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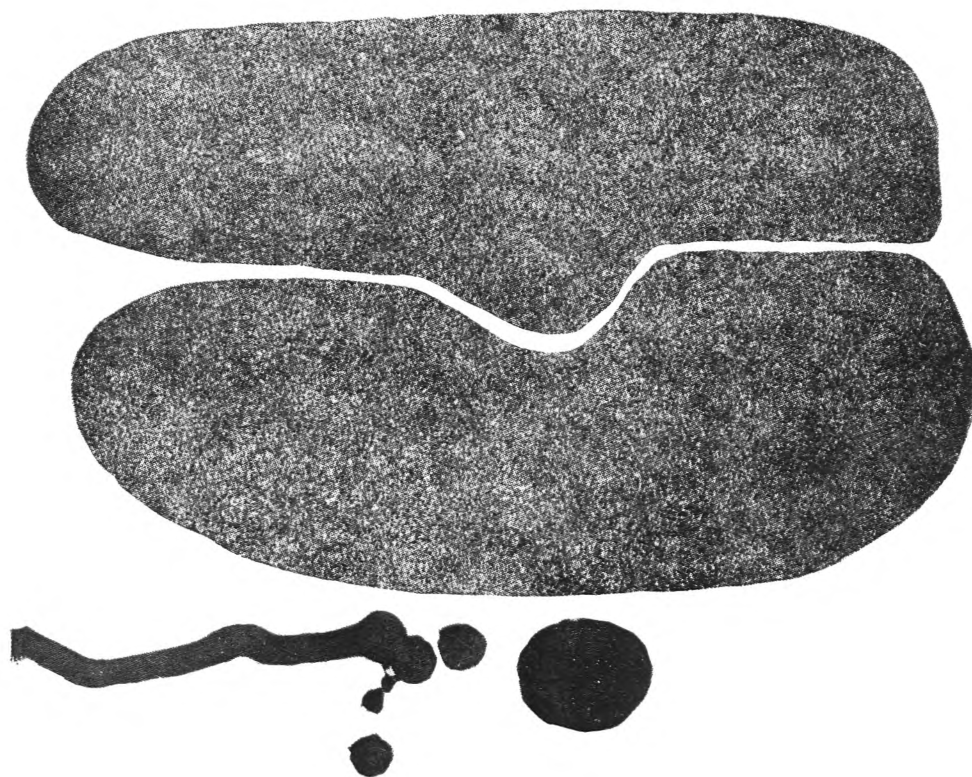

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Editorial

The consultation is the essential basis of good medical practice; upon its outcome depends diagnosis, future management and treatment. At the outset of his study of what happens during this transaction in general practice between patient and doctor, Michael Balint thought that much more happens than is discussed in the traditional text books.[1]

Following his careful analysis of the ways in which a patient may present his 'offers' to the doctor, Balint proceeded to show how the doctor's response is '. . . a highly important contributory factor in the vicissitudes of the developing illness.' This highlighted the need for a fuller understanding of the patient/doctor relationship. Furthermore after careful consideration of the possible levels of diagnosis, Balint made a very good case for the need to elicit and evaluate any possible psychological factors associated with the presenting illness in just the same way in which the doctor has had to 'learn how to evaluate the wealth of data arising from the use of newly developed diagnostic methods such as chest x-ray, electrocardiogram, intravenous or retrograde pyelography, and so on.'

Had Balint stopped there, his contribution might simply have been a repetition of what has been known and said by many people over the centuries; but he was the first to study in a detailed scientific way the content of the consultation in general practice. His conclusions have been wide reaching and his '. . . impact on general practice and on the understanding of the doctor/patient relationship has been felt all round the world . . . Balint demonstrated the vital role of the practitioner in the interpretation of his patients' unexpressed calls for help.'[2]

Balint's ideas have been attacked in recent papers. It has been suggested that'. . . most of the problems brought by patients to general practitioners can be understood in scientific terms . . .'; and 'Michael Balint came to a false conclusion about the nature of the general practitioner's task', while one of the final conclusions was that ' . . . if general practice is to prosper as an independent discipline it must return to a parimarily scientific orientation.'[3]

In a more recent paper another writer stated that '. . . the worst thing about "balintology" is that it appears to suggest that if a psychological factor can be identified then this determines the treatment whatever the complaint . . .'[4]

Another misguided suggestion is that 'Balinting is mind-rape'.[5] The inexperienced doctor may indeed make clumsy attempts to intervene in his patients' emotional lives, with disastrous results; but his incompetence does not invalidate the method; only his own particular use of it.

As a member of one of the original seminars on whose work Balint based his subsequent writings, I can refute all such suggestions: Balint said that *in addition* to instituting any traditional medical treatment required, the doctor should also consider what else might be done to help the patient understand and deal with any emotional difficulties that he may have.

It was to this end that the term *overall diagnosis* was coined, so that the illness could be seen in terms of the patient's physical and emotional state, as revealed by his relationships with other people including his doctor.

After over twenty-five years' experience of this approach in general practice I am certain that patients are helped as much by attention to their emotional problems as they are by surgery for their varicose veins or herniae.The one need not preclude the other.

Our Society is responsible for the further development of Balint's ideas and their dissemination. In September the Fourth International Balint Conference will be held in London (see page 11). It will be a forum for debate of its theme, Aims, Achievements, and Assessment of Balint Training. All who have something to contribute will be welcome.

P.H.

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2. Rosenheim, Lord. (1972) in *Patient-Centred Medicine*. Ed. Philip Hopkins. London. Regional Doctor Publications Ltd.
3. Sowerby, P. (1977) *J. Roy. Coll. Gen. Pract.*, **27**:583.
4. Williamson, J. D. (1978) *J. Roy. Coll. Gen. Pract.*, **28**:207.
5. Zigmond, D. (1978) *Update*, 1 May:1123.

The Balint Society
(Founded 1970)

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Some Medical Defences against Involvement with Patients

Michael Balint Memorial Lecture given by Tom Main on 24th January 1978

After D-Day I worked at Montgomery's 21st Army Group Rear H.Q. as that force's senior psychiatrist, far behind the fighting.

I made regular trips to and from the forward areas to make surveys about acute psychiatric casualties but could not avoid noticing the huge variations in the fighting morale of the various units. Fighting spirit and the will to win seemed to be at its lowest among troops in contact with the enemy. Unwarlike feelings were indeed quite common there and more, were tolerated, even shared, by some junior officers; lack of zest for hardship, dislike of danger, distaste for death, bitter grief about dead comrades, resentful alienation from people leading safe lives, panic at sudden noises and so forth. None here seemed to be fired by Henry the Fifth sentiments; but the further back one went, through battalion, brigade and Divisional Headquarters, the more one could find martial fervour. Fighting morale seemed to rise as the square of the distance from the enemy until, well behind the armies, at Army Group Rear Headquarters, it reached its zenith. One of my seniors here was fierce that the enemy should be attacked all day and every day (by those in front of course), and as for psychiatric casualties, he wanted them all court-martialled, given a fair trial and then shot.

Your Society has invited me, a psycho-analyst and psychiatrist from the rear headquarters of specialist medicine, to address you of the medical front line. My topic is medical defences against involvement with patients, a civilian matter yet reminiscent of the front-line soldier's wish for a quiet life; a topic clearly about timidity and, at its worst, of cowardice in the face of a daunting task.

Like all from the safe rear headquarters, I find it relatively easy to recognise inaction due to cowardice in you of the medical front line; but know I am in good company. In Balint Seminars with general practitioners I have often observed during discussion of a frightening and puzzling case how regularly advice is given that the case should be investigated with more vigour and courage, and how all the doctors present agree about this: except one – the coward in the front line, the doctor in charge of the case.

All analogies eventually become strained but mine can be pursued a little longer. Medicine and war are both serious with issues of life and death, crippledom and loss, sadnesses and terrors about external dangers; and both are also complicated by anxieties from the inner world, unconscious fantasies of primitive sadism, punishment and so on. The front-line officer and the general practitioner is each regularly required first to contain high tensions arising from these two, inner and outer, sources and to withstand pressures from others in similar state, and second to retain the capacity to think out effective professional responses of a sort that will also enlist the co-operation of these others; in the full knowledge that the consequences of misjudgement may be damaging, even lethal, to the others for whom he is responsible. Both need professional egos (to use Enid Balint's term) which are strong enough to withstand and not be overwhelmed by major tensions and which can simultaneously preserve full commonsense and professional skills; all this without resort to pathological defences.

This is an ideal state which your Society seeks to promote and maintain by seminars following Michael Balint's pedagogic breakthrough. Yet we know that it is achievable only intermittently and when the doctor is in good shape, and that failures are common. None of us dares be superior about this but it is important for furtherance of technique that we freely recognise failures of the professional ego when these occur, not to reprove but in order to study their nature, the circumstances under which they arise, the defences used against anxiety and the clinical consequences of these. By defences I mean attitudinal, social, geographic or temporal changes and manoeuvres which, no matter how common or medically hallowed, can be seen to have been devised primarily out of the doctor's need to diminish his anxiety rather than primarily for the patient's welfare.

But now for two contrasting examples of high and low defences in doctors dealing with a sense of helplessness:

The first doctor reported a year's events in a follow-up study. A middle-aged, married, childless woman, a steadily miserable complainer over the last eight years, took to her bed after a fall and was still there complaining two weeks after, despite negative findings including X-ray. The solicitous husband had now called the doctor in yet again, and this doctor, usually mild-mannered and patient with her, now shocked himself by flagrantly bullying the patient. 'There's nothing wrong with you! You are perfectly all right! You are just complaining about nothing!' and with this vigorous reassurance he had stamped out.

Of course there was a long story behind this meeting of an unhappy patient and a doctor helpless and angry. For eight years this woman had troubled her doctor with her miseries. He ascribed these to her mother who had lived with the couple ever since their marriage nearly thirty years ago. The patient never stopped telling the doctor about mother, how vicious and unpleasant, always getting at her, always saying she never had been any good, always saying her cooking was no good etc. etc. The patient, unkempt, miserable and unsure of herself, had ups and downs. At her worst she could not face people, and the husband would bring her to the doctor by car and sit in it with her outside the surgery until her turn came. The doctor had felt for years that it was hopeless because the mother refused to budge. Then two years ago the situation had changed. Following a major row between mother and husband, the doctor had called in a geriatrician, the old woman was admitted to hospital and therefrom was discharged to a flat the husband had arranged for her.

The doctor, content that the mother's unpleasantness had caused the miseries, now expected his patient to be better, but she was little benefited. The doctor had attended and investigated her carefully after her fall and had found nothing. Nor had the hospital where he had sent her for X-rays. She had no reason to complain but went on doing so and her husband also expected the doctor to help her complaints. The doctor felt berated and yet helpless for there were no findings. Thus, unable to understand why she complained, he could not tolerate her complaining and told her she was complaining about nothing. The strain of being helpless in the face of external discontents overwhelmed his professional ego. In this attack he was denying to himself not only his ignorance and helplessness but also her need for any help at all.

Of course there is more to this case but because it is hardly relevant to my topic, I offer only a summary. Subsequent X-ray at a different hospital showed healing fractures of the pelvis. Her depression was openly recognised but not investigated. Several other matters have also not been investigated; her lengthy inability to assert against mother, her own right to have a home of her own; her childless invalidism in the marriage; her view of herself as a suffering victim; why the husband works regularly away from home; and why he took over two decades to row effectively with his mother-in-law. But these investigations may never be made; the patient. on a small daily dose of antidepressant, is now 'bright as a button,' colourful and active, able to visit her mother and tolerate her nagging.

Returning to the doctor's loss of temper, it is known from other case discussions that he can be deeply moved by tragedy, but in order to keep his professional work from being affected he likes to be cheerful and unmoved and restrict his imagination in the face of trouble. Like all of us, this conscientious doctor shies away from lifting more than he can carry, and if he is in danger of feeling more than he can cope with he takes avoiding measures. In this he is like the rest of us. All of us have weak spots and against intolerably painful encounters it is inevitable that defences are erected, laughter, forgetfulness, aloofness, scotomata, denial and so forth. These allow the survival of the doctor but at cost to his effectiveness and the clinical results can of course be deplorable. This doctor's defences against involvement with the woman and the question of why she had to suffer so much were ordinary enough – evasive professional cheerfulness, concentration on somatic troubles or on the environment, plus reassurance. Her pains about the pelvis were the last straw, hence the denial of their validity and his firm reassurance about nothing to worry about.

The case makes clear yet again that all reassurance can be roughly translated as follows: 'Please stop being the way you are. I don't understand you and I don't know what to do and I can't stand being useless. I do not want to observe any more facts that disturb me. Therefore they do not exist. So please stop complaining. Now, look, I really mean it! So watch it! For God's sake keep quiet! Never heard of baby battering?* Shut up! Go to hell! My dear!'

My second case of hopeless trouble is told in extracts from the transcripts of the doctor's

report to the seminar. The doctor is again a man:

'This started as a telephone call. Would I speak to Mr. B. I said 'Hello Sid, how are things?' He said 'Oh blimey, doctor, fucking awful, Oh Christ, can you look in to see me?' I said 'OK Sid.' I made this the first visit. I arrived at a row of Victorian terraced houses, knocked and Sid, who is 83, came to the door. He said 'Hell, doctor, mate, come in, nice to see you,' and I went in to see the patient, his sister. She is 89, is totally deaf – to me anyway – totally blind and she occupies the front room. She is always in bed and was sitting now rocking herself from side to side and groaning 'Please, someone, help me.' I said to Sid 'How long has she been doing this?' and he said 'All bloody night, mate. Poor old cow.' I tried to say 'How are you dear?' and then Sid manages to get through to her, 'IT'S THE DOCTOR, DOLL!' and she said in a very distorted voice 'Who is it? Who is it? Where are you, doctor?' I said 'I'm in front of you, here,' and put my hand on hers. With that she kissed my hand and held it to her face and cried quite profusely. Sid stood behind her and he was crying, tears running down his face, and he was saying 'Poor old fucking cow,' over her head, and I was saying 'Yes.' '

'I listened to her heart and her chest. Physical diagnoses have been many and varied: congestive failure, query-myxoedema, blind, deaf. She has been in hospital a couple of times and come back with a series of diagnoses; and at the bottom of the form 'SOCIAL PROBLEM Y.7792.' It did not feel like that this morning.

Her deafness has been progressive. The blindness came on rapidly. Several years ago she was complaining of loss of vision and I sent her to the hospital as an emergency, and had a battle. I would write saying 'Desperately urgent, increasing blindness,' and would get letters back saying 'Thank you so much for referring this patient, there is nothing abnormal, we will see her in one year'! I would write again 'Getting more blind!' I was put off by their negative findings and thought it might have been hysterical but that would not wash. Eventually they said 'Totally blind. Degenerative retinal changes.' I do not believe in the query-myxoedema.

'She stopped groaning, and said 'You've always been so kind to me, looked after me,' which is not true – I have been of very little use to her. Sid and I went into the back room. I told him to tell her I would give her some tablets to take, because although I speak more loudly than Sid, he does it differently and gets the message through in his gravelly voice. Anyway we had a little discussion, bemoaning our situation in four-letter words in which I joined. And he said 'What can I do, I'm the only one that can, nobody else can.' 'Would you like her to go into a home?' 'Cor, blimey, doc, no, she couldn't stand it.' (She has been in hospital on a couple of occasions with bronchopneumonia but apart from this Sid has always done the caring and I go along.) I think it is this business of standing being complained at, that he complains to me about the awful situation.

'As I left the back room to go out, I looked in again. Mrs. E. had stopped this awful agitated rocking and now there was no sound. Maybe she was right, in some way I had sort of calmed her. Then Sid said 'Thank you, mate,' and slipped me a pound at the door. 'Here y'are doc.' He always gives me a pound note for coming, and always gives me a turkey at Christmas and Easter. Sid seemed to be satisfied that I had been just to hear about his difficulties. The nurses don't like to come in because they don't feel they do anything. Also it's the most incredible battle to get her admitted; they simply don't like her blindness and deafness and no-one else can cope with her. It would be difficult to get her into an old persons' home. He's quite right, he's the only one who could cope. And he does.'

'Was she in pain, or just unhappy?'

'She says 'It's the pain, the pain starts here and goes down my back.' It must be terrible, but I can't reproduce her behaviour, it's terribly distorted. By the time we had gone through this union of three, with all of us in tears, or nearly, it was much more peaceful. I prescribed 10 mg. of Largactil three times a day but I don't know if they have been taken. I stopped her treatment when she came out of hospital on digitalis and diuretics, because the desirability of prolonging this life is questionable. She didn't go into heart failure when I stopped them, but it would be better if she died. I see her about once a fortnight, usually as a result of one of Sid's phone calls, and I usually leave it to Sid to ring up. I said 'We will go on as before,' and that is when he gave me the pound note. It's folded up and pushed at me, a present, not a fee. It's very worrying because I think she could live quite some time. The prospect of her living even many months frightens me, thinking about her isolation.'

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*There was an old woman who lived in a shoe
She had so many children she didn't know what to do.
She gave them some soup without any bread
And whipped them all soundly
And sent them to bed.

Contrasting with the first, this case is of a patient, her relative, and the doctor on a footing of trust and affection. All here squarely face the misery and the pain and all accept each other's hopelessness and freely share the sadness about their helplessness. Moreover, in spite of severe suffering, the patient has no resentment about an unfair fate. Nor is she dissatisfied with her doctor. She complains to him but not at him and he is not pushed to cure, only to care. He is very sad but reproaches neither the patient for suffering so disturbingly nor himself for being so helpless and useless. Two matters support him steadily in this: first, the patient is of great age and nobody could prolong her life for ever; second, she and her brother do not reproach the doctor for failure to cure – rather they are grateful for his readiness to listen to and share their complaints and their burdens. Indeed the case raises again the important question – Is having the right to complain as, or more, or less important than the actual complaint itself? Even in a fatal illness such as this both seek no cure but tell the doctor their troubles and they need him to complain to regularly, and reward him, not for curing the complaint but for accepting their complaining seriously. The doctor, with some embarrassment, enjoys their love for him as a professional of care and in turn he loves them professionally as patients. I ought to say here that love in professional work* is largely unstudied and decidedly much less than hatred, which seems to be more respectable and less shamefaced.

Here then is hopelessness, tragic, sad and painful for the helpless doctor and his distressed patient. But it is without any of the remorse, resentment or despair of the first case with its discontent, its suffering resented, with the tortured doctor and patient, both angry at the doctor's helplessness, and with other strains in the doctor/patient relationship.

The second case, (Sid and his sister), was manifestly painful but not unbearably strainful for the doctor. Perhaps this is why his defences against involvement with the patient and her brother were so few. True, the doctor's comic way of reporting can be best understood as his method of defence against displaying open sadness in the seminar; but he seems to have been little defended clinically. We may suspect too that his professional ego was nearly overwhelmed by helplessness and that his private ego nearly got involved in the tragedy. But he risked this and could be involved deeply. We can only speculate about the question – what was it about these old people which made them so easy to encounter and to love?

Both cases required of the doctors' professional egos tolerance of their own medical helplessness. Why was this possible in the second case and so difficult in the first? The matter cannot be dismissed solely as a matter of the doctors' characters; for each is quite capable of the feelings and deeds demonstrated by the other in the different cases. There were differences between the patients however, but these have not yet been pinpointed. With Sid's sister the reasons for the doctor's helplessness were fairly clear; he was not in much ignorance nor mystery about the patient and the reasons for her unhapiness. In the other case the reasons for the patient's pains after her fall were far from clear. In spite of effort and hospital X-rays the doctor was still mystified, ignorant, in the dark. And still the patient complained.

Unlike Sid's doctor who *knew* why he was helpless, this first doctor was in a situation *beyond his understanding* and he was thus helpless *in an unacceptable way*. He knew he did not understand his patient's miseries – her failure to improve as he expected when mother left, showed that – and despite some praiseworthy efforts he still did not know why she was in pain. It is this *kind* of helplessness which leads to anxiety such as to threaten the professional ego with private feelings, and it is in defence against this anxiety the doctor retreats from encounter and thoughtfulness.

The retreat from encounter saved our first doctor from the anxiety of helplessness, but at the price of crippled professional commonsense. Loss of temper out of ignorance has of course never been unusual in our profession, but to deplore it is merely a pleasant moral luxury fit for the rear headquarters; and will not make it go away. We have to ask why is this form of helplessness so severely disturbing to the doctor as to threaten his commonsense?

The anxiety which arises from the helplessness of *not understanding* is, from birth onwards, the major driving force behind ego-development and the formation of ego-skills. Indeed, man's very search for knowledge has always been driven by this anxiety, this terror of not understanding and of thus being helpless. The need to

*This needs careful distinction from personal, non-professional love for which there can be no place in the professional ego. Professional love is sophisticated, pro-genital and non-sexual, without passion or completion; rather it is quiet and seeks contentment rather than need — satisfaction.

replace helplessness by mastery, and the helplessness of ignorance by the mastery which knowledge brings, ultimately animates all science. Man's search for knowledge and understanding of his environment and his self – yes, and of diagnosis – is thus fundamentally a defence against the anxieties which arise from uncertainty and ignorance. It is worth remarking here that *some* defensive manoeuvres – not all – can through later elaboration and adaptation come to have important secondary, almost independant, aims. But the embrace of knowledge is sought primarily to avoid fearful helplessness and to replace it with a sense of mastery. It is comforting to all; in medicine it is comforting to both doctor and patient that the doctor *knows* what the diagnosis is, what the prognosis is and what should be done and that he is master of the situation, even when the diagnosis is grave. A doctor is turned to primarily in order to alleviate the anxiety of his patient's helplessness with his knowledge and skills; as we know, every clear diagnosis, even a serious one, brings marked relief to a situation which is panicky with uncertainty.

But who can the doctor turn to for relief when *his* anxiety, uncertainty, helplessness and ignorance run rife? There are particular problems in medicine about this. We are trained in objective methods: to examine, observe, elicit and classify symptoms and signs, to undertake special investigations, to sort out differential diagnoses and finally to arrive objectively at a scientific diagnosis for which there is usually a well-known prognosis and well-tested treatments. Over matters of bodily diagnosis general practitioners are therefore reliably competent and if, as on occasions they are in great uncertainty, they have specialists to assist them and allay their anxiety. Yet this same scientific objective method has severe limitations as a method of arriving at all facts. Using the scientific objective method our two doctors could conclude that the two patients so far mentioned, once stripped of subjective emotional prejudices and involvement, were instances of well-known conditions: (a) reactive depression with a fair prognosis in a middle-aged female Caucasian and (b) congestive heart failure with a poor prognosis in a senile female Caucasian. And that would be that. Objective science can certainly get at knowledge of things 'out there' *because* it eschews subjectivity bat it is not wholly satisfying to practitioners simply because it *is* objective. General practice, like the whole of medicine, is not and can never be simply about an uninvolved objective scientist meeting the objectified phenomena of disease. This is because a doctor is like his patient, inescapably also a human, being beset by feelings and wishes, by *subjectivity;* involved not only in the bodily fate of his patients and their lives as 'interesting cases or examples', but also in the other facts – that they are living, experiencing *people*, subjects of experience. He cannot ignore the latter without the major feat of mental blindness which produces scientific objectivity about living creatures; if he is not emotionally blind he will always himself subjectively experience something stemming from *their* subjective experience and react (by identification, reaction formation, placation etc.).

When our patients are under strain we subjectively experience something of that (and react by identification, reaction formation etc.), and no amount of ability to study, name and classify their strains in objective ways can set us at a distance from *our* experiencing something about their pains unless we use blind defences against experiencing something of their subjective strain. *Objective understanding itself involves, by definition, a refusal to reckon with subjective facts.* Thus it contains a distancing defence against subjective encounter, such as our professional egos mobilise whenever our own tension is too great to bear. I will return to that point soon, but meanwhile want only to emphasise the inevitability of strains in our subjective craft, strains which the pure scientist (who studies things and not creatures) need not experience nor notice. The strains of trying to understand the *distress of people* rather than merely objectively observing *pain in various conditions* can be immense; yet it is only by subjectivity with all its strains that we can experience our own lives and joys and pains, and the joys or pains and the livingness of others, and thus begin the task of understanding people and their troubles. Objectivity is safe and sure but very limited for the understanding of human lives, simply because it is concerned with people as instances 'out there', objects to be observed but not subjects to be experienced and felt about.

The trained, disciplined use of subjectivity as a source of scientific information is rare; in the service of medicine moreover it will inevitably often involve us in pain. We need not be surprised therefore, and none of us can afford to be critical, if doctors seek ways of limiting their subjectivity and of alleviating the strains of uncomfortably close encounter; if they distance themselves from patients' distress in various ways, emotional temporal, social and geographic; if they adopt and institutionalise as a profession various defences against the dangers of becoming helpless and stupid by having commonsense swamped in

big feelings about the distresses around them; and if they do their best to be fairly blind or hard of hearing or angry about distress.

Fifteen years ago when renal dialysis was at its beginnings and the country had only four machines, a keen young doctor was spending eight hours each day with his patient who was in the machine. The patients were ill and afraid, and as he stayed with them monitoring their blood chemistry and physics they talked much and he got to know each of them closely. They had treatment every two or three days for a few weeks and he and his few patients became important to each other. They were children, students and young family folk, male and female. He knew their fears and loves and ambitions and they depended gratefully on him for their lives. He also got to know something of their visiting families. Yet in spite of his devoted effort the majority of his patients died, most of them while under his care, the others later at home. After the first six deaths, the doctor became less at ease with his patients and eventually morose, proper, remote and by the end of the year he was careful to have only a distant white-coated relationship with his patients and their relatives. At the end of his job he was apathetic about all hospital medicine and bitter about renology.* During the war I had found a similar withdrawn, apathetic state in certain tank commanders who had lost several tanks in action, escaping themselves from the turrets but leaving their comrades screaming as they burned and died inside.

It would be surprising if sure defences against such forms of helplessness were *not* enshrined in those medical procedures and attitudes of hospital life which keep patient and doctor at a distance ('Me doctor – You patient'!) As students we inherited these safe defences in the *proper* routines of medicine. By and large these consist of the doctor making the patient fit in with his methods and timetable: an excellent defence against experiencing and studying the patient himself. We may therefore suspect history-taking, questioning rather than letting the patient talk, interrupting him when he gets off the medical point; and when things get too free or he gets uncomfortably near to distress, switching to family history. We can wonder at why distress is so often classified under high-faluting names, why physical examinations are done at the particular moment they are done, and we can note how often the doctor may offer blind advice, admonition or wise saws or ideas borrowed from authority rather than thought out for the singular patient. And when we hear the doctor offering generalisations about human beings or reminiscences about cases and procedures based on nothing more than 'That's what I always do,' we can be sure that we are meeting defensive security. For there is always a problem in doctoring – how much strain can one stand and yet keep one's capacity to think? The psychiatrist has a similar dilemma and indeed anyone involved closely with disturbed people faces it and has few choices. To be involved very closely with a *few* patients and share and follow major confusion, anxieties, despairs, fury and then work hard at sorting these out, to understand the patient's painful inner world and the unconscious relations he seeks of others? Or become a descriptive doctor, see many more patients, be cost-effective and kind but more remote and objective? Noting various sufferings only as important symptoms of the disease, and using similar distancing manoeuvres in treatments which do not involve the doctor as a person – physical treatments, community care, alternative environments, the Social Services? Perhaps move away from patients altogether; do research on biochemistry, or genetics, or the epidemiology of distress? Teach? Administer? All these activities, be it noted, *can* be important, useful – nay, essential. Defence against involvement with people is not to be condemned because it is not brave or because it is a sign of pain avoided. Rather it should be assessed – does it serve a real use, or limit potential usefulness?

All successful rigid defence against the pains of human encounter means a loss of some capacity to experience something of oneself and the other. If sometimes the price paid for safety and the avoidance of any form of helplessness seems very high, it is worth remembering that defences are never there for nothing. The bigger the defence, the more sure one may be of the need for it. Again, how much strain can the general practitioner stand and yet retain his capacity to think? Every practitioner has a limit to what he can stand. He may be capable of making close working contact with a few patients in great distress (although usually in a schedule fixed as much by his ambitions as by the patients' wishes) but for

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*It is interesting that when I came recently to check my facts with this doctor fifteen years after the events, he at first said he had had many patients but few deaths. Then slowly he reviewed the figures. At first he denied that any were female; then he remembered the young women. Then he remembered the many deaths, how relatively few patients he had had, and how very few recovered. Last of all he remembered the children who had died.

the very survival of his professional ego he will then need defences against involvement with his other patients and he may be essentially a remote body-doctor with them. Another common way is to attempt sincere but less close and less regular contacts with all. Another is to wait, ready for, but not seeking, short profitable contact with any patient, not now to a fixed schedule but only to seize advantage of a moment when the patient can reveal something of himself in a way the doctor can understand and respond to. This technique – the famous Flash of mutuality – clearly offers the least strain, for it only occurs if the doctor is ready and in good shape at the time.

We may regret that anxiety and defence against close encounter with distress is inevitable in doctors, but this does not mean that defence must be thoughtless. We can have some choices.

First, if we cease to be censorious about defences in ourselves and our colleagues as forms of cowardice, we can study and become conscious of the different *types* of defensive manoeuvre in common use. We can note the moments when they arise and thus be alerted to the half-conscious anxieties they defend against; and then we may consciously and thoughtfully estimate the nature of the doctor's anxieties and thus allow him second thoughts how best to deal with his anxieties about the patient's problems and to make fresh choices, deliberate and conscious now, about whether to encounter further or to defend. Thus we can hope to replace non-thinking, automatic, rigid procedures of careful encounter and defence by thoughtful, elastic and adaptive deliberate techniques. If the doctor deliberately decides he must defend against intolerable strains then he may *choose* his defence and in full awareness decide which defence will be best both for himself and the clinical future of his patient.

Second, while continuing to value scientific objectivity in medicine, we may also avoid using it as a defence against the facts of subjective experience. The scientist deliberately defends himself against feelings about the object of his enquiry. Although too limiting in whole-person medicine, it has unshakeable value in the medicine of organs, as any surgeon or cancer specialist could prove. But if we dare value subjectivity also then we may come to legitimise the study of the subjective feelings of doctors, the ways they at present are ignored in unconscious and undisciplined ways and how they *can* be used in deliberate and disciplined fashion to throw light on the patient and his problems. Thus we may open up a new field for study. Not even this Society has yet developed much science or deliberate skill about subjective responses in various illnesses and under various conditions (such as in February and July – two months when the doctor/patient relationships are quite different). Much of our medicine is blind and silent and frightened about subjective feelings; yet these are nothing new – they have always existed. They and defences against them have however been in *blind* use. What *could* be new is the deliberate study of their nature and ubiquity, in the hope of more disciplined use.

Let me provoke you now by reclassifying a well-known syndrome in subjective terms – severe depression. There are various ways of classifying this, none wholly satisfactory, but now for a subjective classification based on living object-relations. 'There are two kinds of severe depression: those which arouse unbearable pity in others and those which arouse impatience and irritation.' And now for some questions such as might be asked in a students' examination. 'What are these differences due to? Which has the greater suicidal risk? The better prognosis? Which evokes tricyclic drugs and which E.C.T.? And why? Is the comparative effect of E.C.T. or tricyclics on each the same or different?' This provocation is merely to emphasise one point – that such subjective responses already blindly decide much of medicine. Yet they can be an important source of information and therefore a guide to action if they are respected and studied and not unconsciously and wildly acted upon.

One further simple example may illustrate the need for conscious subjectivity for doctors. A married woman doctor of about 30, a promising newcomer to a seminar, was consulted by a single woman of 28. She was nine weeks' pregnant and wanted an abortion. After two years of a steady and sexual love relationship, she had recently broken with her fiancé, having the bad luck of conceiving on the very last weekend of their engagement. She had thought hard about having the baby but had finally decided this would be foolish and unfair. Her own mother had been unmarried and, while loving and kind, had had a hard time bringing the patient up. The doctor, who has a baby of her own and blossoms in motherhood, liked the patient at once and the two of them got on well. The doctor, who has no objections in principle to abortion, followed the recommended abortion counselling procedure. Carefully and gently this intelligent doctor spoke about the risks of abortion – infection and perhaps lifelong sterility; yet made no reference at all to the greater dangers of a

full-term pregnancy and delivery. She also asked about the fiancé's feelings now, but learned that there was no future in that relationship. He could not care less and would certainly not marry her. Then the doctor found herself asking an absurd hypothetical question: 'If you knew that this pregnancy was to be the last one in your life, would you want this abortion?' The patient was puzzled and talked round the question, but the doctor insisted – quite steadily – on it being answered. Yes, said the patient, she would still want an abortion. Now the consultation was faltering, so, feeling she needed time to think, the doctor told the patient to go behind the screen and get ready to be examined. Both parties had heard from the nurse before the consultation began that the pregnancy test was positive, but the doctor now examined and said Yes, she was two months' pregnant. 'How do you know?' The doctor was disconcerted but did not value nor think about that as an important subjective fact and recovering her poise simply explained the softening of the os. Back at the desk, the doctor suggested that the patient should think further about her decision, take more time, a week say, and then come back. Now the patient argued back; she had given the whole matter full, serious thought and had decided that she wanted the green form (certifying that termination should be carried out) today. There it ended.

The doctor now reported to the seminar that she had somehow made the consultation sound more strained than it had been at the time. It was really friendly and had ended without any discord (we may notice here the doctor's need for harmony). Only during the seminar discussion did she ruefully tell that she had in fact signed the green form that day and that the patient had left with it.

A medicine which valued subjectivity as a source of information would surely have allowed this keen doctor to have been more observant about subjective facts, and surer about their importance and more careful to record them. Perhaps then she might have begun: 'Once we got on about mothers and babies my judgement ran out and I got dead keen for her to go ahead because I liked her. We gossiped like sisters but my weakness is that I cannot understand a woman like her not wanting babies. So I tried to frighten her into keeping it with tales of sterility. But that was no go. Then I wanted her to get married to save the baby but that too was no go. Then I tried to frighten her with ideas of future childlessness, but that was no go also. She just fought back so I decided to assert my doctorhood: I knew she was pregnant, but I did a vaginal examination just to let her know who's who. But now she treated *me* as a sister and we fought again. I wanted her to change her mind and told her to take time off and then to think the same as me, but she wouldn't. I hate open rows so I went on pretending that all was harmony and appeased her and signed the form. Peace at any price. So she got what she wanted, but I was fed up with her and sorry about the baby.'

If subjectivity was also *disciplined* the doctor might even have reported: 'I love babies, but I soon realised that she was different. She charmed me and disarmed me and was very determined and I noticed that I found myself doing my best to like her but not managing it, and I tried to scare her. She told me a solid, hard-luck story of being both fatherless and now a deserted fiancée and no sleeping around. I'm not sure about this story. I noticed she was blameless and made me hate her fiancé (if he exists) and want to rescue her. But she only wanted rescue from pregnancy. Perhaps her story is all too good to be true. I am not sure how far she is suffering, but sure that she is a fighting type and although she provoked me into fighting back, I knew she would just get an abortion somewhere else if I didn't sign. So I did. At first I thought 'What a waste,' but then began to wonder what was it about? She's clever and able to get what she wants, and she's ruthless with her hard-luck manoeuvre. But what of her as a mother? She certainly made me so afraid of offending her that I appeased her.'

To conclude, your Society has honoured me by its invitation to give this lecture in the memory of Michael Balint. He was my analyst, teacher, colleague and friend and I hope I may follow his example and add to your burdens and interests. My suggestions are: that in your clinical seminars you become expert at recognising the defensive use to which any feature of an ordinary medical examination may be put, why it is used, when it is used and what its effects are on the patient; that you become expert at respecting and clarifying the anxiety of the immediate moment which evokes the defences of the moment and what part the patient has played in arousing these; that while respecting the need for defences, you become expert critics of any defensive manoeuvre that is thoughtless, rigid and automatic. I know you aim at these matters already. But, asking from the rear headquarters, do you know you do? Deliberately and consciously?

Finally, to escape from automatic and blind defensive procedures and behaviours, perhaps your seminars could make room for deliberate

experiments in the fashioning and use of elastic, bespoke medical defenses tailored for each case and for each doctor. Your only danger could be the creation of new orthodoxies, new rigidities and new general rules. Yet I think you know that for each patient-encounter there can be only one safe general rule, which is: do not have a general rule.

Obituary

Dr MARY L. HARE, BA, MB, BS, DPM.
24.6.1909–25.10.1977

Dr Mary Hare, formerly clinical assistant to the department of psychological medicine, University College Hospital, London, died on 25th October, 1977.

Mary Louise Hare was born on 24th June, 1909. She read Greats at Oxford, and spent some years working with books at the Times Book Shop and the Friends of the British Library. She then decided to become a doctor and studied at University College and University College Hospital, graduating in 1945. She decided to make psychiatry her career and under the aegis of Dr Roger Tredgold she became associated with Michael and Enid Balint.

She worked with Michael in seminars for students at U.C.H. and then became an associate in the general practitioner seminars formed by the Balints at that hospital. After the end of the research seminar which produced *Six Minutes for the Patient*, she became co-leader of a general practitioner group at U.C.H. which began in February 1974 and continued this work until her untimely death. She also co-led a general practitioner group at High Wycombe with Dr Jimmy Carne.

Her command of English and her literary sense were invaluable in the preparation of several of the books emanating from the Balint stable and her quiet remarks during group discussion were always germane, and often of particular value. Yet she was always dubious about the worth of her contributions.

My time as co-leader with her of the seminar of young general practitioners at U.C.H. was happy beyond all expectation. Not only the challenge of the work and the professional exchange with a wise and compassionate colleague, but also the growth of a friendship with a sensitive and profoundly cultured person led to what has been for me a unique relationship.

Happily in her final years she came to realise that she had achieved a professional stature which needed no apology, and to enjoy attending International Conferences where papers based on her work were well received, and so came to feel fulfilled.

Mike Courtenay

The Fourth International Balint Conference

The Fourth International Balint Conference will be held at Imperial College of Science and Technology, South Kensington, London, S.W.7. on 7–10 September 1978, on the theme Aims, Achievements and Assessment.

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Cystitis

by CYRIL GILL
(*General Practitioner, London*)

The idea of this survey arose from discussion with a bewildered medical student who had expected patients to come to the general practitioner with a clear-cut set of symptoms and illnesses, but found instead that they were often making several potential offers to the doctor.

Patients presenting with cystitis seemed a good sample to monitor from this respect. An average sized practice will have one or two new cases per week, and this is an account of 100 consecutive patients with cystitis recently seen by me. With each one I tuned in carefully to hear any offers that the patient made along with the cystitis, but I had to be on my guard against trying too hard.

53 of these 100 patients just wanted their cystitis treated, and did not apparently wish to say anything else, though sometimes they were trailing various leads which I could not pick up; doubtless I missed some who were ready to talk.

Many of the remaining 47 were 'bursting' to say something, and needed only my permission and encouragement to do so. Others were presenting cystitis, often recurrent, with serious problems more deeply hidden. Many of these could genuinely say 'Men hurt me, or are dirty' etc, and perhaps this was easier than facing any accompanying personal problems, which might then be acted out in the consultation. My very discomfiture was then diagnostic, if I could face it. For example there were several varieties of 'Men are bad, and so are you doctor'. I needed a lucky break or a flash to get through this. So it seemed to me that at one extreme the cystitis, though genuine in itself, was used to convey strong emotion to the doctor, which might be too difficult to express directly. At the other extreme, the patient found that the cystitis, miserable though it might be, seemed preferable to facing the emotional problems which might accompany it.

All the patients had urinalysis which showed the usual proportion of roughly half infected and half with no bacterial growth. The mid-stream specimen of urine (MSU) is a very rough test, and one should not draw too many conclusions from it; those with infected urine were just as likely to want to talk as those without. There was a roughly equal scatter in the two groups. There were a few patients with accompanying gynaecological problems, but only three with any serious underlying pathology. Many cases were associated with sexual intercourse, and the usual advice was given about micturition after sexual intercourse, drinking plenty, hygiene and sexual techniques. I cannot say if any of this helped. For those with infection recent papers have suggested that seven to ten days on antibiotics may be unnecessary, and that four or five days would suffice. Most of the patients seemed to know this already!

From the literature which I could find on the subject, there was scant reference to emotional factors in cystitis, except for one paper from Dublin[1] which strongly suggests that patients with severe recurrent cystitis often have pre-existing personal problems which they brought into their marriage. This would certainly be my own impression, though many angry ladies would strongly resist such an interpretation, and it would serve me right if I tried to tell them so without strong indications that they were ready for it!

The problems presented by these patients could be classified as follows:

1. To do with having babies, or not having them. Pregnancy, abortion and sterilisation. Also anxieties about existing children or grandchildren.
2. Anxiety and insecurity. Lost and abandoned feelings.
3. Sexual problems.
4. A few other problems.

There were some that bridged these classifications.

How much was all this to do with the cystitis, and how much were they influenced by my readiness to listen? These are the ordinary problems of women. Perhaps I should have done a control with patients presenting problems directly instead of with cystitis.

It was clear though that patients coming with chronic or recurrent diarrhoea, for example, form an entirely different group. They are not comparable, although during the same period 15 people were seen who agreed that emotional factors were important in their attacks of diarrhoea. Apart from some with anxieties like (2) above, they were mostly concerned with success and failure, status, insults, anger or resentment at authority. This is ignoring the underlying

*From a paper read to the Balint Society on 29th November 1977.

pathology, considering only the meaning attached to the symptoms.

1. The first group of patients with cystitis, those to do with children or pregnancy, included many with an emotional crisis who were 'bursting' to talk. There was one patient whose son's marriage was breaking up and another who had a crisis with a 14 year old child. She recognised that she was handling this as her own mother had handled her. There were some with hopeless longings for pregnancy, and many more with fears or ambivalence about it. In fact thoughts about pregnancy were far commoner than pregnancy itself. There were a few in this group where recurrent cystitis was more organised. One woman had an illegitimate child by her stepfather when she was 15. This baby had been adopted. Later she married, but since her subsequent children were born she had recurrent cystitis, related to mourning her adopted child.

2. This group of frightened and lost people included those with bereavements, and normal but severe anxieties such as leaving home, loss of job, or housing, and family ties. One patient felt her life to be a series of losses, and I referred her to the Tavistock Clinic. When they rejected her as a candidate for analysis she returned to me with cystitis, carrying with it a desperate plea for help and protection.

Another patient said despairingly 'I'm a grown-up woman, I should be able to cope,' though she acknowledged her need for protection.

3. The sexual group included many frustrated girls who kept picking the same sort of unsuitable partners repeatedly, hoping it would come right one day. There were many who found men dirty of damaging, or who spent their thoughts and energies in trying to defeat them, and here the frustrations and scorn of men often flowed uncomfortably onto the doctor/patient relationship. There was one woman who had asthma when she feared that her husband was going off, and cystitis when it was her turn to feel bored with him, and she has repeated this pattern too. In this group also was the only one of the four men in the series who had other offers with his cystitis, which I could hear. He is a minister of religion, who developed angina at a time of loneliness and despair. The association here was obvious to us both, and we discussed it over several interviews, while I dealt with his angina at a physical level. We could see how a lifelong devotion to duty had left him emotionally isolated except for his professional contacts. Indeed his easy intimacy with me was a little disconcerting, since it was clear he had no real warmth from anyone, and we discussed this. He then developed an E.Coli cystitis. This rather took me by surprise and I tried too hard, instead of relaxing and listening to him. Though I gave him the right antibiotic, his symptoms did not clear up until his next visit two weeks later, when I managed to understand what he was trying to say. It concerned his strongly defended homosexual feelings and his dependance on one or two people, his religious superiors, and to some extent now to me also. Sharing this was important, and it would have been difficult to express directly. Here the angina and cystitis, both of which were important at a physical level and both carried important messages to be felt in the doctor/patient relationship.

Another case concerned a woman who came on my list with her husband. They came hand in hand, after a row, and the marriage broke up soon afterwards. She clearly has a split in her needs for nice kind fatherly men, and exciting dangerous nasty sexual ones. She is ever trying and failing to mend this split. She came with cystitis, saying 'My gynaecologist usually gives me tablets for this, but he is away.' With mounting irritation I discovered that she used this gynaecologist as another general practitioner. He gave her slimming tablets and anything she asked for, at the price of a consultation. I told her that she must choose between us, and she agreed at once to drop the other doctor. Though I controlled my anger, she sensed it, and was pleased to have roused me in this way. I commented on this, and pointed out that she was testing out this nice, kind, fatherly doctor to see how I would react. This was a good shot, and she has in fact dropped the other doctor. We have had a rather exacting difficult relationship since then. It would certainly have been easier if I had just given her the tablets!

Among the 53 patients who did not want to talk, there were several whose frustrations were only too clear. One demanding, voluble and frustrated patient gets relief from Valium, which she sees as breaking the reaction of spasm of her bladder which happens when anything upsets her nerves. I must accept this physiological explanation rather than discuss the 'nerves'.

The figure of 47 who were prepared to talk surprised me, but I have noticed that since I finished the 100 cases, the new ones are still prepared to talk. The bladder and uterus are closely connected, both in their origins and anatomically, so it is not surprising that some of the emotions get displaced so often in this way.

Reference

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Difficult Doctors

by M J F COURTENAY (*General Practitioner*) and
MARY HARE (*late Clinical Assistant, University College Hospital*)

Doctors often discuss the problem of 'difficult patients', not in the sense of the patient having a difficult diagnostic problem which poses an interesting intellectual challenge, but in the way in which the patient behaves as a person towards the doctor. This attitude ignores the contribution of the doctor to the difficulty: the doctor's personality is not taken into account.

This attitude is implicitly encouraged by traditional medical education which, in providing the necessary information and developing the necessary skills to practise medicine, tends to produce an attitude that the doctor knows what is best for the patient even in areas which are not strictly related to the clinical responsibility which every doctor must bear.

Michael Balint in his work with general practitioners observed that each doctor appeared to have very strong views about how patients should behave in the face of illness or distress of any kind, and these views seemed based more on some private revelation than on any principles which he had learned in his medical training. This often seemed to lead doctor and patient into conflict so that the patient would inevitably get less satisfaction from the doctor's efforts than he should have had. So doctors and patients often appear to be working for different ends because of preconceived and different ideas on each side. Extending the doctor's responsibility to deal with the relational aspects of the transaction would seem a way forward. The traditional clinical responsibility of the doctor must remain to the end, but it must take into account that there are two people engaged in a working relationship rather than a depersonalised intelligence scanning a pathological package. This means that the doctor must understand more about himself as a person, and how his preconceived ideas may interfere with a therapeutic doctor/patient relationship.

In a Balint seminar for general practitioners held at University College Hospital, London, England, the authors have observed various categories of difficulty in the doctor/patient relationship which appear to reduce the efficacy of the doctor's work. Most of these arise from personal characteristics, but one seems to arise from the early results of the Balint training.

It seemed to us that patients appeared to behave in general like children towards a doctor-parent. The patient-child has to put himself in the hands of the powerful doctor-parent, and because he must become dependent and has fears of being so, often makes his needs felt by the doctor by showing pain and distress in a forceful way, like a child screaming. This dependence is likely to reactivate the patient's childish modes of behaviour and place the doctor in a parental position which he is at one and the same time ready to assume in some respects but to reject in others. Doctors are often unaware of the distinction between their perceived medical functions and their personal attitudes towards the patient, and it is this that seems to produce the difficulty in most instances.

The relationship is complicated by another factor; the doctor has the power to leave the patient by rejecting him as a patient in a way a parent is likely to do. Although this may damage the doctor's self-esteem in having to relinquish his professional care of the patient and perhaps threatening the well-being of his medical practice, it remains a possibility if the patient's way of showing distress becomes intolerable.

Of course the patient can also leave the doctor, either by rejecting him as being therapeutically inadequate, or by 'getting better' and not requiring the doctor's attention; but this will force him to seek another dependent relationship, perhaps with even greater difficulty, or merely deny that the distress persists.

Returning to the difficulties of a continuing relationship: the anxious and dependent patient will seek by various means to limit the power bestowed on the doctor. Some will be positive, either a seductive attitude, or paying compliments to the doctor, or bringing him presents (or in terms of the British National Health Service suggesting he becomes a private paying patient). Less positively the patient may express anxiety in an overwhelming manner, or may appeal to the doctor's compassion in an attempt to satisfy his perceived needs. Finally a negative approach may involve threatening the doctor with other authoritarian figures or trying to shame him into taking the kind of action which the patient wants.

The first illustration shows that very often the first warning that there is a problem in the doctor/patient relationship is an emotion felt by the doctor, in this case, anger.

This was an elderly couple who lived rather a long way from the doctor's office. The man had a stroke a few years ago, and after that his wife asked the doctor if they could become private patients. This irritated the doctor because he prided himself that he gave a high standard of care to all his patients registered under the National Health Service, and also because he sensed some criticism of his handling of the management of his patient when he had had the stroke. His anger prevented him seeing that the wife's request was just as likely to be complimentary; she wished to retain the doctor's excellent services, but realised that since her husband now had difficulty in walking, getting to the doctor's office would be more difficult, and because of the distance involved she might have thought that private fees would compensate for the extra time the doctor would have to spend making a home visit.

In fact visiting the patient was time-consuming, and the doctor's expectation seemed to be that the patients would only call in an emergency unless he visited by appointment. The doctor's partner was called one night because the husband had severe leg muscle cramp, and the doctor visited next day and was angry with the wife for sending late for a non-urgent condition. The wife answered the doctor back with some wit, putting her point of view that she was entitled to her anxiety on her husband's behalf when he suffered from severe pain. The doctor left still angry, but realised that he had not examined the husband adequately, and so rang to say he would return next day and do some tests. It was fortunate that he did so as the husband had suffered from mild left-ventricular failure during the night, and really needed medical attention for a condition which would have fully justified the wife seeking assistance earlier, though she was probably inhibited from doing so by the events of the previous day. So the doctor's preconceived ideas as to how this couple should behave towards him might have had serious consequences.

The problems here lie mostly in the positive category, in which there was an attempt to reward the doctor and to ensure that he should remain in charge of the patient. Unfortunately this was misconstrued by the doctor, because the terms of the reward offended against his image of himself. The anger engendered by this led him to betray the very standards which he valued.

The second illustration concerns the more negative elements. A young married woman first made herself known to the doctor (a woman) by telephoning to say that her husband was having an epileptic fit. The doctor, who wanted to finish seeing the patients already at the office, tried to delay a visit by giving first-aid advice on the telephone, but the patient countered by saying that if the doctor did not come at once she would call the emergency ambulance. This made the doctor angry, but achieved its object. The husband's epilepsy was investigated and treated, and soon came under control. At this point the wife began coming to the doctor for herself, presenting various minor complaints with a great deal of anxiety, apparently unable to accept the doctor's reassurance, and appearing to be unsatisfied with the doctor's diagnoses and treatments. One day the patient's father-in-law telephoned the doctor saying she was hysterical. As he was shouting down the telephone the doctor was prompted to ask 'Who is hysterical?'. This calmed the caller, and the doctor was able to visit in a calm state of mind. However, such was the patient's anxiety about her symptoms, the doctor felt compelled to send her to a specialist, even though she was convinced that there was no serious organic disease, but because she seemed unable to satisfy the patient. The patient subsequently underwent a series of investigations, some of them rather unpleasant, all of which turned out to be negative.

The seminar actually suggested that the patient appeared to the doctor as a screaming child which the doctor wanted to shake to stop it screaming. Being unable to comfort the child-patient, she became an angry parent-doctor. When the group suggested that under the cover of her importunings the patient must be depressed, the doctor recalled that she had actually experienced a feeling of depression while with the patient on one occasion, but this important 'symptom of the patient', as Michael Balint termed any strong emotion felt by the doctor during a consultation, had become overlaid by the other qualities of the relationship.

When she next saw the patient, she expressed regret for subjecting her to the uncomfortable series of unrewarding investigations and while the patient seemed nonplussed by the doctor's apology, a calm and positive relationship grew up at that contact. The patient subsequently became pregnant and the relationship continued warmly in spite of the patient having developed pyelitis of pregnancy. However in the last month of the pregnancy she had a virus infection with high fever, and this immediately brought further urgent and repeated requests for medical attention, and made the doctor begin to feel hostile again. However the previous experience alerted

her to the need to search for the underlying distress, which rapidly emerged as the fear of giving birth to a damaged baby.

In this case the patient initially shamed the doctor by threatening to summon alternative and more rapid help (the ambulance) at the first contact. At a later stage she engaged the help of another authoritarian (parental) figure to underline her distress. The doctor shamed the patient by apologising for arranging for the sterile investigations and this ended the first phase of the relationship. The new relationship continued well for some time, until it was disturbed briefly by a recapitulation of the patient's initial pattern of complaint, but another painful episode was cut short by the doctor being able to discern the patient's real distress. Initially the doctor had reacted to the patient's feelings rather than trying to understand them.

The dangers of a patient's relative calling in authoritarian figures is illustrated by another case of a married couple in their thirties. The wife came complaining of her husband's threatening words and attitudes towards her. She appeared restless and demanded that the doctor should do something about the husband, but the doctor felt that he was not able to act unless the husband himself consulted him. Soon after a man telephoned, purporting to be a friend of the wife, and tried to coerce the doctor into taking action without waiting for the husband to come to him but this was ignored. The husband came eventually and appeared restless, unable to sit down, and told the doctor that his work was of great national importance, opening his briefcase to show the doctor that it was stuffed with papers. However, he did wish to seek help. The doctor wanted to spend time with him to understand what was wrong, but the patient left after a few minutes. His wife came soon afterwards, accompanied by a neighbour who suggested that the husband's condition was beyond the competence of the doctor to treat, which made the doctor angry, but he nevertheless referred the husband to a psychiatrist as an out-patient, although the wife thought he should be an in-patient.

By the time he was seen in out-patients he was clearly hypomanic and out-patient treatment was instituted. However, the wife rang the psychiatrist one evening soon after and insisted that he should be admitted. The psychiatrist asked the doctor to arrange the admission, under a compulsory order, which he did, but not before the husband had assaulted him. The wife actually allowed their small daughter to witness his removal. Subsequently the wife came to the doctor to say how dissatisfied she had been with his handling of her husband.

There seemed no doubt to the seminar that the negative feelings of the doctor towards the wife had made him act too slowly in his handling of the patient's developing illness, and was in the event not in the best interests of either patient or doctor.

What seemed to have happened was that the wife had alienated the doctor's sympathy by her complaints about her husband in the first place and he had appeared to her to be deaf to her distress. She had then called in friends and neighbours to corroborate her evidence, but unfortunately one of these disparaged the doctor's status, so that he remained resistant. When the husband came the doctor was sympathetic, but in trying to protect him from his wife's apparent hostility he abdicated his medical responsibility so that the husband received the necessary treatment later than was required, and in a manner which was unpleasant for the doctor in that he had to use force and to allow the wife to witness the husband's humiliation in being admitted to hospital under compulsion. The unresolved difficulties in the doctor's relationship with the wife prevented the most productive relationship with the husband.

An alternative to an angry or resistant approach on the part of the doctor is one where the doctor's capacity to deal effectively with the situation appears to be paralysed. This obviously arises from something in the doctor/patient relationship rather than from any deficiency of knowledge or skill.

As an illustration of this there was a family presented in the seminar consisting of a couple with two sons. The initial contact was when the doctor was called to see the two children, aged twelve and nine respectively, in bed with mild virus infections. The mother was afraid that they might have poliomyelitis, although they had both been immunised, and as the doctor was unable to allay her anxiety on the telephone, he agreed to visit. She felt annoyed while driving to the house, but as soon as she arrived and was in the presence of the mother she ceased to be so. This is what always happens when she is asked for a house-call. The house is very clean and tidy, and the children are always lying quietly in neatly-made beds, without a hair out of place.

The seminar felt that the patient had an overwhelming need to control everything, so that nothing bad could happen, and in the process made the doctor completely unable to act in her own way, but only in a way that would calm the mother's fears.

This was supported by the subsequent contacts. The mother came for herself, complaining of sexual disharmony in the marriage, and strong sexual inhibitions emerged in the course of the discussion, but the doctor was not able to encourage the patient towards self-disclosure and eventually treated her with pills and an attempt to bully her out of her inhibitions. This, not unnaturally, failed. Later the younger son presented with school-refusal, showing his despair in a histrionic way. The doctor was able to understand that this behaviour was due to the boy's separation from his maternal grandmother, to whom he had been very much attached. The group thought that the way forward might involve referring the boy for specialist help, thus meeting his needs and allowing the doctor to try and make a better relationship with his mother.

The next contact reported concerned the boy, who complained of abdominal pain, but again behaved in a distracted manner, crying, wringing his hands, and making rocking movements when on the weighing-machine. It was noticed that the mother made no effort either to comfort or restrain him during this time. The doctor wanted to shake the boy, and realised that his was an indication of his depression, but nevertheless did not refer him for specialist help.

The doctor dreaded going to make a home-visit, and arranged for a colleague to do so whenever possible. (The doctor yawned during the case presentation at this point).

Clearly the mother has a special effect on the doctor, as if she were also tucking the doctor up in bed and smoothing the sheets, producing an uncharacteristic passivity in her professional behaviour. It was thought possible that the doctor was protecting herself from feeling too much pain by identifying with (the denial of?) the pain in the family. However, it emerged that the doctor was quite able to relate normally with the father and the other boy, who had had an urinary infection, so the special effect on the doctor seemed to be something between the mother and the doctor.

It would seem that the patient's anxiety was too much for the doctor to bear (perhaps symbolised by the fact that the doctor kept yawning during the case presentation in the seminar), and so she withdrew and became passive. This was perhaps seen as the only alternative to a bullying approach of the type which she had used when the mother came complaining of frigidity. The result was that the child did not receive the treatment he so clearly required.

A variant of this pattern seems concerned with close personal identification with the patient. This is illustrated by a case in which the doctor saw a child at her office in the morning complaining of abdominal pain. This did not seem serious, but the doctor asked the mother to bring the child back in the evening to make sure. The child was not brought, so the doctor felt impelled to do a home-visit to make sure the child didn't have appendicitis. When she arrived she found the mother dressed to go out for the evening. The doctor knew that the husband had to work away from home a lot of the time to make enough money to support his wife and four children, and in addition the wife worked as a part-time waitress to boost the family budget. In fact the occasion she was going to was the annual staff party at the club where she worked, and was one of the very rare occasions on which she had a night out.

When they went to see the child his mother said 'tell the doctor if you have the pain', in a way which invited him to conceal any pain he might have. He looked ill, but denied pain or tenderness, so the doctor left him at home and implicitly gave permission for the mother to go out and enjoy herself. Later, when the mother returned, she had to call out the doctor's partner, who admitted him to hospital with a diagnosis of acute abdomen. In the even the child did not come to serious harm, but the doctor's identification with the mother's social needs might have had serious consequences.

The mother controlled the doctor by not bringing the child to the office as she was asked, and also saw to it that the child minimised his symptoms, but it was the doctor's identification with the mother's personal needs which led to her relinquishing her proper medical responsibility towards the child.

For some patients the anxiety about becoming dependent may be so great that they present this to the doctor in a way which seems to ask him to abdicate his responsibility towards them, although from the patient's point of view it may seem that the procedure is only intended to make the doctor's task easy.

One doctor was asked by a woman of sixty with osteoarthritis for treatment at a Continental spa under the auspices of the National Health Service. The doctor, who has a special interest in rheumatology and does not consider spa treatment to be very useful, became angry. He expressed this by placing the responsibility for making the arrangements on the patient, thinking that the request would not be countenanced by the authorities. He was further annoyed when the patient brought a leaflet explaining that the spa treatment could be arranged if it was ap-

proved by a specialist, and he was unable to contain his anger in the interview. This is a clear example of the clash which may be caused by the different expectations of patient and doctor.

The last type of difficulty to be related is partly a product of the Balint training process itself. As the doctors in the seminar begin to appreciate the needs of their patients as whole-people depending on their doctor, there is a danger that they will become impatient of the time it takes people to change their preconceived ideas of what is wrong with them, and of their scepticism about what the doctors consider the cause of their illnesses. A new relationship cannot be forced on one person by another, and time to develop a new trust must also be allowed.

So the doctor may have become partly aware of his own preconceived ideas about how patients should behave, and may have modified his techniques to try and meet the newly perceived needs; but may then have generated a whole new conception of how to treat a patient which is just as didactic in essence as the original method: a sort of psychotherapy by injection so to speak.

As an example of this, a doctor presented the case of a divorced woman in her late thirties with one daughter. She was attending a course of study for a postgraduate diploma and was attracted to one of the lecturers. This relationship seemed to be of a rather adolescent type for a woman of her age, and her history showed a lifelong problem with making good relationships. Her father had been an alcoholic, she had a cold relationship with mother, her marriage had broken down, and various later relationships with men had failed one way or another.

The doctor, seeking a here-and-now basis for treatment, asked her how she liked doctors. This produced a response that she did not like the doctor's partner, and the doctor then asked how she like him. This produced silence at the time, but the following day the patient rang the doctor up to invite him out to the theatre, an invitation which he declined. At the next interview he discussed the invitation and it was clear that he needed her help as much as she needed his.

While the doctor had appreciated the problem the patient had with making relationships in general, and had considered that the doctor/patient relationship might be a good way of helping her to achieve a better way of relating, he had used a technique of asking questions as well as personalising the relationship in a way which led the patient to consider it an invitation to establish an extra-professional relationship. This was not the doctor's intention, but the consequence of having acquired insight more rapidly than the necessary skills to match it.

He had seen the need to understand the doctor/patient relationship, but had separated the medical function and the personal attitude instead of combining the two.

These then are examples of the difficulties observed in the doctor/patient relationship which lead the doctors concerned into becoming 'bad doctors' to these patients by behaving in uncharacteristic ways. All the difficulties have a common theme, a confusion between the need to control the patient and to remain responsible for the patient. If the doctor is not secure in his self-knowledge he may become a 'difficult doctor' with certain patients and so fail them.

Understanding the importance of all aspects of relating to the patient does not deflect the doctor's attention away from the medical care of his patient, but rather builds upon the traditional model through a scrutiny of his own ways of behaving with patients who tend to place him in a parental or other powerful role. It may be in the patient's interest that the doctor retains some measure of control, but only enought to discharge his responsibility. The increased insight allows him to escape from behaviour stemming either from a conscious authoritarian position or an unconscious and powerful need to make patients behave in a manner which the doctor considers safe.

Sadly, even after long training, it is inevitable that the small but significant change in personality aimed for will not suffice to make every doctor/patient relationship satisfactory, so that certain patients will always provoke a reaction rather than an understanding from a given doctor. At least training will reduce the number of these unsatisfactory relationships and allow the doctors to be good doctors to more of their patients.

Six Minutes for the Patient

H STEPHEN PASMORE
(*General Practitioner, London*)

I was on my way home with my wife from a holiday abroad with a large group of travellers, and had just boarded a D.C. 10 in Rome for the final flight to London. There was a spare seat beside me and I hailed a pleasant woman of about 60 whom we had met on our travels. Miss B. was obviously very pleased to find a seat beside someone she had met before. The plane did not take off on time, and the pilot explained over the intercom. that he was waiting for clearance instructions. Miss B., who knew I was a doctor, then mentioned in an amusing way that she sometimes felt a little apprehensive over a flight. I was on holiday and did not feel inclined to take up the cue. Fifteen minutes went by and the plane remained on the tarmac. Miss B. was now breathing a little heavily and had developed a nervous cough, and she periodically took sips of water from a little flask she kept in her handbag. She turned to me again and said apologetically she thought she had a bit of a cold. I nodded and said I was sure her symptoms would be better when we were all airborne. Another fifteen minutes went by and I began to feel it was time I took Miss B. more seriously, not only for her sake but also to deal with my own problems of guilt. I would give her six minutes.

'You are feeling a bit nervous, aren't you?' I said, and Miss B. agreed.

'What are you afraid of?' I inquired rather fatuously, though I thought I was being sympathetic. She did not know.

'Perhaps it's in your unconscious?' I said expectantly, and to my great amusement she replied, 'Where's that?' I did my best to inform her and then asked her another question.

'Are you afraid of being high-jacked?'

'No.' Miss B. was quite clear about that. I suggested a few more possibilities, but to no purpose. Three minutes had gone by and in desperation I made what turned out to be the right move – the move to examine her feelings.

'What do you feel might happen?' I asked. Miss B. thought carefully.

'I feel the plane might disintegrate.'

'I wonder why you feel that?' I replied, 'Something in your past, perhaps in your childhood? Do you remember any incident connected with flying or heights?'

It was like pressing a button on a machine in an amusement arcade and hitting the jackpot!

'Well, when I was a child of about ten I remember doing the flying angel and falling,' said Miss B. revealingly.

'The flying angel?'

'Yes, in the gymnasium at school. You pull yourself up on a pair of rings, put your feet in them, and form a sort of traingle. I was doing this and fell. I thought the rings had given way.'

'And you got no sympathy when you fell?' I hazarded, feeling that if she had worked through the painful event properly with her instructor she would not have had such bad memories of it later.

'No! No sympathy at all!' she replied emphatically. 'I'm fascinated by what you've said. I believe that's it. I'm feeling much better already and can breathe again.'

My six minutes had expired. The pilot then spoke for the second time on the intercom.

'You will be pleased to hear we are now ready for take-off—my apologies again for the long delay.'

Miss B. had no further symptoms and at the end of the flight thanked me again for the talk.

I was grateful for her thanks, though I knew from past experience that such thanks often represent temporary relief, rather than permanent cure.

Stephen Pasmore

The Society for Psychosomatic Research: Kenneth Reeves Essay Prize

Not more than 5,000 words on a psychosomatic subject. Open to applicants who have been qualified in their discipline for not more than 10 years.

Preference will be given for original work. The prize is £50.00. It is expected that a lecture based on the prize essay will be given by the Society in April 1979.

Application forms are obtainable from: Dr. Jean Harrison, Dept. of Psychological Medicine, St. Bartholomew's Hospital, London E.C.1. Closing date 31st December, 1978.

The Balint Society

Income and Expenditure Account for the Year Ended 31st March, 1978

Secretarial Expenses	£326.02	Subscriptions			£699.50
Room Hire	52.20	Journal Receipts			44.05
Memorial Fund Expenses	42.62	Oxford Seminar Receipts		£226.81	
Token of appreciation	30.22	*Less:* Payments		226.81	
		A.G.M. Dinner Receipts		£200.00	
		Less: Payments		200.00	
		Book Receipts		£70.04	
		Less: Payments		42.74	27.30
		B.P.M.F. Grants		£216.00	
		Less: Payments to:			
		a) R.C.G.P.	£106.05		
		b) Sundry Seminary Expenses	23.62	£129.67	
					86.33
		Bank Interest (net)			103.28
Excess Income over Expenditure	£515.92	Sundry Income			6.52
	£966.98				£966.98

Balance Sheet as at 31st March, 1978

General Fund			*Cash at Bank*	
Balance 1st April 1977		£1,177.42	Current Account	£(20.41)
Income for the year		515.92	Deposit Account (Including Memorial Fund	2,796.48
		£1,693.34		
Memorial Fund				
Balance 1st April 1977	£391.59			
Bank Interest	21.15	412.74		
Creditors				
Sundry Creditors	£52.20			
Prepaid Subscriptions	617.79	669.99		
		£2,776.07		£2,776.07

In my opinion and to the best of my information and according to the explanations given to me the said Accounts give the information required and the Balance Sheet gives a true and fair view of the state of the Society's affairs as at 31st March 1978 and the Income and Expenditure Account gives a true and fair view of the excess income over expenditure for the year ended that date.

HENRYK DRYSCH, A.C.C.A.
13 Southdown Avenue, W.7.

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

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