sometimes spot symptoms that the GP has overlooked. For instance, a case was cited of dyspepsia diagnosed by the GP, and carcinoma by the consultant; and the consultant's direct referral to a surgeon to get on with what was needed was seen as a constructive action for which any GP would naturally be grateful.

The best way of dealing with a consultant was considered. Can a letter describe a referral adequately? If there is disagreement with his action or report, should the GP so inform him and give reasons? It is well known that doctors, consultants as well as general practitioners dislike being criticised. How should the consultant be chosen? From personal or professional knowledge? And how should the patient be prepared for the referral?

It was admitted that the limited time available to consultants for each referral is probably a key factor in any unsatisfactory contacts with them. This was probably so in Mrs G's case, rather than a mere oversight or a mistaken idea that she was to be handed over completely. One of the group mentioned that consultants frequently ignore the GP's letter and do not show signs of having read it. They waste time stating points or asking questions about something they have already been told, or they may present it as if it were new. When a consultant completely ignores what a GP has written and does not seem to have glanced at the letter, it can be infuriating.

It was agrreed that the GP should study how to maintain good relations with the consultant not only for any case in hand but for future referrals. Can the GP's referral letter with supporting tabular matter be so organised as to require the minimum time for the consultant to grasp the details of the patient's situation? Can it include, in a separate last paragraph, a request for an early report or, where the patient is being handed over completely, a request to be told, at a convenient time, how the case is progressing? Sometimes GPs are at fault in not making the report in clear language, and in not stating precisely what is wanted from the consultant. They should set out the history, then include the treatment they have given, with the results. This is good training for the GP, and useful in his future contacts with the patient if, as he should, he keeps a copy.

As regards the exchanges between the consultant and the GP, the Group noted that, while the GP's answering letter was polite, setting out the patient's condition and implying no criticism, the consultant's letter had in effect, criticised the GP: 'This is not myxoedema but a depression.' On the other hand, was it not the tests that enabled him to rule out myxoedema? And why did he quickly fasten on to depression, implying that the GP, who knew the patient better than he, had not spotted it?

Care should be taken, it was pointed out, to be sure that the GP's disagreement with a referral is not based on an attitude towards a particular consultant. Likewise, caution should always be exercised in accepting a patient's report on a consultant.

Finally, the discussion focused on the doctor's handling of Mrs G's case and the good doctor/patient relationship maintained in spite of the consultant physician's abrupt action. It was apparent that previous knowledge enabled her to discount whatever depressing impression Mrs G had made on the consultant.

D *Continuing care shared*

High scores from the more possessive amongst us, who protect patients from too much of the hospital merry-go-round. It was pleasing to note that competition developed so infrequently.

D1. In co-operation. Here is a splendid example of care shared in co-operation.

Mrs H: Continuing Care Shared

Mrs H, aged 30, with a 3 year-old-daughter joined my NHS list, having come from another city. Whilst I was caring for illnesses related to this patient's child, and then for gynaecological complaint related to the patient herself I sensed that she was carrying a heavy personal load.

One morning I received an emergency call: Mrs H's husband has been drowned in a yachting accident; she was distraught and inconsolable. I remained for a considerable time, and she began to tell me of the tragedies of her life. Prior to marriage, she had lived for years with a man who died tragically, by suicide, soon after her wedding. She was carrying very severe guilt feelings as a result.

The patient remained in a mixture of severe reactive, together with endogenous, depression in spite of treatment of an exploratory nature and psychotropic drugs. A phobic element also appeared in her symptoms. I referred her to a psychiatrist and eventually she was admitted to a mental hospital, where she remained for several months; then went back to the city where she had spent her early married life. She stayed there for a year and continued out-patient psychiatric care throughout that time. On returning to her home, she seemed to be much better. However, she gradually deteriorated, became very unsure of herself, and the phobic symptoms returned.

I referred her back to the psychiatrist who had first seen her; he said he would see her about once in three months and would carry out a very contained, almost surgical approach. He asked me if I would be agreeable to sharing in the patient's treatment by seeing her more often, in a supportive role. He was careful to emphasise that the two methods of approach would be different; the one highly specialised, the other reassuring and explanatory.

Over a period of two years this arrangement has continued. Mrs H is nearly well again, looks bright, walks and acts briskly, and is better than I have ever seen her. She has voluntarily spaced out the intervals between her visits both to the psychiatrist and myself. The psychiatrist has been helping her towards the day when she can be weaned from both himself and me, except that I remain in my role of family doctor.

I have been greatly impressed by the 'surgical' technique, which was at times very traumatic to the patient. I felt privileged to be in a position of medically softening the blow, and I have learned a great deal from the experience of continuing care shared between consultant and general practitioner.

On each occasion when the psychiatrist saw Mrs H, he wrote me a full letter. Similarly, I sent the psychiatrist my notes before each consultation he had with her. On no occasion did he make any comment, adverse or otherwise, on my notes and method of approach; so the psychiatrist must have felt the doctor was following his brief. The shared care of this patient still continues.

D2 IN COMPETITION. Now for one where some competition crept in.

Mr K: Fie to you both!

Mr K, aged 45, was a sort of flabby man whom I rather disliked. He was sent into hospital with acute pancreatitis, and took a very long time getting better after he came out. I referred him to a consultant physician to see whether his gall bladder should be removed. It was, but later he had severe abdominal pains and was re-admitted to hospital with my diagnosis of recurrent pancreatitis. He came out seeming still to be ill, and with a mass in his stomach which I thought was a fluid cyst in the lesser sac, so I sent him back into hospital. He came out again and gradually got better. But both he and his wife seemed to me to be fairly hostile. She had been smothering her husband all the time, while I thought he ought to be pushed. He then exchanged a fairly heavy factory job for a lighter job and has not been seen in the surgery since, a matter of six months.

In group discussion regarding competition between the general practitioner and the consultant, I admitted that I felt some competition on my part. The consultant had put Mr K. on a rigid diet; whereas I had told him to eat what he liked. The consultant had advised rest and convalescence; I had encouraged him to return to work.

Group III: Results of Referral

A For the patient. The patient's destiny was fairly easy to grade into one of 5 groups:

A1 CURE. Most likely to occur in a surgeon's hands. The chance of cure was naturally inversely proportional to the age of the patient.

A2 IMPROVEMENT. More the physician's prerogative. GP scoring here had to be partly guesswork.

A3 NO CHANGE. Quite a large count at 19%, but as time goes by it should fall as patients on waiting lists receive treatment. Nevertheless, with the hospital service costing what it does, cost-effectiveness experts in the NHS might take note.

A4 DETERIORATION. Mostly inevitable, either from degenerative processes or from malignant spread. We did not find any admission of iatrogenic scoring here.

A5 DEATH. We found that we had to form a separate category for this, as the more philosophical among us argued that it might otherwise be held to score under 1, 2 or 4!

B For the doctor. Did the referral supplement his skills in *Diagnosis* or in *Treatment?* Low scores, you will see, are humbling for both parties, and reflect poor communication. Older practitioners recall how much more was learned by the GP in attending a true consultation with a specialist. Letters do not do half as well. Also, clinical blindness is more likely to reign unchecked, as this rolling stone of a referral shows.

Mrs L: A Lesson in Diagnosis

Mrs L.'s husband approached me to see his wife for the first time. Aged 68, she had developed severe paranoid symptoms over the previous three months. She had been depressed since the death of her sister from disseminated sclerosis, one year previously. He thought his wife's condition was deteriorating rapidly.

Mrs L agreed to see me. She exhibited marked paranoia, complaining of her neighbours watching her through a hole in the wall and of hearing voices accusing her of various crimes such as shoplifting, and adultery. She admitted to a severe depressive episode when she was aged 40. She had spent six months in a psychiatric hospital at that time. She was very agitated during the interview and very loquacious. I made a diagnosis of depression with paranoid symptoms. Drug treatment was started and an urgent psychiatric outpatients appointment made.

The consultant psychiatrist agreed with my diagnosis and suggested additional drug therapy. In his letter to me, he commented on Mrs L's additional symptoms when walking, and suggested referral to a

neurologist. Five days later, however, Mrs L had to be admitted to a psychiatric hospital under Section 25. She was treated with electro-convulsive therapy and drugs, remaining in hospital for nine weeks, latterly as an informal patient.

Following discharge from hospital, Mrs L. again came to see me. She complained of left wrist drop which had started following her second electro-convulsive therapy. I diagnosed left radial nerve palsy. Her mental state was very much improved. The discharge letter from the psychiatric hospital commented on her loose, dry skin, paraesthesiae of the hands and feet, and her unsteadiness in walking. Mrs L's family were, very understandably, distressed by her wrist drop and demanded an early appointment. An urgent referral was made to a consultant neurologist.

The consultant confirmed the diagnosis of left radial nerve palsy. In addition, he found Mrs L. to be clearly myxoedematous, and confirmed this with blood tests. She was referred to a consultant physician by the neurologist. The physician agreed with the diagnosis of myxoedema and quickly started treatment with thyroxine. Mrs L improved on this and was kept under observation by the consultant physician for two years. The left radial nerve palsy cleared completely in nine months.

This case provided a salutary lesson in diagnosis as I had completely missed the diagnosis of myxoedema. I had been misled by considering Mrs L's psychiatric symptoms to the exclusion of physical disease, despite a history of weight gain after her stay in the psychiatric hospital, dry skin, and some hair loss, all very suggestive of myxoedema.

C *For the doctor/patient relationship*. For all that we started out to study the effect of the referral on the GP/patient relationship, statistically we found it was altered seldom by the process, and we found alteration impossible to assess in relation to the referral alone. Our breakdown in the table into (1) relationship altered, and (2) insight on patient, is therefore best regarded as somewhat arbitrary.

Possibly we may be smug, or unperceptive, but after we have watched our patients adventuring through our colleagues' hands, it is surprising that we did not score more improved insights upon them, for they usually had a tale to tell on returning to the care-worn calm of our consulting rooms.

Here are three differing cases where change was observed, the first being game, set and match to the surgical ward.

Mrs M: Thanks to the Surgeon

Mrs M, aged 69, who had rarely appeared in the doctor's surgery before, came in great fear and only because of her husband's insistence, as she had post-menopausal bleeding. Her gross obesity made examination very difficult, and the proposal that she should be referred to a gynaecologist was not well received. She was, however, persuaded to attend the hospital, and when admission was advised she again needed strong persuasion to go in. She underwent the major operation of hysterectomy for carcinoma, with the added bonus of omentectomy, and was put on a very strict reducing diet.

On returning home, her relationship with the whole medical profession was reversed, for she declared she would never mind what treatment might be advised in the future, and would advise all her friends to do the same. Since then, she has persisted with her diet, losing weight steadily, and none of her original fears and suspicion of her own GP, and of doctors in general, has reappeared, nor has her carcinoma.

Now one where the husband tried to be the doctor, and the consultant achieved a restoration of rapport.

Mrs N: Huntington's Chorea

The course of the doctor/patient relationship reported here has been particularly instructive to me because of its occurring in the context of Huntington's chorea.

Mrs N is a woman of 63 whose children I had attended when they were young, and who had come to me ten years earlier complaining of throbbing in her right leg, and showing anxiety because she realised there was a strong possibility that she might be afflicted with Huntington's chorea; she had seen her father and sister develop it, and later die of it in a mental hospital; and she knew that two uncles had also suffered from it.

At that time there was no evidence that she was developing the disease, but she was found to have slightly raised blood pressure, and therefore attended regularly to have this checked and to be reassured about her condition. She was of below average intelligence, but pleasant and appreciative of the attention given her. Both the patient and I realised that some of her many symptoms might indicate that she was developing the dreaded disease; but, as we both also knew there was no treatment for it, I never pressed her to have further advice to confirm this nor, indeed, did she seek it.

The situation changed a year ago when Mrs N became worried about the prospect of her husband's retirement and feared that she might become a burden to him. I then asked her if she would like to see a specialist and she readily agreed. Although I referred her to a consultant neurologist, she was seen by a senior registrar who was well versed in this particular illness and told her frankly that she was suffering from it. Thereafter she became depressed, and deteriorated generally.

At that time her husband, whom I had only known slightly before, began to play an important part in the situation and I realised why the wife feared him. He had recently retired from a position where he had managed a large staff. In a similar way he seemed to take over the management of his wife's illness and combine the role of husband with that of doctor, nurse and domestic help. His manner was rather aggressive and domineering although tempered with kindness and a desire to help.

The couple have three sons, all doing well, and none had developed the disease so far, although they were aware of the possibility; they had no children. Living with the couple were the youngest son, who held a less responsible job than his brothers, and his wife, who was clearly suffering from a psychological illness.

The patient's husband was not satisfied with his wife's hospital visit, although he admitted that the registrar's opinion of the disease was correct, as he had read it up himself to confirm it. Through my partner he made an appointment to see the consultant privately, and attended without his wife's knowledge, and cancelled her follow-up appointment. She became more depressed and retired to bed, refusing to eat, or wash or dress herself. Occasionally she came down and sat dejectedly in front of the television.

Her husband declined all offers of help, and so she became completely dependent on him. Upon my return from a period of absence, I was shocked by the change in her condition. Besides, I was finding it increasingly difficult to help because of the husband's attitude and his attempt to take over the doctor's role himself.

However, at the husband's suggestion, I asked the neurologist to take Mrs N into hospital for a short period of observation, ostensibly to confirm the diagnosis of the disease, although medically this was unnecessary. The consultant willingly agreed, and, on visiting the patient in hospital, I saw at once that she was happier and pleased with everything that was being done for her. Also her relationship with me was once more re-established. Since then the management of the case has been easier, Mrs N attending regularly and seeing me alone, and the re-established doctor/patient relationship has continued harmoniously.

Olive: ? A Battered Child

My partner asked me to visit Olive, aged three years, whom he had seen in the surgery. He had noted her negative reactions, and thought a home visit might sort out the true reason for the child's state.

Olive was the second child in a family of four; a sister of five, another of two years, and a new-born brother.

Olive's father, aged 29 years, a factoryworker, was not in regular employment and getting behind with the mortgage repayments. Her mother, aged 24 years, was an aggressive woman, whose first contact with my partner, six months before, had been to demand the termination of a 24-weeks pregnancy. With hindsight this was probably the first cry for help in a worsening situation.

At the first home visit, I noted that Olive had normal hearing, and she played with her sisters, but seemed nervous and very jealous for her mother's attention. She retreated into herself whenever her mother got angry or spanked her, and this she frequently did.

Sixteen months later Olive was brought to the surgery by both parents. The story was that on the previous day the family had been to the seaside; in the afternoon a holidaymaker had pointed out to her mother that blood was coming out of Olive's shoe. The parents took Olive to the hospital, where the Casualty Officer found severe abrasions of the sole of the foot, and many bruises of the head and limbs. The parents' explanation of the injuries was that the child had tripped on the beach and got sand in her shoe! The Casualty Officer had the child's limbs and skull X-rayed; no bone injury was found but he kindly rang me, stating the facts and that he suspected a 'battered child'.

Both father and mother were very angry and complained of the hospital treatment and the delay caused by it. The foot was in a bad state, so the mother was persuaded to bring Olive for frequent dressings. During the next few days, increased bruising continued but I was told that the child had fallen over, or walked into a doorpost.

I decided to ask for a paediatrician's opinion, and wrote giving the history, and saying that the Casualty Officer and I found it hard to equate the parents' story with the injuries seen. Was there any defect of vision or balance? Or perhaps a blood dyscrasia? The mother needed a lot of persuading to see the consultant.

The consultant told the mother that the hospital visit was not necessary, and he wrote to me that no child of four, which Olive now was, was a 'battered child'; he said that at that age they were nimble enough to get out of the way! (Perhaps that was why she did not have a fracture!)

Four weeks later the NSPCC were asked by a passer-by to investigate why Olive was walking stiffly and was in a bruised condition. The NSPCC officer called, to be met by a furious mother; soon the furious mother was on my door-step, convinced that I had called the NSPCC.

Luckily, I was able to persuade the mother that I was on her side and I advised weekly visits to the surgery for the nurse to 'try different vitamins to lessen the bruising'. This continued for several weeks and with some improvement until the family left the district.

The Group thought that I had not given sufficient facts to the consultant, and I had to admit that I gave the letter for the consultant to the mother.

Conclusion

Our conclusion is brief. It is that we gained far more insight into our relationship with our patients by discussing it in our seminar, than we ever achieved through the use of the consultant service; but we must also acknowledge those other caring agents: husbands, wives, receptionists, social workers, even village sleuths, who have helped us to appreciate the realities of our patients' situations.

Coda

Now, as a coda to our piece, and to illustrate the dense tangle that attempts at classification can produce, here is a frantic tale of a patient who cured himself, but not before putting many a doctor to flight, and running considerable iatrogenic risks.

Mr P: The End of the Affair

Mr P presents a case which can be included under almost every group. His referrals include surgical, medical, psychiatric; even the assistance of an obstetrician was needed. He has had diagnostic investigations, he has been sent for doctor's reassurance, for doctor's escape, for the patient's request for reassurance, for other resources, and for escape. As to the nature of the referrals, they are of complete

handover, advice and resumption of care, and continuing care shared, both in competition and in co-operation. As to the results, they have been: improvement; at other times no change; and, at one stage, definite deterioration.

Mr P became my patient in 1968. He had been in the Polish Army, and subsequently imprisoned and maltreated in Russia, but eventually found his way to England and had been working for many years in a local factory. He is highly thought of and has been kept on in spite of having reached retiring age.

Mr P's medical records go back to 1953. An anal flavour is immediately in evidence. By 1960 he had several visits for injections for piles, and a surgeon pronounced himself 'unable to find a cause for pain felt in the perineum'. Another surgeon fared no better. Full investigations and reassurance brought no relief.

In 1967 he went privately to Queen Square. The neurologist decided the symptoms were definitely of an organic nature, though he was not sure where they arose, and asked a surgical colleague to assist him in that matter. He in turn excised some perineal tissue, which proved histologically normal.

Mr P felt better for a period of six months. Then pain returned again to the same area. Two years later his perineal pain was joined by impotence. At his own request he revisited Queen Square, and was once again rapidly handed over to the surgeon, who could not resist the temptation to excise a further piece of meat from the perineum. This time results were poor from the start, and Mr P underwent local ischio-rectal blocking injections without success. Now an obstetrician was summoned to give him a pudendal block. It, too, failed, and the surgeon gave up after suggesting a further neurologist's opinion, who in turn, suggested a psychiatrist. The referral never materialised owing to the psychiatrist's own ill health, but Mr P was very outspoken about this breed of men, and persistently referred to them as headshrinkers and to all psychotropic drugs as 'head-shrinking medications which were useless'. (He even had his own MIMS to keep a check on the doctor!)

One day Mr P requested a plain X-ray of his perineum. In fact, he went so far as to give exact details as to how the X-ray was to be positioned. I discovered that many years previously he had had a foreign body in his palm which no one believed until the X-ray revealed it. I referred him privately to a radiologist, who obligingly took some X-rays of the perineum, which proved perfectly normal, and Mr P has improved ever since.

Discussion

A selection has been made of what seem the most important parts from the eager discussion that followed and in indented setting after each part, is the group's collective comment, made at its next session in Cambridge.

'There is one aspect of the referral that has not been mentioned, that is that over the years one learns what to expect from each kind of person to whom each patient is referred. Put another way, we all learn which patient to refer to which particular consultant; the kind of letter that will appeal to that particular consultant; and the kind of results that we're likely to get. I can think, for example, of two ENT surgeons at a particular teaching hospital; one will give a very valuable opinion taking in the whole patient, and the other will give a totally useless opinion.'

'Are you implying that if you get the right answer, the referring doctor had something to do with it?'

'It's very complicated. It may be the referring doctor, it may be the particular doctor you refer the patient to—that is another thing; the patient may present you with one story, and present the consultant with a very, very different story—and that is another complication again. I was thinking much more about choosing your consultant and knowing that you are going to get a particular kind of answer from a particular consultant, and, in the same speciality, if you send the patient to another consultant, you will get a different answer altogether.'

'This commonly occurs in tonsillectomy. It is the mother who wants the tonsillectomy, not the child. You choose the consultant who you know will give your opinion. It is the same with termination, and other things.'

'Even the more basic things like choosing your diagnosis—you can send a patient with an abdominal pain to a gastroenterologist you get one opinion; you send him to a surgeon you get another.'

'Yes, in urology, you get a different answer from referral to a urological physician than from a urological surgeon.'

'I am surprised to see such a high referral rate to surgeons. Perhaps it is because I have an impression I do not refer to surgeons; maybe if I put my figures down I would be surprised.'

The point brought out here is valid, that is, the GP's relationship with the consultant to whom he is referring, and his previous knowledge of that consultant, certainly do affect the outcome of that referral.

Our choice of consultant *will* influence the treatment; we think that a referral to a consultant whose personality we know can be matched to what we believe are the needs of our patient.

The surprise expressed at such a high referral rate to surgeons was answered, we think, by one of us who said that many surgical referrals do not make demands in time and energy once a diagnosis has been made and the letter written. But when they are counted, it is surprising that they form such a high proportion of the total. One should remember that minor surgical conditions are usually referred; minor medical ones are dealt with by the GP. We have now counted our gynaecological cases and find that they constitute 19% of surgical.

'With all this material we tend to miss the trees for all the wood. If, for instance, we had the pattern of each doctor's referrals, we might get nearer to the nitty-gritty. What goes on when you refer a patient, for escape, and reassurance, and so on?'

'I wish you had explored the psychological implications of the patient's role in the referral. I would like to follow up this work to see if you can explore what really has been going on. We have had an excellent over-all impression, but it has of necessity been rather superficial. I have a hunch that if we did more work in terms of the individual doctor and referrals, we would have more surprises.

This has been raised in various discussions of the group, and we felt that we could not cover each doctor's pattern in our presentation; we plan to go more deeply into this in the future.

In our samples, we were talking about all patients gathered over a six-month period (the average number per GP is about 140), and with that number of patients we do not feel that we can go deeply enough to provide a satisfactory answer, unless we select certain cases.

It would be better to do a prospective study of patients we sense might have potential to provide suitable material. Dr Singer feels that our present study should really be called an introductory paper, and that the serious work is about to start. (Hoots of mirth!)

'Have you estimated how often patients returned with symptom shift?'

We found symptom shift very hard to define, and felt that time was lacking for this research .Among the several possible definitions we considered were situations (a) where patients were re-referred regardless of what they were originally referred for, and (b) where it amplified failure on the doctor's part either to make an accurate diagnosis or to satisfy the patient's need.

'I was intrigued by the doctor who shared care with a consultant and each time he saw the patient the consultant wrote a letter, and the GP let the consultant see his notes. It reminded me of the system for shared antenatal care. This has enormous implications and I do not see why it could not be applied in other fields.'

'I feel the most interest in the ones that got away. And I know patients who would not dream of letting a third party interfere with the cosy relationship they have with the doctor. Is there no possibility of matching these contented patients with the others in some way? For all we know, these represent the majority of cases.'

Of course it may also be the doctor who does not like the third-party interference with his cosy relationship with the patient. It may be difficult to count contented patients, or contented doctors, or the contented relationship, and it may well be that this is due to collusion between them.

We felt that the members of the Balint Society had the impression that the GP was placed in a secondary role by the psychiatrist. The GP had acknowledged his need for expert help and appreciated the consultant's willingness to work in co-operation. It enabled the consultant's sessions to be reduced, and the GP maintained continuity and involvement in the treatment, to the patient's and the consultant's benefit.

'I would like to hear more about the case of shared care between the general practitioner and psychiatrist, and which treatment was given by each.' (The case of Mrs H see *p.*18. Ed.)

'Well he stuck to just one point. She has actually gone over nine years. It's two years since she came back from being away. Her previous friend committed suicide when she married, so she had tremendous guilt feelings about that; her husband was killed and she felt it was her fault. She thought she was an evil person, and she thought that everything she did and everything she touched would produce evil results. She was absolutely terrified that she would do evil things to her daughter. He worked on the business of being evil and he made it quite clear that he did not want me to encroach on his field, he did not want me to start talking to her about being evil. So I kept right off what he was talking about. But in fact there was so much else to get down to that it was quite easy to avoid stepping on his territory, so to speak; on the other hand, I had to step on his territory a certain amount because I was seeing her fortnightly and he was seeing her three-monthly. This was the time sequence that he asked me to do: "You see her for three-quarters of an hour every fortnight and I'll see her every three months." '

'What was the role of the psychiatrist? What was the reason for all this? And what was she like?'

'Well, she was at that time very withdrawn; she had delusions about the house falling down; she would not shop; and she became inert. This was why I had to get in some help. She is 5 feet 6 inches tall, dark; well, one tends to think what she did look like; she looks quite different now, can smile, but at that time was very withdrawn, mask-faced.

'To come back to the technique, was it you that found difficulty in talking about the evil, and was the psychiatrist helping you to talk about something that you found difficult to talk about, or was he making use of you because he only wanted to see her every three months?

'She was very difficult to talk to about anything at that stage; she had regressed. He said that she was a person who was almost 100%

good in feeling, or 100% bad in feeling. She hadn't any normal way of realising the degrees of goodness and badness; she had a goodness-and-badness split. He tried to make her see this and work her way through it.'

'Could you explain why he felt the need to split her? Because she split everything? She had two husbands.'

'I think he knew that at every interview she would leave in a shattered state, which she did do. He wanted her picked up and supported, I think.'

'Was this a good way of treating the patient, or were you and the psychiatrist treating each other?'

'All I can say is that a withdrawn, hopeless girl is now able to go out, and is socialising and apparently much better'.

'I agree with that, from what you say, but could you not have done it all, or could the psychiatrist not have done it all? Why the need for both of you?'

'She needed him because of my lack of confidence; and he needed me because he did not want to see her every two weeks. He also knew that I was interested in the subject.'

'I think what emerges from the discussion is that we are a little greedy for more information about relationships and so on. I do not know that we have learned very much from the figures themselves; it is interesting to look back and see relationships that have improved.

One of the first researches that we did with Michael Balint was one in which we collected a lot of facts and figures, and the end result was very disappointing. We had a mass of figures about patients and what they had done, and nothing very much had come out of it—we felt that massive collation was not worthwhile, and we tended to miss the gems of relationships in our eagerness to collect figures.'

The Michael Balint Institute in Hamburg

This new Institute opened in Hamburg on 31st January 1974, with a ceremony attended by Mrs Enid Balint, and a gathering of distinguished psychiatrists and psychoanalysts involved in the running of Balint Groups.

The Institute occupies a newly furnished and modernised floor of the building used by the Freie und Hansestadt Hamburg mostly as a clinic. Analysts will be trained there and Balint Groups held.

The founder is Dr med Ulrich Ehebald, a psychoanalyst and old acquaintance of Michael Balint, who has for some years run Balint Groups in Hamburg, and it is the result of some very long-cherished plans which have at last succeeded.

The Society wishes this venture every good fortune and it is hoped that it will be a most appropriate venue for the Third International Conference.

ANNOUNCEMENTS

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 from Dr Stephen Pasmore, Hon. Sec., 21 Edwardes Square, London, W.8.

Dr. Max Clyne has vacancies in his Training GP Seminar at University College Hospital. The Seminar meets on alternate Wednesdays, 2-4 pm.

Will those interested please apply to: 150, Lady Margaret Road, Southall, or Telephone: 01-574 2812.

Book Reviews

Six Minutes for the Patient Interactions in General Practice Consultation. Edited by Enid Balint and J. S. Norell. (Pp. 182 £2.25) Tavistock Publications, London, 1973.

When Michael Balint started his seminars, most of the participating doctors thought that they were going to learn how to carry out 'psychotherapy in general practice'. They were soon disappointed, but the belief lingered on. Even now many doctors think that Michael and Enid Balint's work had to do with the teaching of psychotherapy and psychotherapeutic methods.

Many doctors believe that carrying out psychotherapy means digging into the patient's past, especially his childhood, studying his dreams and fantasies, and using such methods of formal psychotherapy as regular, say once weekly, long sessions.

In the introductory chapter of the book under review Michael Balint is pointing out the truth that we recognised slowly and painfully, namely that the long interview, the hour-long session with the patient is really alien to general practice. In what is now the distant past of the early seminars led by the Balints, we certainly presented many case reports of patients with whom we had spent hours together. But this did not seem to be the ordinary run of our general practices, and we had misgivings. Michael and Enid Balint then tried to develop the concept of focal therapy and apply it to our work in general practice.

This also proved unsatisfactory, because it did not correspond to what, in fact, was done in general practice. In our latest research seminar, the results of which are presented in the book, we decided to look at what actually happens in what we believed to be good general practice, in practices where doctors experienced in the use of the doctor/patient relationship were working.

During the six years of research work we made a number of important discoveries, culminating in the recognition of a certain important interaction which we gave the name of the 'flash'.

This book describes the development of this work. Once we had freed ourselves from the fetters of preconceived ideas and psychological structures, we were able to formulate new concepts of diagnosis and diagnostic methods ('detective work' and 'listening'), of a typology of interviews, and of prognostication. We discovered the ways in which patients should and, in fact do, use the doctor therapeutically. Much of what we found belongs to that category of medical interaction that academic medicinelikes to call the 'art of medicine', somewhat condescendingly and contemptuously perhaps, something one cannot do without but would rather not know about.

We tried to study this part of medicine with the same serious intent and the same scientific spirit that we had used during our student and hospital days for the study of traditional scientific medicine. We designed forms to enable us to structure and better conceptualise ideas and facts from our interviews with patients.

The most important outcome of our study was the discovery of the 'flash', an interaction between doctor and patient that not only explains otherwise inexplicable experiences in general practice, but the recognition and conscious use of which may also enable doctors to work with greater efficicacy.

Our book does not make easy reading. Having read through the cold print now, some time after I had read the chapters in draft form and taken part in their discussion, I think that the tyro, the uninitiated, the doctor steeped in medicine as a natural science may at times find it puzzling. It will repay study, however. I cannot imagine any general practitioner, or consultant who does outpatient sessions, for that matter, able to function properly without having given thought to what we have to say in this book.

M. B. CLYNE

Currents in Psychoanalysis. Editor: Irwin M. Marcus. (Pp. 393. $13.50) New York International Universities Press, Inc. 1971

The publication of this book was to mark the twentieth anniversary of the New Orleans Psychoanalytic Institute, and the twenty-two contributors are drawn from different parts of the United States. They are all training and supervising analysts, the majority working in university departments, so this is decidedly an account of psychoanalysis by the American Establishment, a fact which must be borne in mind by British readers to whom some of the topics may seem more eddies than currents.

The volume brings together papers on a variety of subjects, and the difficulties inherent in a work of multiple authorship, all too often an editor's nightmare, are here only too apparent. The

individual contributions are of uneven style, length and quality, and it is perhaps the variation in style which is the most disconcerting. A chapter in lucid prose is succeeded by one with tortured writing and replete with jargon terms like 'pre-logical mentation'.

The following (p.76) will serve as a sample, the final phrase providing unintentional humour: 'Why do I not simply speak of the externalisation of unconscious conflicts, of acting out as an adolescent-specific modality of behavior, as a defense against a depressive core and object loss, as a form of remembering, as a symbolic replication of the past—and let it go at that?'

The editor has gathered the papers into five main sections reflecting American interest in psychoanalytic education, childhood and adolescence, dreams, theory, and clinical practice. The non-specialist will find much of it heavy going because a familiarity with psychoanalytic theory is assumed, but there is a good deal to interest the general reader. For example, we are given insights into the problem of the education and training of analysts; and we are shown a possible role for psychoanalysis and its neighbouring disciplines in unravelling the developmental processes of childhood and adolescence. Of particular interest to members of this Society are the references to Michael Balint's writings on the training analysis.

Elsewhere, the reader is struck by the rumination over theories; by the pre-occupation with what it was that Freud actually said—or meant; by textual criticism and commentary reminiscent of biblical scholarship, and worthy of the Talmud. But there are compensations, especially in the outstanding chapter by Wallerstein and Sampson entitled, 'Issues in Research in the Psychoanalytic Process'.

These authors give a candid account of the difficulties besetting analysts who attempt to validate their work and who must avoid circularity of argument—a common enough failing. They refer to the central dilemma 'between the significant and the exact', (a distinction which we in general practice appreciate), and they point out that Science proceeds by refutation not by verification. This chapter could be read with profit by all doctors, indeed by anyone who claims to adopt the scientific method.

That particular chapter is a reminder that there is more which unites the various medical discipline than separates them. It might have been any doctor's child—it happened to be an analyst's—who, when asked what he wanted to be when he grew up, replied gravely. 'I want to be a patient.'

J. S. Norell

Personalia

Our Society is small, a pigmy among medical societies, yet its influence may be quite considerable, as many of our members hold important positions in medical teaching institutions, medical societies and medico-political committees. Our thoughts about the importance of the doctor/patient relationship, its scientific study, and its use in diagnosis and treatment may be disseminated more widely than the number of our members would suggest. What seems to be a natural reticence on the part of members has impeded the flow of voluntary information from members to the Editor regarding lectures given, honours received, appointments held, etc., in spite of requests made in our Journal.

The Editors have therefore been forced to carry out a task the like of which they would have abhorred in their medical practices, namely detective work (see *Six Minutes for the Patient*, reviewed in this issue on page 25).

The results of their investigations have shown that: **Enid Balint** has been taking part in six Lecture-Discussions on Psychoanalytical Observation and Thinking at the Middlesex Hospital Medical School.

Michael Courtenay has been appointed co-ordinator of the St Thomas's Hospital Medical School G.P. Vocational Training Scheme.

John Horder has been appointed John Hunt Fellow of the Royal College of General Practitioners. The John Hunt Fellow is the senior of two Deans of Studies.

Jack Norell is the other. Both are concerned with raising the quality of training for general practitioners, and with career guidance. **John Horder** has also taken part in a symposium on 'Psychiatric training in the National Health Service with particular reference to the training of overseas graduates', organised by the Royal College of Psychiatrists.

Marshall Marinker has been appointed to the Chair of Community Medicine at Leicester. It is a significant and unique event nowadays for a practising general practitioner to enter the field of what used to be called Public Health in a senior teaching position, and it indicates an acceptance of the growing importance of general practice and our kind of thought in the academic field; it may also signify a breakdown of some of the compartmentalisation in medicine. Dr Marinker takes our best wishes with him in his new appointment. He is also the Chairman of the Education Committee of the Royal College of General Practitioners.

Philip Hopkins has been awarded an Upjohn Travelling Fellowship of the Royal College of General Practitioners. He intends to study the applicability of cryosurgery in general practice. It is healthy that some of us should also work in fields of general practice not solely concerned with the more cerebral aspects of the doctor/patient relationship.

M. R. Salkind has been awarded the degree of Ph.D. of the University of London, for work in the field of depression and anxiety.

Aaron Lask has been appointed Clinical Assistant in the Psychiatric Department of Wembley Hospital and at Friern Barnet Hospital.

Paul Freeling has been appointed Nuffield Tutor to the Royal College of General Practitioners. This appointment is supported by the Nuffield Provincial Hospital Trust.

Christopher Donovan has been appointed Chairman of the Education Committee of the North London Faculty of the Royal College of General Practitioners.

Max Clyne has been appointed corresponding member of the German Society for Psychotherapy and Social Medicine, and has been appointed to the Editorial Boards of the French Journal *Annales de Psychotherapie*, and the German Journal *Sexualmedizin*. He has spoken by invitation to the Students' Union of the University of Marburg (Germany) about psychotherapy in general practice, when over 600 students and doctors attended.

We know of the following seminars being held by:

Enid Balint and Cyril Gill, GP Seminar, University College Hospital;

Michael Courtenay, Trainee-half-day release course, St Thomas's Hospital;

Aaron Lask, Samaritans Seminar, Ealing;

Max Clyne, GP Seminar, University College Hospital;

James Carne and Cyril Gill, Trainee-linkage Seminar, North London.

Max Clyne has been holding weekend seminars (four sessions, Saturday and Sunday) at two or three months interval for German general practitioners and specialists in various German towns. There are now seven such groups.

This is surely an incomplete list of news about our members. How much better if members were to write to the Editors and let them know about their appointments, lectures, papers published, seminars in which they are participating, or leading, honours, and other personal news.

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 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.

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