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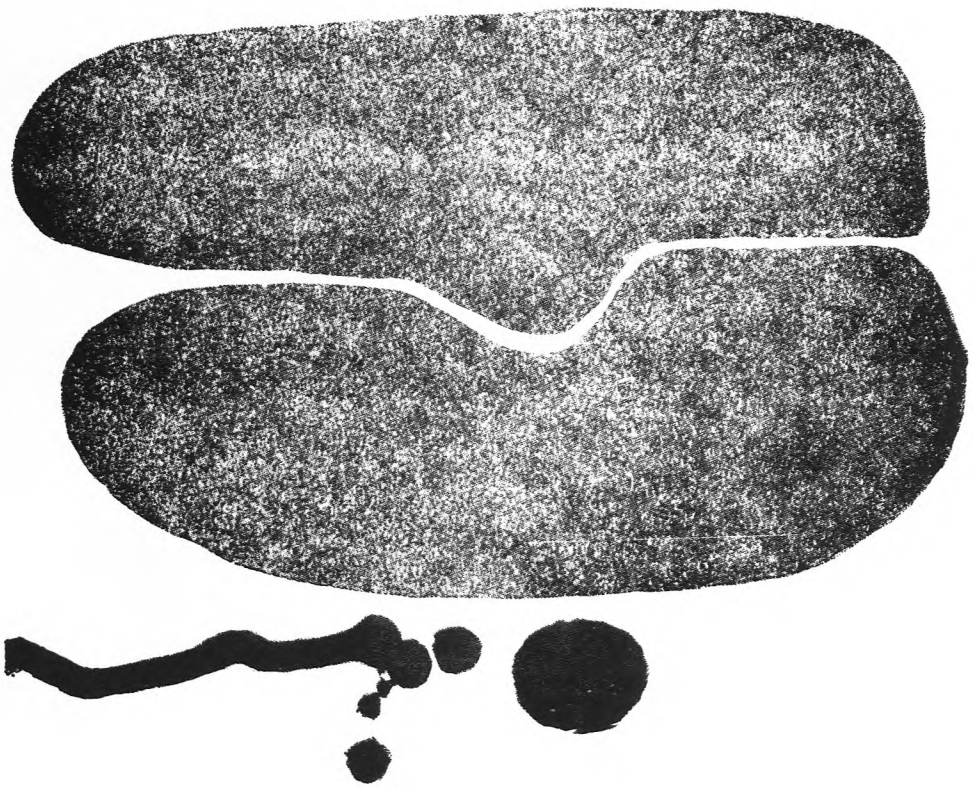

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Editor: Philip Hopkins

Editorial

Is There Anybody There . . .?

Once again there is to be a further reorganisation of our National Health Service following the recommendations made by the Griffiths inquiry for management reforms.[1]

As a result, we are in danger of being excluded even further from having any influence on how we are to offer our patients what we think is in their best interests.

Sadly, in the past, it seems to have been the influence of those doctors more concerned with traditional disease-centred medicine who have gone along with those in political office, and who have encouraged the practice of medicine in groups of doctors, or in Health Centres, with a variety of paramedicals and ancillaries, to relieve the heavy pressure brought about by the earlier mal-organization of our health service.

The resultant system requires each general practitioner to look after too large a number of patients. In turn, this led to our attempting to achieve the impossible task of satisfying our patients' needs without having the time required for full and adequate history-taking, clinical examination followed by the holistic approach in their treatment, which Michael Balint demonstrated so clearly is essential if we are to understand the real problems confronting them and us.[2]

I was privileged not only to be a member of the first, but also of one of the last groups led by Michael and Enid until the time of Michael's death. The group continued to meet until the publication of the book in which we recorded something of our findings concerning the 'flash', in which I wrote, 'At the end of six years work on this project, there still remains much to be learned about the way in which the short interviews can best be used to produce the flash between patient and doctor, and how to use this therapeutically to the best possible advantage.[3]

Twelve years have passed since then, and what I think most of us have learned is that Michael said it all when he wrote . . . the time available is always limited and is either pre-determined by the doctor's personality, or varied within limits, by the doctor's response to the patient's needs.[4]

Yet even with our insights we persisted, and still persist today, in trying to fit the patient to the system — rather than change the system to fit the needs of the patient!

It is hardly surprising that in recent years there have been signs of gross dissatisfaction on the part of our patients, who have turned for help more and more to various forms of alternative medicine; and among doctors who have looked for new methods of approach — as some of us did when we responded to Michael Balint's invitation to join his seminars in the Fifties.

Questionning voices are now raised in our Society. Most eloquent of all, that of Max Mayer, who addressed us last year (p. 24). Subsequently, in his Presidential Address at the Annual General Meeting, Jack Norell, referred to the 'enormous gap in the care of our patients', (p. 39) which led to the renewal of Michael Balint's interest in general practice, (he had, of course, led general practitioner seminars in Budapest in the Twenties).[5]

That this 'enormous gap' still exists was demonstrated well enough at our recent Oxford Weekend, where a number of doctors, having experienced the satisfaction and benefit of working in Balint-groups over the weekend, spoke angrily of their frustration at not being able to find Balint-groups to attend outside London (p. 47).

Allegations of 'elitism' were made and, at the same time, questions raised as to the validity of continuing to try to apply Balint's teachings in present-day circumstances.

Echoing Max Mayer's assertions that Society's attitudes have changed, and perhaps with the advent of wanting to be more independent, people were rejecting use of the doctor/patient relationship?

After all, there are patients we are told, who prefer to consult the practice-nurse, or the counsellor, or the psychiatric social worker, or the community psychiatric nurse, or simply the local, friendly pharmacist who has all those drugs to dispense . . . or are these patients simply following the moves and proposals made by their doctors?

Should we ask, whose counter-transference is this? Are these new ways patients are using to mask their emotional problems?

Or have the increasing demands made on general practitioners simply increased their inherent reluctance to get too involved with their patients? Can we change this within the system in which we have to work? Max Mayer asks, 'What would Michael have said . . .?' (p. 26).

But if we continue to ask questions, we will surely continue only to get answers.

Thinking that it might be helpful to see again what Michael actually did say, his presidential address to the Medical Section of the British Psychological Society in 1955, one of his earliest published papers, is reproduced in this issue (p. 3). Clearly it is based on his preparation for his book which was published, with the same title, two years later. [6]

Essentially, he discussed the need for the general practitioner to respond to his patient's propositions in order to find out how best to help him. This could equally well have been written today and surely underlines the need for us to answer the call from all those who are clamouring for Balint-groups to attend.

It may well be that in this way Balint's work can be developed further — and perhaps, by the time more doctors have had the opportunity to develop their skills along the lines that they so badly want and need, our planners may have seen the light and organized the systems so as to allow each doctor to give more of himself and his time to each of his patients.

Michael will not then have to say: 'Tell them I came and no one answered . . .' P. H.

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The Doctor, His Patient, and the Illness*

by Michael Balint

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For some years now we have organised research seminars in the Tavistock Clinic to study psychological implications in general medical practice. In one of these seminars the first topic discussed was the drugs usually prescribed by the practitioner. Very soon the discussion revealed—certainly not for the first time in the history of medicine—that by far the most frequently used drug in general practice was *the doctor himself*. It was not only the medicine in the bottle, or the pills in the box, that mattered, but the way the doctor gave them to his patient—in fact the whole atmosphere in which the drug was given and taken.

Unfortunately we soon discovered that as yet this important drug has no pharmacology. No textbook advises the doctor as to the dosage in which he should prescribe himself, in what form, and how frequently. Nor is there any literature on the hazards of this kind of medication, on the allergic responses encountered, or on the undesirable side-effects. The reassuring statement is often made that experience and common sense will help the doctor to acquire the necessary skill in prescribing himself. But this is very different from the very careful and detailed instructions with which every new drug is nowadays introduced into practice.

We decided forthwith that one of the tasks of our research should be to start devising this new pharmacology.

The importance of a study of this kind is perhaps greater nowadays than ever before. Particularly through urbanisation, a great number of people have lost their roots and connections, and the large families with their complex and intimate interrelations are tending to disappear. The individual thus becomes more and more solitary, even lonely. If in trouble, he has hardly anyone to go to for advice, consolation, or even an opportunity to pour out his heart. He is more and more thrown back on himself. We know that in quite a number of people, perhaps in all of us, any mental or emotional stress or strain is either accompanied by, or tantamount to, some bodily sensations. In such troubled states, one of the possible outlets is to drop in on one's doctor and complain. (I have deliberately left the verb without an object because in these initial stages we do not know which is the more important of the two—the act of complaining itself or the particular complaints.) It is here that the doctor's attitude becomes decisive.

As a basis for discussion of the unexpected consequences of the doctor's response to his patient's complaints I shall quote an example recently reported at one of our seminars.

* * *

The patient was a well-dressed and well-spoken, but very unhappy-looking, married woman of 38, complaining of aches and pains between the shoulder-blades. Although she had been on the doctor's list for many years the doctor had seen her only twice before, when she had come complaining about some insect bites. A physical examination revealed nothing except an almost certainly insignificant nodule in her thyroid gland. As the husband was not on the doctor's list, the doctor half casually asked her if she lived with her husband, to which she answered 'Yes,' and continued that they had no children although they had been married for fourteen years and now they did not bother about it any more. The doctor then asked if she was happy with her husband otherwise, to which she replied, 'Unfortunately not'; they had had nothing to do with each other for the past five years, and that 'his affections went elsewhere.' All this was said quite dispassionately and calmly. The doctor then asked if *her* affections had gone elsewhere too. She became rather hestitant, but finally said 'No.' Here the doctor stopped, and gave the patient some aspirin preparation—enough for about a week—telling her to come back if she did not feel better. He entered on his card a provisional non-commital diagnosis of ? fibrositis. He thought that by his questions and human approach he had possibly opened the door, and that the patient would come back to him in a few days and would then be able to talk more freely and openly about her real troubles.

A whole host of questions arise here. Perhaps the first should be, was the doctor medically justified in probing into the patient's hitherto private misery? Would it not have been wiser to be less inquisitive? After all, the woman was working, was coping with her misery, although possibly at the cost of considerable mental strain and of some physical pain. Perhaps what she wanted from the doctor was only some relief for her pains. Or if, as a sexually unsatisfied woman, she unconsciously sought some satisfaction from being undressed and touched by a male doctor, would it not have been best to accept this and to stop there?

On the other hand it might be argued that the slight pain in the back was the first sign of her

* From the chairman's address to the Medical Section of the British Psychological Society on Jan. 26, 1955.

defences cracking—a sign not to be treated lightly. This idea is familiar to every doctor; a slight cough (eg, in a young pregnant woman) may be just a slight cough, but it may also be the first sign of a tuberculous process. It certainly calls for a proper examination. The same is true in our case; slight and uncertain physical complaints in an unhappy woman may be of considerable importance and must be taken seriously.

* * *

But, if the doctor was justified in asking his questions, was his technique correct? When examining the woman he came to the conclusion that he ought to probe further; and the information he obtained proves that his assumption was well founded. But was he right to probe further *at that moment*? This problem—the problem of when to start—is but little known to the specialist; for when the patient arrives at a hospital or at a Harley Street consulting-room, he has got miles beyond this point. But it is of great importance for the general practitioner, cropping up almost every day.

In every illness there are periods when what the patient needs most is to be left in peace—not to be stirred up, even by sympathetic interest. And there are other periods when any help is desirable even if it means facing fairly severe strain or accepting pain. The general practitioner has to decide what the patient's requirements really are. He has to decide at his own peril and at that of his patient. For his solution of the problem of 'when to start' has important consequences for the further development of the illness.

* * *

Let us assume that in our case the doctor's probing was timely—that he started at the right moment. We have now to inquire further whether he ought to have stopped when the patient first showed some signs of emotion. Was he really opening the door, as he hoped; or was he, on the contrary, frightening the patient into further repression? In this case he could count on the strained home situation as his therapeutic ally: if his assessment was right, the home situation must remain unresolved, causing increasing tension in the woman, which would in due course bring her back to the doctor. But, even so, some other approach might have saved her unnecessary suffering. We must also ask what will be the effect of the doctor's question about her affections having gone elsewhere? Will she be helped to arrive at a sensible solution of this most important problem of her emotional life, or will she be frightened into a snap decision?

But, having said all this, we must recognise that the doctor had to act in some way or other. The patient was there waiting for help; the waiting-room was there too, filled probably with further patients; and he had to decide on the spur of the moment whether to ask his questions or not to ask them.

As we know, he decided to ask some questions, and to stop at the first sign that he had touched on a tender spot. Had he been a specialist, working either in a hospital outpatient department or in his private rooms, he might never have learnt to what far-reaching consequences his examination led. The general practitioner is in a different position, both more and less enviable. His practice is such that a follow-up is almost automatic: sooner or later he learns the consequences of prescribing himself. Sometimes the information comes in a short notice from the executive council asking him to forward the patient's medical notes to another practitioner. Our doctor may give a sigh of relief, but he cannot escape realising the the drug—himself—did *not* work as intended.

In our case nothing happened for more than six weeks. Then out of the blue the doctor of the factory where the woman works rang up our practitioner. He reported that the woman complained to him of her strained family life and asked for help. The factory doctor suggested bromide medication and asked our practitioner to let her have it on the N.H.S. Our doctor, quite rightly, told his colleague that in the case of this patient there was more than bromide could help; that he was always there if the patient wanted to see him; and that he did not mind at all trying first with bromides. In spite of his accommodating attitude the patient had not turned up yet. The doctor concluded his report to our seminar by admitting that apparently he had made a serious mistake.

We cannot but agree with this conclusion, although it is somewhat hard on the doctor. After all, he did not do anything against the medical textbooks. He examined his patient carefully and conscientiously, as he was taught to do, and his few questions were well within the limits of what is called 'medical history taking.' What he asked amounted to hardly more than an inquiry whether the patient lived with her husband, had any children, and had a proper adult sexual life. Nowadays questions of this kind are fairly well tolerated both by doctors and by their patients. Consequently it is not the questions themselves that constitute the serious mistake admitted by the doctor. It was the way he put his questions, especially the way he took the patient unawares. Before the woman knew where she was, she was faced with the highly unpleasant fact that she had given herself away, that a stranger—her N.H.S. doctor—had got unnoticed under her defences. The doctor made a mistake in showing to his patient too early that he knew too much: he administered himself in a too heavy dosage. This much frankly admitted, let us see now what else happened in addition to the mistake. The patient, it is true, was frightened away to another doctor; but when arriving there she did not complain any more of aches and pains. Instead she complained of her strained marital life.

* * *

In our seminars we developed a theory to explain this and similar histories. As it may sound rather unorthodox, let me introduce it gradually.

When this patient was examined, the doctor found four possible illnesses—two physical and two

psychological. There was the nodule in her thyroid gland, which could have served as a pointer. The doctor, however, dismissed it as irrelevant, probably correctly. There was then the rheumatic pains in the back. The doctor searched carefully for confirmatory physical signs, and, although he found none, he still prescribed some medicine for the pains. That is, he took notice of them, but his whole behaviour was meant to impress the patient not to take them too seriously. Then there was the depression, which the doctor noticed correctly but which he assumed to be a reaction to the unhappy marriage—a kind of secondary symptom. And lastly there was the marriage itself. So at least four illnesses were 'proposed by the patient': a slight hypertrophy of the thyroid gland, muscular rheumatism, depression, and chronic sexual frustration causing unhappiness.

A great number of patients, in the initial stages of their becoming ill—ie, before they settle down to a definite illness—*offer or propose* a variety of illnesses to the doctor. The variety available to any one person is limited by his constitution, upbringing, social position, conscious or unconscious fears, and conceptions of illness. Still, despite these limitations, there are almost always several offers or propositions. Perhaps the most important side-effect of the drug 'doctor' is his response to the patient's offer. In this case the doctor did not respond at all to the thyroid hypertrophy, made light of the rheumatism, decided that the depression was symptomatic only, but emphasised the importance of the frustrated and unhappy marital life. The patient rejected him but accepted his response as correct. Was this a desirable development? In other words: has the prospect of therapy become better or worse thereby?

My next question is, what were the factors that determined the doctor's response? Mark you, the doctor's reaction to any offer of an illness is very complex; and when we examined this response we found that much of it depended on what might be called his 'apostolic function.' By this we meant that every doctor has a set of fairly firm beliefs as to which illnesses are acceptable and which are not; how much pain, suffering, fears, and deprivations a patient should tolerate, and when he has the right to ask for help or relief; how much nuisance the patient is allowed to make of himself, and to whom; &c., &c. These beliefs are hardly ever stated explicitly but are nevertheless very strong. They compel the doctor to do his best to convert all his patients to accept his own standards and to be ill and to get well according to them.

The effect of the apostolic function on the ways the doctor can administer himself to his patients is fundamental. This effect amounts always to a restriction of the doctor's freedom: certain ways and forms simply do not exist for him, or if they do exist, somehow they do not come off well and therefore are habitually avoided. This kind of limitation in the way he can use himself is determined chiefly by the doctor's personality, training, ways of thinking, and so on, and consequently has little to do with the actual demands of the case. So it comes about that in certain aspects it is not the patient's actual needs, requirements, and interests that determine the doctor's response to the illnesses proposed to him, but the doctor's idiosyncrasies. The ultimate development—ie, whether the patient gets cured or settles down to one of the illnesses proposed by him, and to which—represents a compromise between the patient's propositions and the doctor's responses. Obviously the weight of the contributions of the two partners varies from case to case, and even in the same case may vary in the different phases of the illness. One of the periods when the doctor's contributions are most important is the initial stage of a patient becoming ill—what I call the 'unorganised' period. The woman whose case we are discussing is just in that period, and, as we have learnt from the case-history, a few questions had unexpected and far-reaching consequences. One may wonder what would have happened if the doctor had accepted the rheumatism and sent his patient for physiotherapy.

The doctor's contribution—his apostolic function—has many complex sources and many aspects. Most of them are, so to speak, private; they are expressions of the doctor's individuality; and though their importance is obvious, I shall say nothing more about them. Instead I wish to say something about the public aspects of the doctor's apostolic function. By this I mean an almost compulsory way of responding to a patient's propositions—a way imposed upon the doctor by his training.

The case-history we are discussing illustrates how automatic the doctor's responses usually are. The first doctor, although he immediately noticed the pathetic unhappiness of his patient, made a very careful physical examination, to the extent of discovering an almost certainly harmless nodule in the thyroid, noted down on his card the results of his physical examination and his very likely irrelevant diagnosis, and prescribed then some aspirin against an illness which he himself queried. All the time he was fully aware of the depression and unhappiness glaring at him, but all these 'psychological symptoms' remained for him beyond the professional pale.

If, instead of having a depressed mien, the patient had been pale, with anaemic lips and mucous membranes, the doctor's response would have been—again quite automatically—absolutely different. Perhaps he would have done a haemoglobin estimation on the spot and then arranged a blood-count. Certainly he would not have hesitated to ask a host of detailed questions about possible sources of blood-loss, such as menorrhagia, haemorrhoids, cough, and vomiting. Not only would he be quite confident in asking this kind of question, but his patient would also find them quite natural and would probably not object to a vaginal or rectal examination if her symptoms pointed to the need.

Thus it appears that doctor and patient are joined by a tacit understanding that any examination of the body should be tolerated if the doctor thinks it

necessary. The patient is indeed already conditioned as to what kind of reception he (or she) may expect; and what otherwise would constitute a serious violation of modesty is acceptable to, or even demanded by, the general public if it is done for medical purposes. History shows, however, that this attitude is fairly young, possibly fifty to sixty years old, and that it is the result of the apostolic function of a few generations of physicians.

With most doctors and patients the situation is utterly different with regard to any psychological examination. As in the case discussed, the doctor is more hesitant, the patient reacts to the examination more openly with emotions, and in turn the doctor is more easily put off. If the doctor had made the standard request to his patient to strip to the waist, and the patient had shown emotion or reluctance, the doctor would hardly have regarded this as sufficient reason for discontinuing his examination. But the difference between examining the body and examining the mind is quite general; it is the heritage of centuries of medical thinking and of our own training; and, consequently, it is not easily changed. On the other hand change is not at all impossible. During the few years of our research seminars most of the general practitioners taking part have acquired in their areas the reputation of minor psychotherapists. Almost all of them have been approached by patients, not always on their lists, who have explicitly asked them to discuss their psychological problems—which means that they were not only willing to undergo, but demanded, a psychological examination. This is further proof of the efficacy and speedy action of the apostolic function.

After this diversion, let us return to our case. As you remember, the patient proposed four different illnesses to her doctor. Has she got four different diseases, independent of one another? Or is one the consequence or the symptom of the others? If so, which is the real cause? Further, if it is impracticable to cure the deepest cause, where is the best prospect for any real therapy?

For instance, was she a genuine depressive, whose constant dark mood and repressed ambivalent hostility the husband could not stand, with the result that in time 'his affections went elsewhere'? Or was she a fairly average woman who unfortunately married a basically unfaithful husband? If so, her unhappiness might be the expression of her insoluble ambivalent love, which possibly has led to a reactive depression. Again, we could regard her vague pains as a kind of conversion symptom, expressing her inability either to bear in forgiving love all the strains or to free herself aggressively from them. Or do both the slight nodule in the thyroid and the vague muscular pains point to some endocrine disturbance, of which both the depression and the sexual unhappiness are possibly secondary symptoms? We might continue indefinitely this kind of speculation about the possible causes and dynamisms of her state.

We must bear in mind, however, that this speculating is not merely a useless pastime, because it is exactly in this way that the doctor comes to decide what to treat, when, and how. The end-result of this half-conscious half-unconscious reconstruction of the patient's dynamic pathology is the basis of the doctor's response to the patient's propositions.

Conditioned by their training, doctors in general choose first among the proposed illnesses a physical one, because they can understand it better, they have learnt more and so they know more about it, and they can express their findings more easily and more precisely. This almost automatic response might—and quite often does—lead to a great number of unnecessary specialist examinations and to prescribing unnecessary medicines.

An opposite danger, however, is that the doctor may be tempted to brush aside all physical symptoms and make a bee-line for what he thinks is the psychological root of the trouble. This kind of diagnosis or therapeutic method means that the doctor tries to take away the symptom from the patient, and at the same time to force him to face up consciously to the painful problem possibly causing it. In other words, the patient is forced to change his limited symptoms back into the severe mental suffering which he tried to avoid by a flight into a more bearable physical suffering.

This kind of psychological *tour-de-force,* which is really a violation of a person's private life, is attempted nowadays much more commonly than ever before. Psychoanalysis in particular has given professional people—doctors, psychologists, social workers—methods previously undreamt of. Many of these people have become sensitive to hitherto neglected munute details, and can arrive at conclusions with increasing accuracy. We call this procedure psychological or psychiatric interview technique and we seem to have inherited from our medical ancestors a not very praiseworthy indifference about it. If our diagnostic conclusions are fairly accurate we do not appear to care greatly how much suffering is caused to the patient by our diagnostic methods. Obviously a specialist, or a psychological tester, can indulge more freely in the *belle indifférence des diagnosticiens* than a general practitioner: the patient is not his; and when the examination is over the patient is referred back. Unfortunately the general practitioner is the last line; the patient is his and he has to see him through. I wonder how many specialists care to find out what the patients say to their family doctors about the specialist's methods and behaviour.

The real risks, however, are even more considerable. Psychoanalysis has taught us not only to observe and interpret minute details correctly, but also to use our skill and knowledge with some assurance, even daring. We psychoanalysts can do so because, first, we have the patient's transference mostly as our ally, and secondly we remain in a most intimate psychological contact with our patient for long periods. Should anything untoward threaten, we are at hand to notice it and to intervene in any emergency. A number of people have acquired considerable diagnostic skill and knowledge by studying psychoanalytic literature assiduously, but they ought to bear in mind that in a short psychiatric

or social interview the conditions are quite different; and I think this difference ought to be respected both by non-analysts and analysts.

It is no exaggeration to say that this kind of diagnostic procedure is, in fact, almost as serious an intervention as a surgical operation. Like a surgical operation it should be undertaken at the right time, by the right man, and in the right way. The person who has in the first instance to decide whether there is a good or fair prospect of satisfying these three conditions is the general practitioner: he can ask for help from his colleagues, but the final decision is always his. In the case of a psychodiagnostic or psychotherapeutic intervention, the situation is still more stringent, because asking for advice psychologically already means the beginning of the intervention. The practitioner is here entirely on his own and he has to bear the whole responsibility of this vital decision. We are only at the beginning of our research on the diagnostic criteria which will enable the doctor to decide 'when to start' with his psychological investigations and therapy, and in which cases.

Obviously this new kind of diagnosis will demand a somewhat different approach to the patient's problems and a somewhat different way of thinking about them. If we are right, it may have far-reaching consequences for general practice—perhaps also for the whole of medical thinking and consequently for medical training.

As a contrast to the first case, I shall quote a second one in which the question of 'when to start' was not raised: patient and doctor drifted along together into a rather difficult situation. In addition this second case illustrates yet another aspect of the doctor's apostolic function. In general it is taken for granted that the doctor ought to do his best to help his patient, to relieve the sufferings—ie, he ought to be a good and helpful doctor. We all know the extreme case of this urge to help, the *furor therapeuticus*, against the dangers of which every experienced medical teacher should and does warn his students. On the other hand, very little has been written about the compelling need of certain patients to have a 'bad', useless, therapeutically impotent doctor. The reason is that there are very few practitioners who can tolerate this rôle, and still fewer who can adapt themselves to it with their eyes open. The overwhelming majority of us, driven by our apostolic zeal, must do everything to impress our patients—and ourselves—that we are helpful, good doctors. These two opposing tendencies— the doctor's need to be helpful and the patient's need to prove that his doctor is no good—usually lead to strain. Our second case-history shows this strain and the somewhat unorthodox means chosen by the doctor to relieve it.

The patient is a man of 58 and has been on the general practitioner's list since May, 1939; but his medical history goes back to 1925—ie, for exactly thirty years, sixteen of which were with his present doctor. During all this time he has never ceased complaining. He has had pains in his rectum which 'make him faint.' Numbness in left leg. Bad headaches 'only relieved by military march on the wireless.' Feels terrible when waiting for trains and buses, becomes giddy when standing about. He knows 'he will never get rid of the giddiness until he is in his box.' Indigestion is 'shocking,' and to prove it some of the interviews with his doctor are punctuated by belches. In addition, shortness of breath, 'nerves,' always blown up, pains in every part of the body, and so on.

Of course he has been seen during the thirty years by innumerable specialists; in fact his notes require a special case. The diagnosis has varied from neurosis, through nervous debility and hypochondriasis, to neurasthenia. Apart from these rather irrelevant and unhelpful tags, the specialists' reports contain only negative findings such as: no carcinoma in the rectum, barium meal and cholecystography negative, and chest clear. I have to add that the psychiatrist's report is in exactly the same vein.

Despite all this, the patient has been able to maintain a good enough relation to his wife; and, although they have no children and intercourse occurs but rarely, his wife describes him as a 'good husband.' Moreover in the past twenty-five years he has only been away from work for two to three weeks, although he has been in a responsible and at times strenuous job as an examiner in a large factory.

The patient must have come to the conclusion, a good many years ago, that doctors can do nothing for him, as no medicine has ever made any difference to his complaints. Still, during all this time he has come almost every Friday evening for a bottle of medicine. Every time he says, 'Nobody can do me any good.' The doctor has learnt to accept his criticism and still to prescribe a new medicine if it is asked for. On occasions he has even taken down the pharmacopoeia, saying, 'I have given you everything in this book and nothing has done you any good; will you choose now what you would like.' Mark you, this was never said in irritation or annoyance, but in a friendly and, although defeated, still sincerely sympathetic tone. By the way, the patient seems to like these scenes; perhaps he accepts them as a sign of confidence in him!

The doctor summed up the situation to our seminar in this way: 'Over the years I have established a relationship with the patient in which I accept that nothing does him any good and commiserate with him; we metaphorically slap each other on the back more or less cheerfully when he attends for his weekly bottle of medicine, which we both agree will not do him any good. He has no resentment towards me, and I am not incompetent because I cannot cure him. In fact I am a good fellow; not like some of those other doctors. He has some pride in his toughness to resist the bad effects of my medicines and tablets and especially in his ability to carry on in spite of the considerable cross he has to bear ('unlike some of the weak-kneed younger men of today'). He is no worry to me. He senses when I want him to go and disappears quickly. If I am busy he comes in and is prepared to leave without much discussion, telling me happily

that 'there is a mob in the waiting-room.' He is on my side, in fact.'

The doctor could have ended his report equally truthfully: 'I am on his side, in fact have been for many years.'

Now this is a case which bristles with puzzling problems. Let us see, then, whether our new ideas are of any use here.

It is obvious that the patient has been offering to his doctor illness after illness. Faithful to his training, the doctor himself patiently examined every offer, and then asked the counsel of his more learned brethren, but had to reject every offer as unacceptable. During this 'unorganised' period, the patient gradually withdrew into the 'you doctors are no good but I can take it because I am tough' attitude. If we accept the year 1925 as the beginning of the 'unorganised' period—very likely it started earlier—the patient was then 28. You remember I asked the rhetorical question of what would have happened to the woman patient if her doctor, instead of asking his hesitant questions, had sent her for physiotherapy? Although admittedly our second patient is far more ill than the woman, his case could be considered as a pointer of the direction the woman's illness might have taken. We may here ask the corresponding question of what would have been the fate of this man if, instead of sending him to specialists and prescribing him bottles and bottles of medicine, someone had asked a few pertinent questions at the right moment. Who knows?

Anyhow, our man settled down and created and grew an impressive illness involving his whole life. Although the superficial symptoms varied and changed, the basic structure of the illness remained the same and became firmer and firmer with the years. One aspect of the illness was to play hell with his practitioner, to rub in time and again that he was no good, absolutely useless. One cannot exclude altogether the possibility that this was partly a revenge for the doctor's rejection of the patient's propositions. Although it is not mentioned in the report, we can well imagine that there were quite a few not very pleasant periods for the doctor. He asked for help from his specialist colleagues, but what he got was only negative advice. That is, he was told what *not* to do, but he got no help whatever on how he could help his patient. I wonder how many of us—whether general practitioners, psychologists, psychiatrists, or social workers—would have remained, under this irritating fire, as calm and imperturbable and as friendly and sympathetic as our doctor. How many of us would have thought of taking down the pharmacopoeia and offering it sincerely to the patient to choose from if the medicine he thinks might help him.

It was this atmosphere of unshakable friendly sympathy that enabled the patient to make his peace with his bad and useless doctor and to accept his company for all the troubled years of illness, pain, and suffering. He has obviously been badly in need of company, and without his doctor he would not have been able to keep fit and maintain a tolerable, or perhaps even a not completely unhappy, private life.

To sum up: in this case all the organic illnesses proposed by the patient were rejected one by one, but the doctor accepted the pain and the suffering and honestly tried at least to relieve them. This counter-proposition of his was in turn rejected by the patient, who—perhaps prompted also by his resentment—wanted to have his doctor bad and impotent. The doctor then agreed to this last proposition—ie, that he cannot relieve the suffering and pain, and agreed also to remain friendly and sympathetic. On these terms a working compromise was established, and patient and doctor settled down to a form of illness acceptable to them both.

* * *

Now imagine that this patient had been on the list of a doctor who—because of his personality—must be a good and helpful man, whose apostolic function compels him to try everything in his power to cure his patients without exeption—or mercy . . .

* * *

I promised to talk about The Doctor, his Patient, and the Illness. But really 'the doctor' should have been in the plural, for in any difficult case specialists are called in to advise. This brings in quite a number of new complications. From now on the patient cannot escape feeling that he has got to deal with the whole medical profession, facing him, a single person, in concerted action. This inevitably stirs up reminiscences of his early life, when, as a single child, he had to face the whole world of adults who tried to educate him in their apostolic functions. It is in this way that the present situation mobilises all the anxieties, animosities, fears and frustrations, blind confidence and dire suspicions, of that early age. This fact explains why so many patients regress to surprisingly childish methods in their relation to their doctor or doctors—eg, to complete subordination, or swearing blindly by the doctor's words; to an almost crazy rebelliousness, ridiculing and belittling anything and everything that the doctor proposes; or to a habit of playing off one doctor against the other. But behind their unrealistic attitude is always the gnawing fear and the abject dependence. They feel that possibly something very important has gone wrong in their body or mind; that they cannot put it right by themselves; but that almost certainly this can be done by outside expert help. With this help they may survive: without it they are doomed.

* * *

We know that during the initial 'unorganised' period of their illnesses, patients gradually withdraw from their environment and first create and then grow the illness on their own, out of themselves. This period is only poorly understood: our psychoanalytic methods do not enable us to follow in detail the patient in his struggle with the growing illness. In this situation there is as yet no second powerful person present, and certainly no external partner on

whom emotions could be transferred and thereby made accessible to our analytic methods. But the situation changes fundamentally when the patient reaches the stage of complaining. Although his illness is usually still unorganised, he now needs, and usually also finds, a partner, a superior one, from whom help can be expected, on whom emotions can be transferred. Here we analysts are more at home and can use our methods with more confidence, and our ideas may be of some use to the general practitioner in his arduous task.

It is equally true, however, that we can also learn from the experiences of the general practitioners; for it is only seldom that we see patients in the unorganised state in which the practitioner first encounters them, and we have mostly avoided getting involved with them at this stage. On the other hand the psychoanalytic process is tantamount to stirring up rigid, settled-in attitudes and forms of reaction, and almost every day we witness and have to work with both kinds of transition—from organised to unorganised and from unorganised to organised states. Expressed in our new terms we find again the patient proposing something to his analyst and the analyst responding to it according to his own apostolic function. Compared with the general practitioner, we analysts are in a better position because we possess a considerable literature which advises us in some detail which parts and aspects of the material produced by our patient should be interpreted, when and how. Despite this important difference, the apostolic function operates automatically—exactly as in the case of the general practitioner. The illness as it develops and changes in the two-person analytic situation is always the result of a compromise, of an interaction, between the analyst and his patient.

To show what I mean by this interaction I wish to quote a historical example:

In Freud's early writings the illnesses most frequently mentioned were hysteria, phobia, and the group he called actual neuroses, foremost amongst them neurasthenia. It was he who detached from that group the obsessions, and in the next period these seem to have dominated the field. In still later years actual neuroses practically disappeared from the literature and almost every case was described either as character neurosis or neurotic character disorder. Nowadays we have learnt to recognise the importance of depressive, paranoid, and other psychotic mechanisms in nearly all our cases.

Does this mean that the patient material itself had changed? In my opinion it means rather that our knowledge of the human mind has changed, has deepened and widened, and that consequently our responses to the patient's propositions and offers are different now from what they were fifty, thirty, or even twenty years ago. A consequence, and a very important one, of this change in our responses, in our apostolic function, is that by them we determine, so to speak, the main spheres of the mind, where the most important parts of the analytic work have to be done. This may explain why analyses today are so different from what they used to be.

analyses today are so different from what they used to be.

I have discussed the need for the general practitioner to respond to his patient's propositions in such a way that the ensuing compromise should focus attention and interest on the proposition which offers the best prospect of therapeutic help. But there is equal need for us psycho-analysts to ask ourselves whether our present responses to our patient's propositions—ie, our present ways of interpreting the material produced by the patient—lead to a compromise which focuses attention, interest, and libido on the proposition which offers the best prospect of therapeutic help.

I know that these ideas throw a heavy and alarming responsibility on all of us—general practitioners, specialists, psychoanalysts alike — but I cannot see how any one of us can avoid shouldering it. And I firmly believe that, by becoming more and more aware of our rôles in the patient/doctor relationship—ie, of our side-effects as drugs—our therapeutic effeciency will grow apace.

POSTSCRIPT

Throughout this address I have used the word 'illness' in the same sense as it is used in general medicine. For example, in the first case discussed, the four conditions were described as illnesses in their own right, although obviously they may influence one another or one may be secondary to the other.

If I am right, psychoanalysis is about to develop a new conception, which may be called 'basic illness' or perhaps 'basic fault' in the biological structure of the individual, involving in varying degrees both his mind and his body. The origin of this basic fault may be traced back to a discrepancy in the early formative years (or possibly months) of the individual between his own needs and the care and nursing available at the relevant times. This creates a state of deficiency whose consequences are only partly reversible. Although the individual may achieve a good, or even very good, adjustment, the vestiges of his early experiences remain and contribute to what is called his constitution, his individuality, or his character make-up both in the psychological and the biological sense. The cause of this early discrepancy may be congenital—ie, the infant's needs may be too exacting—or may be environmental, such as insufficient, careless, haphazard, over-anxious, over-protecting, or only un-understanding care.

Should this theoritical approach prove correct, then all the pathological states of later years, the 'clinical illnesses,' must be considered as symptoms or exacerbations of the 'basic illness,' brought about by the various crises in the development, external and internal, psychological or biological, of the individual. I wish to explain that my address was concerned only with the 'clinical illnesses' of later years and not at all with the 'basic illness.'

Tensions in General Practice

Michael Balint Memorial Lecture given on 26th February 1985

by Cyril H. Gill
General Practitioner, London

It is a great honour for me to address you tonight, and it is also a pleasure to talk to colleagues and friends for a while without the risk of being answered back until afterwards.

It is perhaps strange that we should honour the memory of Michael Balint with a lecture, when he spent his life encouraging us to listen rather than talk, but it is a tonic for a general practitioner to prepare a lecture occasionally, as a break from all the grunting and nodding that we do in the surgery. Also, preparing a lecture encourages a careful look at all my vague ideas and feelings about the general practitioner's work. In a Balint-group we focus on the patient's end of the doctor-patient relationship, but in a lecture I feel I have licence to look more closely at the doctor's tensions as well, and at how these may affect the consultation. So my title is Tensions in General Practise.

It has occurred to me that, like a doctor in a Balint-group, I may at this moment be taking on the role of 'patient' and presenting myself to you as 'doctors' for treatment. However, I thought of this first, and like any good patient I have tried to conceal my own problems behind generalities. Like any patient I have probably failed. So I shall start with a catalogue of doctors' tensions, then go on to expand on some of these, and then discuss how they may affect the consultation, and finally I shall give a few case-histories.

First, one must just mention extraneous individual matters such as our own personal tensions, big and small, practice problems, transient anxieties such as worrying about another patient instead of the one before us, or the thought that we must go and do a 'well baby clinic' shortly, or some equally demanding and difficult task.

We may have a cold or worse illness, or tiredness for some reason. The patient before us may rouse in us quite inappropriate feelings because he reminds us of someone else, or because of prejudices that we do not acknowledge to ourselves. We may have mood swings, or vague feelings of frustration which makes us try too hard, or boredom which stops us listening altogether. I imagine that we all go 'off the boil' at time for such reasons, in our own individual ways. I know I may sometimes spend a whole day with extremely poor attention for extraneous reasons of this kind, and that I may put up barriers to some patients because of them.

Then there are the tensions inherent in the work of the general practitioner.

We need to polish up our knowledge and skills in many directions all our working lives, and we are rightly anxious about our weaknesses. We are therefore sensitive to criticism or insults, real or imaginary, from patients, colleagues and the general public.

We feel rushed and do not like patients to make too many demands on us.

We are anxious to prove that we are real doctors, doing something useful, and the work often gives us less than satisfactory feedback in this respect. This frustration often makes us try harder to do something in the medical model. It is often very difficult for us to stop trying too hard and to let the patient do the work. Patients are keen that we find a decent medical solution too, so we get pushed into medical games which preserve their defences as well as our own.

'My doctor won't listen to me' may well be a true statement, but it often needs the addition 'and I don't want to tell him either'. Since we are sensitive to insults we are also vulnerable to flattery and all the subtle (and crude) blends of flirtation, and manipulation, which makes us give patients what they want rather than what they need. Caught between private demands for sedatives and public censure for over-prescribing, we are forced into the role of stern parent, which may be very useful and necessary, but is not always appropriate, and is often uncomfortable. There are some doctors who deny their own tensions, and they may develop therapeutic zeal or 'apostolic function'. Unable to face their own problems they try to purge their patients of theirs. A doctor who cannot stand muddle may become over keen on flow charts and schedules for patients that will not fit them. He may hand out leaflets which they cannot understand. A campaign to make patients live a healthy life, may be a cover up for the doctor's own unhealthy inclinations, and it will prevent him hearing what the patients want. I think most of us here have more subtle problems than these, but dangers abound.

Occasionally we develop relationships which are more enjoyable than useful. These may involve flirtation or flattery or some unrecognised need of our own. We may over identify with some patients. These dangers are inherent in the intimacy and confidentiality of our work, and they are rightly disturbing to us. More often, the failure to understand the patient's needs may make us cut off. Our efforts may even be reduced to getting rid of him as quickly and decently as we can.

In the surgery we hope to give relaxed attention to the patient before us, but background tensions such as these are always there, either in the

way of what the patient is trying to tell us, or perhaps ready to be activated like resonant circuits, to the patient's own problems, and this makes them more important for our work.

Then there are the tensions of the patient. This of course is what we are there for. These tensions will be presented to us in a fine mixture of display and concealment, with emotional and physical components reflecting each other, and they will be enacted in the interview with us.

In the surgery we must be listening in two ways at once. The patient's vaguely felt symptoms may represent both physical diagnoses and emotional problems. So we must open and shut various diagnostic pigeon holes in our own heads, as it were, and at the same time we must tune in to what the patient may be feeling. Our critics sometimes say that we neglect the physical diagnosis in our search for the emotional problems, but I do not believe this. Listening is all one, body and mind reflect each other so accurately that encouraging the patient to describe his symptoms and the feelings that accompany them can be done simultaneously and actually enhance each other. It is boredom and indifference that is dangerous, and unrecognised feelings in the doctor, whether of rejection or over involvement of some kind.

By the end of the interview we have formulated some sort of diagnostic or therapeutic plan in our traditional rôle as doctor, and we may feel obliged to do something or give the patient something even if it is only reassurance. Throughout the interview our listening process continues, through the examination process as well, encouraging the patient to open up, but giving him the choice of what material to bring up and how to focus it. Confusion is quite useful here, since it encourages the patient to do the work. So we need to be active as doctors, but at the same time reflective and puzzled.

Understanding must arise from the confusion, and the patient must be free to use it in his own way. I do not think we find any problems about functioning in these two ways simultaneously, but letting the patient arrive at an understanding and work with it, is a much less tangible process, and we can never be quite sure what we have done, still less what we may have missed. We need the 'courage of our stupidity'[1] and a necessary tension of uncertainty. A vague hope that we might have started something is more useful than a satisfactory feeling that we have done something, but it is much less satisfying to the doctor of course.

Several fellow members of the Balint Society have shared my surprise at the tensions which arise in general meetings of the society. An invited speaker gets applause at the end of his paper, then in the ensuing discussion one can detect knives being sharpened, until a banner is raised, as it were, saying 'We know all about this, we general practitioners can do it ourselves we don't need others to tell us'. Soon another banner is raised, by older members of the society. 'We know even better than you, because Michael Balint said so and so in 1963'. I think this must imply considerable anxiety about our function and our professional potency. Other occupations have their tensions no doubt, but to respond in 6 minutes to an anxious and demanding and possibly ill patient, in a way that is cheap, efficient, sensitive and rational, is often too much. We know that nobody else could tell us exactly what we should be doing at any particular interview, yet we know too that everybody else thinks they could and are keen to tell us. We must carry a burden of uncertainty and self doubts which is reinforced by the fact that general practitioners as a group are ready targets for criticism from the press as well as specialists. We do not mind too much if the patients do not take the tablets we prescribe, we actually have our doubts about them too, but we do want the patients to trust our judgement, and we get very upset if they go to another doctor behind our backs.

Sandy Bourne in his book *Under the Doctor,*[2] describes his experience in leading a group of physiotherapists. He describes their professional image in a very nice phrase. 'If doctors are clever and nurses kind, then physiotherapists are healthy'. To rephrase that for our purposes. If hospital doctors are clever, and nurses kind, general practitioners are busy. This image, 'the busy GP' may be a defence against our own inefficiency. The fact that we are really are busy makes the defence even better.

When I have my harrassed look in the surgery I hope patients will interpret the hunched shoulders and furrowed brow as a determined effort to respond to their needs as quickly as possible, rather than a puzzled incomprehension of what on earth everybody wants and what I am meant to be doing about it. The paradox here is that unless I go through a period of confusion in an interview, or even a series of interviews, I am probably not doing anything useful, at least as far as the emotional problems are concerned. I know a doctor who makes a point of being calmly omniscient and unperturbed through all the tensions in the surgery. His mind is unclouded by doubts, and he is unlikely to hear what the patient is worrying about. His mind is made up in advance about most things. He is proudly in command in the midst of all the chaos the patients bring him. To parody Kipling: 'If you can keep your head when all around are losing theirs — you have probably missed the point.' There has to be confusion before light dawns, but too much of it is rather uncomfortable.

My partner and I shared our discomfort during a coffee break in a busy surgery recently. We could not blame the patients, nor ourselves of course, it must be the poor National Health Service, starved of resources, which did not give us enough time to do a proper job. We returned fortified to our patients.

Perhaps though, if we had as much time as we needed, we would be even more uncomfortable. I have a nasty thought that I have adapted to the system so well, that the scant time available for each patient now matches my ability to do things for them. As we get older it becomes more difficult to keep up-to-date. The wisdom of experience does not

always plug the holes in our knowledge, try as we may. Yet we feel we are skilled at picking up what is important from the hot moments in the surgery. We congratulate ourselves for not spending too much time and money investigating and treating things that are not important. The pressures upon us make it impossible to do much preventive work, but they force us to be efficient and can excuse our failures at the same time. We can easily get trapped into a circular argument. If we have adapted so well to the system, it must be an excellent system after all.

But we have an uncomfortable image of the great general practitioners of the past. Going out with forceps and chloroform at all hours, keeping careful notes and drawing scientific conclusions from them. No deputising service to do the work, and no trainee to keep them up to date. What is the modern equivalent? There are no clear standards. From Michael and Enid Balint we get no comfortable solutions to the problem of what we should be doing. Instead we get more exciting challenges and possibilites. It is difficult to prove to our critics in the profession that we are doing anything. They do not accept anecdotal evidence, and therefore they do not believe that we are sometimes helping to bring about subtle changes in patients. We are often not too sure of it ourselves. We do not as a rule formulate a clear diagnosis and make therapeutic plans which can be tested scientifically. We tend rather to create an atmosphere of understanding in which something useful may happen. This is far harder to validate to ourselves or our critics. All this leaves us unsure of our strengths and weaknesses. In a Balint-group even experienced doctors denigrate their efforts, knowing all the time that they are excellent doctors really — or so they hope. We are ready targets for criticism by angry patients, journalists, specialists, and experts of all kinds, who need to negate our efforts to enhance their own.

I have been told by a patient: 'My chiropodist says I'm to tell you I need Vitamin B', and even 'My analyst says you are to send me to a migraine clinic'. Many people need to keep the image of the general practitioner as a bumbling moron, and this is naturally disquieting to us, since much of the time we are groping about, rather puzzled about what is going on, and that is what should be happening. If there was general acceptance that our job was difficult, it would be easier for us than the general assumption that we are no good at it. Uneasiness about our status in the patient's eyes will have a profound effect on what happens when the patient comes to enact similar problems of his own, and it is vital that we deal with these feelings well enough to see through them to the patient's problem.

So, we are uneasy about our rôle, our ability, and our status, and lack of time is both a tension in itself and a defence against feelings of inefficiency. Perhaps we are like perpetual adolescents in many ways. Indeed, often in our trainee-group we get a confession of sexual temptation from a doctor, usually a heavily bearded young man in jeans. He gets excellent support from the group. I hope that this experience is enough to reinforce all the group in our sense of duty, and to mobilise our therapeutic concern for the patient, so that any gratifications in the interview may be instantly recognised and subordinated to the patient's needs. However, I get the picture that all of us are swimming about in a very murky sea, with our heads hopefully above water in the air marked 'Therapeutic intentions'. Below the water lie hurt pride, feeling rushed, ignorance, indifference and contempt for patients, and gratifications for the doctor such as sexual pleasure or enjoying power over patients, or getting their approval and gratitude. Amongst all the awful pitfalls below water one should perhaps include 'Doing Good', the last hurdle of the general practitioner on the road to perfection.

It is easy to make the mistake of over-indentifying or sympathising with the patient instead of understanding. Comfort and warmth may be all one can give to some patients and they may well need, but there is the danger of giving comfort when it might be more helpful to the patient to consider his discomfort and learn from it. We must be sure too that it is the patient's need to receive comfort rather than our need to give it, which is guiding us.

Melbourne is supposed to have advised the young Queen Victoria on many things, and is reported to have told her:- "Above all madam, do not try to do any good, for then at least it is less likely that you will do any harm." I feel there is a parallel here for the general practitioner who works out his own needs on his patients. Can we always be sure we are not doing so?

Many years ago Michael Balint said in a group 'You can be an excellent person and a perfectly awful doctor' (I could agree with that) 'and you can be a perfectly awful person and a very good doctor'. I drew in breath to protest at this, but I had not worked out what to say before the discussion had moved on. That was always happening to me, but I still have not quite worked this one out. In some interviews that go wrong, I may be a perfectly awful person and a bad doctor, though I can still sometimes say to myself: 'Ah well, he needed a bad doctor today so that he could blame me'. But can one be an awful person and a good doctor?

Clearly we need to care if patients get better or not, though it is not always clear what getting better may mean. A doctor who is feeling awful towards his patients will presumably not want to understand them, even if he could. But a warm glow of satisfaction is probably almost as much of an impediment. It is probably easier to be a good doctor if we regard with suspicion any sort of good or bad feelings in ourselves. If one asks a new medical student about his aspirations, there are usually clear hints of various emotional drives, such as ridding the world of suffering for some reason. I suspect that some of these drives leave remnants which survive into our consulting rooms. The danger here is that we may feel good about patients who seem to be satisfying our vaguely felt urge to be the good doctor, and we may tend to ignore all the rest. Our sense of duty should be to all our patients, not just those that fit our ideas of the good patient.

A doctor who is sometimes moved by strong feelings such as 'You poor little thing, let me help you', will get landed with many poor little things who will not let him help them, but more importantly, he may not realise that he is turning a deaf ear to other patients who do not fit this image at all. An elderly psychotherapist told me she had been day-dreaming about her own funeral. All her patients were there in an enormous shocked congregation. She told me this with self disgust, and I thought it was very honest of her to share this with me. My workaday gratifications are not quite like that, but I realised how dangerous it is for us general practitioners, with our heavy case load, to pick up only the distress which we want to hear, or think we do, and avoid what may distress us.

It seems to me that general practitioners occasionally get unduly interested in patients whose problems match their own in some way, then they get stuck with them, each acting out their problems endlessly across the safe barrier of the professional relationship. Sometimes the patient has nobody else, sometimes perhaps the doctor has nobody but his patients too. The danger is there, just as much, for those doctors who have never heard of the term hysterical counter-transference, since they can get entangled just as easily without knowing it. We certainly do not need problems of our own to understand those of our patients, but I think we need to be aware of our vulnerable spots where we may be shut off completely from our patient's needs, or perhaps be roused inappropriately and react without understanding. We may also be dragged into an ongoing relationship where we are ostensibly trying to understand the patient, and unconsciously working something out in ourselves.

The dividing line between supportive therapy and *folie á deux* is a thin one. There are some patients, for example, who need a dose of nice kind doctoring occasionally, and may legitimately be supported in this way be a doctor who is aware of what he is doing, and looks for opportunites to help the patient to change. But the doctor who enjoys playing the rôle of nice kind doctor, will probably do so inapporpriately. When the patients rouses us to anger, it may be even more difficult for us to see this in terms of the patient's own anger and needs. Since doctors are people, just like patients, it is not surprising that problems often resonate in the consultation. Michael Balint told us long ago that if we feel something disturbing us in the interview we should look at it. But the more we are disturbed the more difficult this is, and the more important it is.

We general practitioners are not psychoanalysts, holding a clear mirror to our patients, we are in the farmyard, up to the neck in it with out patients, and it is a lucky moment when we can stand back enough to understand something. More often we reach a compromise between our feelings of duty, the patient's cries for help, and our own bewildered reaction to it all. Fortunately the patient usually gives us several chances. There are of course moments of clarity when we understand something without effort, but with me anyway, this is usually preceded by a letting go from the usual doctor's tensions for some reason.

So how can one describe the ideal state of attention in the interview, and how do the doctor's own tensions fit into this? The old adage of hte General Medical Council is not too bad. 'The doctor must behave with proper professional interest and concern.' This implies the two cardinal sins of neglect, and improper, unprofessional interest. I hope we are aiming for something more helpful than avoiding the extremes of culpable neglect or immoral over-involvement, but in a more subtle form these dangers are always there for us, in each interview. We may cut off from the patient, or react with little or no awareness. Rejection or collusion (neglect or impropriety as it were).

Our President in his Pickles lecture used the word 'thoughtfulness' to describe the ideal attitude of the doctor.[3] Dr. Trenkel (see p. 17) and Dr. Sapir both spoke at the 6th International Balint Conference at Montreux about leaving the patient freedom to work at different levels. Enid Balint summed up much of what I am trying to say now. She said we need 'a desire to understand, rather than an ability to sympathise'.[4] We need to contain all the feelings aroused in the interview in ourselves, understand them in terms of the patient's distress, then stand back and let the patient do the work. All these descriptions seem to be on similar lines.

First we must become aware that we are being roused by the patient, then we must be sufficiently detached from our own feelings to understand this in terms of the patient's problems, then we need to avoid the temptation of being too kind or too clever or too anything other than thoughtful and attentive, so that the patient can use the understanding. It is certainly concern rather than just curiosity that we need, but we must somehow leave the patient room to gather his own thoughts and feelings and not swamp him with our own. When we stop trying too hard, something useful may happen.

As each patient walks through the door, our tensions are usually in the form of a mild discomfort. Any therapeutic zeal is usually spread too thinly over each patient to matter very much, but we may well be trying too hard, or uneasy or inattentive for some reason. We may hope for a quick resolution — 'It's just conjunctivitis, doctor', or perhaps we can fit the interview comfortably into the regular pattern for this particular patient. Our discomfort usually deepens as he describes his problems. We long for a nice clear cut pattern to resolve the interview. 'Aha, myxoedema' is a very satisfactory one, it resolves the tensions by letting us do something useful. We must be careful though that this diagnosis does not blind us to other possible diagnoses, or to other things the patient is trying to say. The thought 'Aha, conflicting needs of dependance and independance' may need different handling. It is even more likely to get in the way of what the patient is trying to say, if we give way to the temptation of feeding it back to the patient too soon, as a sample of the skills we are offering, or as a gift to the patient to take home like a prescription. It is often far more useful to leave the interview in a

mess, leading the patient towards discovering such things for himself.

Unfortunately, our own frustrations as doctors may lead us to swamp the patient with our own ideas, so that we feel we are doing something, instead of allowing the patient to respond slowly to our new perception. When we have no clear ideas about what the patient is telling us, we must of course continue to be alert for a physical diagnosis, and the patient may hope we will find one too, as part of his defences. This means that we cannot avoid being dragged into frustrating doctoring activity at the same time as we are trying to understand the patient.

These frustrations must be seen as an indication of the patient's defences, which is not always easy. So often we get dragged into a compromise of repeat prescription or repeat investigation, where doctor and patient play medical games instead of looking at the distress that lies behind them.

I have mentioned a whole range of tensions — time, status. self-doubts, temptations and gratifications both crude and subtle, some so subtle that the seem like virtues (eg. 'My doctor is so kind and clever'). All of these tensions, and of course an infinite range of more personal ones, may be roused in the doctor as a reaction to the patient's presentation of his problems, and will almost certainly be related to them. This may either put us off altogether, or maybe we will react to the feelings roused, in us without recognising their origins in ourselves or the patient. With luck we may be able to understand what it all means and allow the patient to share this and use it, in his own way.

I would like to describe a few cases-histories to illustrate some of these points. Since this is a public lecture I have been careful to conceal both the patient and the doctor by altering a few details in each case. Let me start with a case where the doctor felt his professional status was challenged.

Mr. Pin Stripe was a retired business man, or so he implied. Perhaps he had really been sacked. Anyway he wore a neatly pressed blue suit, though it was getting rather shabby. He usually came in with a forced smile, and declared that he was no better. Then there was usually another new problem as well. The doctor felt challenged by this man. He could never make him better, and he always felt his desk was untidy, and his own fingernails dirty, as the patient came into the room. One day he had a student with him. He liked to explain a little about each patient to the student beforehand, but he found he could say nothing about this patient except that he was demanding and difficult. The doctor introduced patient and student and soon got the two of them talking. To his surprise he noticed that the patient was relaxed and smiling in a genuine way with the student. They were discussing matters of no medical importance, and the student could give him nothing except his interest. Suddenly he realised that this patient was not expecting to be cured of anything at all. His neatness was perhaps more an attempt to identify with the doctor than to challenge him. His complaints too were respectable symptoms of the despair which he was reluctant to face. He was a sad, lonely widower, whose respectable, somewhat obsessional defences had got the doctor in a sensitive spot so that he felt devalued as a doctor. The aggression in the interviews had mounted, but it had been contained between them in a useless game of doctor and patient.

Since then, though the patient still comes with physical complaints, they do not fill the interview, and he sometimes complains a little of his isolation and even shows a little feeling in the process. The doctor tries to encourage this. He no longer feels so bad about this patient, the anger has subsided. Perhaps the patient feels a little better too. This is no grand success story. There is no marvellous intervention and cure. Like the majority of people he is no candidate for any sophisticated intervention, he finds it hard to make the simplest of links between his symptoms and his feelings, but one can only guess that the slight shift in his relationship to his doctor, a relationship which is clearly important, may help him in other relationships, or may allow some further changes in future.

Sometimes it seems as though all our years in medical school, and all our training in groups, has equipped us just for this. A slight shift towards honesty in the average ongoing case that makes up so much of our daily grind. It is difficult to evaluate, easy to denigrate or over-value. Is it all worth while? The answer must be a resounding 'Well perhaps, sometimes', or a definite 'may be', and we must put up with that. There are some cases with a clearer outcome of course, though they are apt to seem less clear when we look carefully at what has happened. I suspect that our best work often consists of a nudge of some kind, that turns out to be important, but neither doctor nor patient may have been fully aware of it at the time. The next case-history illustrates this, and it has a sexual content too.

The patient was an attractive girl, new to the practice, who gave the doctor details almost in a whisper. Eventually, the doctor asked 'What can I do for you today?'. She made a strange gesture, dropping her head forwards and flicking her hair up to reveal the nape of her neck, which had patches of psoriasis on it. This was apparently all she had come about, and she said she had no other patches just now, though they came elsewhere at times. The doctor knew nothing else about her, but he was struck by the dramatic gesture to reveal her neck, which was not too badly disfigured, and her evident distress. He felt she was enacting something very important, but it was not clear what. Should he ask her more questions? She had not responded very well to the simplest of factual questions when she first came in, and he hesitated.

Could it be that the psoriasis was a disaster in her eyes? Did she feel her faults outweighed her virtues in other respects? He felt somehow it was all there if only he could say the right thing. Anyway she was a pretty girl. He would not be put off by a few scaly patches on her neck, gosh no. Overcoming such lecherous thoughts he attempted to put this to her. 'Does this rash bother you very much?' He got no tanglible answer. He made one or two other

hesitant efforts on the same lines. 'I expect this feels worse to you than it looks to me.' She remained glowering and inscrutable, and he felt he had better extricate himself at once. He prescribed an ointment. She did not return for several months, then she surprised the doctor by hurrying into the surgery with the remark: 'I must get this right, what did you mean last time?' The doctor was startled. He had written the interview off as a failure and recorded only the ointment, but he then remembered the whole interview only too clearly. In fact he had been somewhere near the target. She had interpreted his remarks as a dismissal. 'Why are you bothering me with this trivial, ugly complaint, you aren't worth worrying about.' Yet she had felt at the same time that this was not so, and he had perhaps been trying to say something helpful to her. Most people, doctors as well as boyfriends, either flirted with her or dismissed her as 'stupid', and she was desperately needing help in this area after yet another break-up with a boyfriend. She had unconsciously set up the doctor to prove herself once again that men are no good, or perhaps to find one that actually cared about her. You can guess the background problems that emerged, and the further hysterical behaviour too. Yet some useful work was done. This was initiated from the first interview, where the doctor was aware that she was attractive. He neither suppressed this nor flirted with her, but tried to fit his feelings into the puzzling picture that she presented, and she was able to respond to his sincerity and concern. It was in fact a safe model for the sincerity and concern which she was unable to allow men to give to her.

Patients are aware of the fact that we are usually in a hurry, and this often gets woven into their problems. It surfaces in such remarks as. 'I don't want to waste your time doctor, you have so many important patients to attent to', or 'You know me doctor, I would never waste your time unless it was really necessary', or 'To cut a long story short . . .' In such remarks the ambivalence is clear, and the implication is usually 'You have had that last patient in here too long, now it's my turn'. Sometimes though, our sense of hurry has an important relationship to the problem the patient is bringing to us.

An old lady came with many complaints, written on a list which she kept losing in her handbag. Her complaints were imponderable, and whenever she found the list again she started at the beginning. The doctor became increasingly impatient, and at last he leant forwards and tried to take the list from her, to take charge of the interview. This flustered her even more, and she looked so miserable that the doctor was brought to his senses and apologised for rushing her. This brought an apology from her in return. 'My daughter gets so annoyed with me sometimes, I get in such a muddle these days'. She went on with the list, with items like 'eyes', 'teeth', 'lips'. (Lips — now what was that. Oh, no, I think it's hips really doctor. Now what was I going to say about them?' But they are disposed of these items fairly quickly. Most of them had already been treated as far as possible anyway, but these problems were now seen by both of them as part of the burden of old age, and they ended the interview by sharing her despair at being old and useless. In this case the patient did not like to acknowledge her slowness and confusion, and presented instead an impossible list of symptoms. In doing so, she displayed the very slowness and confusion which she was ambivalently trying to conceal, which exasperated the doctor. I'm afraid there are much such interviews where we fail to get the breakthrough that occurred here, but it is likely that the patient will return and give us another chance. A slight change in the doctor's attitude from exasperation towards understanding and acceptance, may help such patients to accept marginally better what cannot be changed.

Finally, here is a case where the patient's problems seemed to rouse the doctor in several directions, and between them they just managed to make it therapeutic. One young woman was well known to her doctor. She was always calm and capable, but she had an unsatisfactory marriage. Her father had been violent and alcoholic. She escaped from home early and married a man who seemed gentle and sober. But when he lost his job he became depressed, while she remained calm and capable as usual, until eventually he became violent and alcoholic, just like her father after all. A common story, and a glib summary of what patient and doctor had already shared. He liked her, though she was perhaps rather too icy.

Then she had a spontaneous pneumothorax, and after a few months a second one. For non-medicals I should explain that this is a sudden puncture in a defective air sac at the surface of the lung, which may collapse to some extent, like a punctured balloon, allowing air to escape into the space around it, inside the ribcage. This is painful and a medical emergency. The doctor sent her into hospital each time. In the second episode they sprayed an irritant substance into the chest cavity which is supposed to glue the expanded lung to the rib cage. This was painful. She was anxious about recurrence afterwards.

Some weeks later she reappeared at the doctor's surgery with a brief discharge note from another hospital. Her employer had sent her privately to doctors elsewhere who had done a more thorough operation. The doctor was annoyed at this and asked why he had not been consulted. She went through the motions of apologising, but remained her usual placid self. This roused the doctor further, but by now she had undressed and shown him an enormous scar round her chest, which disarmed him, and also he was intrigued once again by her calmness. After examining her, he commented on this calm reaction to his own outburst and said, 'I suppose you have had plenty of practice at this, with your husband's outbursts'. She agreed that she was well practiced in keeping her own feelings under control. He had been wondering how it was that she made her employer get her chest gashed open while she had reduced her normally calm and sober doctor to anger, and then disarmed him so effectively. Why was this woman so provoking. He wondered if her

mother was like this too perhaps? He could understand how the husband took to drinking too much — and father too. But she was on another tack completely as a result of the doctor's remarks. She said that she had just realised that each time she had punctured her lung, their marriage had been in a severe crisis: her husband had been threatening her and she though of leaving him. Each time this had culminated in pneumothorax. It semed to her that this was not so much a hysterical escape into a caring hospital situation, but rather a release of pent up emotion which could not be expressed directly.

Here is another source of tension for the general practitioner. How on earth could pent up emotion blow a hole in the lung? Our surgical colleagues and indeed many other people would consider such ideas nonsensical. Yet patients are always finding such explanations for things in the surgery, and I usually believe them. Are they true? Oddly enough it doesn't much matter if they are not. This patient thought she had made an important discovery about herself, and she subsequently made attempts to understand herself and her marriage at greater intensity. The doctor had been able to help because he had got to know her very well from similar brief interviews in the past, both with her and her husband. On this occasion he had been able to stand back from his own annoyance, see its importance, and say 'look what is happening between us'. This had enabled her to arrive at a different but important understanding of herself, her husband, and her recent illness.

Michael and Enid Balint have brought to general practice an understanding of what goes on in our patients' lives, and how this may be reflected in what goes on in our surgeries. Closely related to this, they have brought us a technique of learning in small groups.

In the group we are at the meeting point of two giant disciplines, medicine and psychoanalysis. It is not surprising we have problems. Some of the tensions I have been discussing, relate very much to this, and one can see them reflected in the history of Balint-groups. We have attempted to use the medical model with such terms as 'overall diagnosis', 'therapeutic aims', 'the dosage of the doctor'. We have attempted to use the psychotherapeutic model by taking patients out of the regular routine of general practice for long interviews. Neither of these patterns quite fits our work. In the group that looked at the 'Six minute' interview, we probably over-valued what we called 'The Flash', that is, those sudden moments of mutual understanding shared by doctor and patient.[5] We were searching rather frantically for good work. At the same time, another group was looking at Repeat Prescriptions. This was an honest look at what so often happens in general practice. That is, a more or less dishonest or collusive compromise relationship between a bewildered doctor and a demanding patient.[6]

One group was acknowledging our worst failures, while another group was frantically sifting our work for success. One can detect again the anxious ambivalence about our rôle as general practitioners.

Recently a group met for a while under Enid's leadership, looking at important moments of change in relationships between doctor and patient. The results were very inconclusive of course, but in the four cases I have just described, something happened which enabled the doctor to see past his own reactions and find a simple answer to the simple question 'What's going on here?' When this increases the understanding already established in the surgery, it may bring about an advance in the relationship, and the patient may be able to use it.

Perhaps this is as much as we should expect of ourselves in the surgery. To work towards honesty and understanding with our patients, and leave them to use it if they can. When we can see through some of our tensions, our patients may be able to see through some of theirs.

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The Basis, Specificity and Perspectives of Balint-Work*

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Introduction

When the time came for me to choose a title for the introductory paper to this conference, I accepted the request of my friends on the Organizing Committee to describe the fundamental principles of Balint-work and the perspectives it holds out for us today. My colleagues felt that the most successful way to tackle the subject was to draw as far as possible on my own experience, and to draw conclusions from it.

I must say that I felt most attracted to the subject matter since in fulfilling my task I would be forced to formulate my opinions and the priorities that they entailed in words, or at least to make an attempt to do so. The suggestion made to me seemed all the more relevant in connection with the theme of our conference, since in my opinion the *leitmotif* of our work is the change that occurs in the doctor himself, and what he can learn from it. I am convinced that our work also has a modifying effect on group-leaders.

I do not intend to talk about the basis, the specificity and the perspectives of Balint-work from the expert's standpoint, but rather from that of a doctor who has participated in this work and who, as a result, has witnessed a change in his own way of being a doctor — the considerable though limited change in the doctor's personality, along the lines suggested by Balint, which has sparked off in me a development to which there seems to be at present no end.[1]

When I started to structure my ideas on the subject, it soon became apparent that all attempts to get to the very core of the matter, even from a less subjective view, automatically led me to the change that takes place within the doctor. Both the *basis* and the *specificity,* not to mention the more far-reaching *perspectives,* of Balint-work seemed to me in the final analysis to be the aspects of the effects of the event of central importance: the change that takes place within the doctor. I suddenly saw the three topics mentioned in the title of my paper as three different well-shafts, all leading down to the same source, namely to the importance of the doctor as a person in relationship to his profession.

You will no doubt be thinking that after 30 years' experience with Balint-methods there is little need to organise an international conference to reach this conclusion. Yet I am not certain whether it must mean that I am boring and old-fashioned simply because I have the courage to take the rediscovery of myself seriously. It may be that the courage I have shown actually belongs to the realm of 'the courage of one's own stupidity'; but still this would not deter me from pressing ahead. On the contrary, it is my belief that Balint's phrase, which I have just quoted, hits the nail firmly on the head by providing us with the most direct path of access to the core of the matter, and indeed to the difficulty which prevents us from reaching that core.[1]. I understand the phrase, 'the courage of one's own stupidity', as a coded key which in the form of a 'bon mot' incites us to redefine ourselves — an invitation which, upon closer inspection, is certainly not as trivial and harmless as it first appears. This witty phrase does in fact contain an encouragement for the doctor to be himself in everything that he chooses to do or not to do in his professional capacity.

The Basis

The *'courage of one's own stupidity'* could be placed at the very beginning of what we refer to as the 'basis' of Balint-work. It defines the first step towards the 'process of liberation and general relaxation' of the doctor and thus towards a personal change. While Michael and Enid Balint were concerned with researching the psychological dimensions of general medicine with the help of practising doctors and, in the process, with discovering realistic ways which could be used for training in psychotherapy, they were convinced from the very outset that their work could only be meaningful if it focussed on the doctor as a person, i.e. someone with his own ways of perceiving and observing things, and not just on the knowledge and skill that someone had acquired. It was this aspect that marked a new departure for the experiment, and even today it still remains the fundamental basis for our group-work.

For both the Balints it was clear, moreover, that day-to-day practice contained other elements which could not be comprehended by preconceived theories which only worked on single levels. What lies at the basis of our work is, in my opinion, the recognition of, and importance attached to, this open sphere of experience provided by real practice. One of the things this means is that the doctor does not have to provoke everything that happens in this sphere himself. It is not, nor was it ever a question of acquiring additional knowledge in the field of psychology, psychiatry or even psychoanalysis, and then applying that knowledge empirically, but more importantly it is a way of sharpening one's own understanding of events and processes which, although always occurring within these different activities, trigger off other effects because of the very fact that we perceive them and take them seriously.

The starting point for Balint-work is thus *medical practice exactly as it is experienced,* ie,

* Paper read at the Sixth International Balint Conference at Montreux, 1984.

practice, as it is; patients and doctors, as they are, and the way they react to one another. The material on which we work is not theory or generalization, nor is it something abstract which takes on a more tangible aspect through practical application; we work with the living element from the start, or to borrow a metaphor, we are wet even before we get into the water.

What I am saying here may well sound banal, but I am trying to explain something which in my view is one of the most important characteristics of Balint-work. During undergraduate training and postgraduate training, all the new elements we learn are served to us on a platter, that is to say as a well-ordered system of procedures with a theoretical basis that has been tested empirically and an almost rigid set of instructions. Not only are the operating instructions included with the system, but also the correct approach to be adopted, ie, a binding set of attitudes to be applied even before seeing a patient. The opposite is true of Balint-work. No preconceived ideas are provided on the only correct approach which is then justified with reference to experiments or general consensus among practitioners. There can, therefore, be no preconceived course with a pre-determined structure and a clearly defined goal. We always start from the same point, that is in the heart of professional activity, whenever we have a patient in front of us, and are unable to say in advance how he will arouse our interest, and to what extent he is a typical case.

In traditional teaching methods a case serves to illustrate how an abstract idea appears in reality. What the Balint-group does, on the other hand, is to illustrate what is specific to, and special about the history of the individual in sickness and in health, in his relationship with himself and with others, and it seeks to determine those aspects of reality to which access can be gained through his relationship with the doctor. It does not provide a standardized approach but rather encourages the doctor to use his own powers of perception — in the broadcast sense of the term — and to develop these through constant practice so that they can become a reliable working tool. It was this idea that marked a new and unfamiliar departure, and the only way one can feel fully at ease with it is to have the courage not only to develop an attentive ear to one's own perceptions, but also to explain those perceptions to others.

All this is part, I feel, of what is meant by 'the courage of one's own stupidity'. It is, as I have said, the first step towards that change in ourselves, and even this first step will no doubt be experienced by each person in his own individual way. It is a virtual certainty that all subsequent steps until the final change occurs in the doctor, will be highly personalised.

My own experience was not the original one, nor can it be said to be the usual or even the typical one, since I was neither part of the pioneer group in England nor have I actually worked in a Balint-group as a participant. I was introduced to this work almost 20 years ago in Sils-Maria where Michael and Enid Balint were once again attending a study workshop organised by the Swiss Society for Psychosomatic Medicine in order to present their group method to us. I was thrown, like many other Swiss colleagues, in at the deep end by being made to lead a small group although this was the first time I had ever done anything of the kind and I had no practical experience whatever.

But Michael Balint also went into uncharted waters, since he led a large group which for him was a new experience. We were thus given an opportunity to discover his working methods *in vivo* as it were. Attending the sessions in the large group we learned what it meant to take a particular case, have it presented, and to bring it to life by asking the participants to let their free associations come into play. We saw that this liveliness infected the listeners, both stimulating and exciting them. The atmosphere was one which we were not at all accustomed to seeing in other meetings and conferences, with the result that Michael Balint appeared at first to be something of a magician.

However, the secret of the effect he had produced was not as impenetrable upon closer inspection; it lay essentially in *his* courage not to resort to any technical jargon and to spur the participants on continually to express themselves in down-to-earth language, keeping it as authentic as possible. I often felt embarassed, indeed even annoyed, that Balint would often interrupt someone who had used a technical expression, no matter how to the point and appropriate, asking the person what he actually meant when he used the words 'depressive', 'hysterical', 'schizoid', 'narcissistic', etc. These questions prompted the speaker to delve deeply into his own experience thus affording him insight into the very great discrepancy between his own perceptions and the reactions that had been acquired from others. At the same time it became possible to discover the feeling and emotions, especially the 'anxieties', which lay at the threshold between that which was interiorized and that which was exteriorized, ie, between the subjective perception and the attempt to express it to others in an understandable manner. Furthermore, we discovered the importance of having an interested and open audience in this process.

Perhaps the first experiences one gains with Balint-work, with all due respect to the bias of each individual, are not so different to the extent that nobody escapes the obligation of looking deeply into themselves and discovering their own possibilities, irrespective of whether they begin as a participant or as a group-leader. I have already pointed out that for me *this way of beginning* represents an essential part of the whole approach; it is not, nor should it be seen solely within the historical framework and simply accepted 'for want of anything better' just because no structured teaching and training course is available for every new system which is developed. I think that trying to turn Balint-work into a teaching programme would be to rob it of its essential spontaneity; it is rooted solely in the practical experience of the doctor and can be developed through an open dialogue about this experience.

The *dialogue,* which always has to begin anew within the group and each time has a direct relationship with the content, is also one of the determining characteristics of Balint-work. In the group discussions, which are so often repeated and yet never the same, there is a lot of material one discovers and experiences for the very first time which can then shed new light on the dialogue between doctor and patient, thus rendering that dialogue all the more useful. The most important ingredient is a relaxed and playful (in the positive sense of the word) atmosphere, one that is marked by openness and an absence of preconceived ideas allowing enough room for unexpected insights and chance occurrences to surface. Within this atmosphere one can actually watch the interactions and interplay between the different centres of experience, seeing how ideas generate other ideas, how they are taken up or simply passed over, and how, finally, the threads come together forming a kind of consensus, leaving nevertheless much still hanging loosely in the air. Listening to one another, talking to one another, perceiving one another, taking seriously the comments of the others, confronting one another without any enduring enmity, stopping for a moment of silence — all this and more will be experienced and practised in the group, it being clear to everybody that imperfection is part of our reality.

As far as the reporting doctor is concerned, I no longer think that chance can be at work when he shows the doctor/patient relationship as having been drastically changed as a result of the discussions within the group. I am convinced that the group-discussions usually ease the relationship and that the associative ideas of the group-members cause it to move, thereby lending it a new dimension. Group-discussions often led the doctor to gain access to the patient from a different angle, which implies a change in the internal distance. The decisive element here, it seems to me, is the atmosphere in its most literal sense, ie, a space where everyone can breathe, where there is room for selection and rejection and therefore for change. *A space which is not already obstructed in advance,* a *'terrain vague'* (wasteland) to use Pierre Bernachon's phrase, is an equally important basis of our work.[2]

Today's doctor tends to be so caught up in rôle-playing and other constraints, that he no longer knows what it is like to have this room for manoeuvre in his professional activity. At best he searches for and finds it somewhere completely different, for example on holiday, so that it always remains divorced from his everyday professional life. It is so far removed from what he is accustomed to in his professional world that it can at most influence it only marginally.

Specificity

Balint-work has its source within the professional world itself; it does not essentially aim to change the personality of an individual who just happens to be a doctor, but rather to change the way the doctor is a doctor. In this it differs quite considerably from the majority of models which seek to offer the doctor a given therapy, and from the traditional patterns of further training in the medical field. It is neither therapy nor further training in the usual sense of the term, rather it is a form of training which affects the way the doctor practises medicine and can thus pave the way for a change in therapeutic methods.

This is where I think that the specificity of the method lies; it has its own originality and is not merely the application of techniques that have been developed elsewhere in other experimental fields. Of course the entire psychoanalytical background does play an important rôle — to my mind principally the sum of the leader's experiences which he obviously carries with him and brings into play. In this respect Balint was himself an impressive example. There is no doubt that he was a very competent psychoanalyst, but this did not prevent him from maintaining an open curiosity and an unbiased attitude which theoretical dogmas and rigid rules were never allowed to imprison. Although he himself worked on theoretical concepts, which he was primarily interested in was the dyadic situation of the analytical process and, more particularly, the rôle played by the therapist in this process. To my mind it was the same Balint who tried to shape his perceptions as a psychoanalyst and who developed an analogous interest in the experiences of the general practitioner.

As far as the dyadic situation is concerned, Michael Balint was in both cases looking for a basic human reality which he then tried to express in psychological terms. The two-person perspective undoubtedly takes place on a perceptual level of its own that is difficult to pinpoint and to grasp. Balint-work has opened up new paths for medicine which at first we hesitate to follow; for me, the first step is that change in ourselves which allows us to use our own experience as a perceptual organ.

I find that Heidegger's term 'the step backwards' describes such a change most aptly.[3] In this connection it means that the doctor has the courage first to face his own human reality and from there to develop a new approach to his patients, their illnesses, to medicine as a system and as an institution, and to himself as a doctor. This 'step backwards' which the Balint-group expects of us, and is confident we can achieve, is in my opinion more than just a change of attitude. It is the beginning of a process which concerns our entire being, not just our thoughts, opinions and beliefs. It is rather a step towards what Winnicott refers to as the 'true self'.[4] I do not imagine this to be a state of being which is fully accessible, or which one might describe, or even define in such a way as to have general validity; it is a subjective area of self-perception and self-experience which every child is aware of in its own way, but which only partly flows into communication with others. We all naturally understand this reality, but because we can only gain access to it through experiencing it consciously, and because we find it extremely difficult to express in scientific terms, we tend by and large to forget it.

If we allow ourselves to take this 'step backwards', we distance ourselves from the attitudes we have acquired and from a shortsighted adherence to what is tangible and can be objectively described, since seen from this angle nothing else is real. We gain space for ourselves and flexibility vis-a-vis the codified knowledge of our times, be it scientific or psychological. Distancing ourselves from and relativizing acquired knowledge does not imply an escape into some paramedical sphere, but rather a frame of mind which would be completely natural if only we had not been trapped in the net we have woven around ourselves.

Today I am rather inclined to think that this is precisely what Balint meant when he spoke of the 'limited but essential change' of the doctor through the group, a phrase which has been much quoted. I have given a great deal of thought to the meaning of the word 'limited' as used here by Balint. How and where does the change in the doctor remain limited? Is the limitation referred to here a necessary evil or perhaps a decisive characteristic of the change? Today I would tend to opt for the latter explanation, and I shall attempt to explain why.

When I refer my 'step backwards' ie, the process of distancing myself and trying to come naturally face to face with what is opposite me, not only to the mass of our acquired knowledge with all its institutions and implied constraints, but also to the fundamental dyadic situation described by Balint, then it is certainly necessary for me to set a limit to the distance I create and not withdraw too far. My withdrawal is not intended as an escape from the relationship, but is on the contrary a way of creating it and making it worthwhile through this face-to-face with my interlocutor. The 'step backwards' into the core of my inner being, where I am myself, releases my interlocutor — in the doctor's surgery this is the patient — into his own world. Only by giving him space, distance and room for manoeuvre, do I allow him to perceive himself in his relationship to me. The type of relationship thus established is not characterized from the start as subject versus object but permits reciprocity within the intersubjective sphere, ie, within the area of the perception of the ego and the self. This relationship is both original and real; what we in psychoanalysis refer to as transferral and counter-transferral can also come into play, and usually does so, although it does not cover the entire spectrum of the dyadic situation from the start.

By learning during the time we are with out patients, to use the ability which we exercise in the group, namely the ability to be in tune with ourselves and our own emotions, feelings and fantasies, while we listen to our interlocutor, we change the relational form quite considerably. Where formerly the channels of communication had been characterized by the rôles played by both sides and were limited to the matter at hand, they now open up a new dimension in the personal sphere allowing the participants to perceive themselves as two human beings facing one another. As a result, communication assumes the quality of a dialogue, ie, a recoprocal exchange in several dimensions or 'languages', but not just the verbal form. Michael Balint termed this extended and open communication 'listening at another level', and he expressed his conviction that decisive therapeutic processes took place in this intermediate sphere.

The interactions between the members of the group, which I have tried to describe above and which instill life into the group like a stream of turbulent air, acquire a tangible and serious meaning: they open up this 'other level' and allow the doctor to gain a deep-rooted understanding of it. The group thus acts as a *'terrain vague'* or, if one prefers, a transitional world where the doctor can learn in an endless ebb and flow to abandon and then to take up anew his relationship with his patient; it represents a laboratory where one can test out this 'other level' and engage in an open dialogue. The more confidently the doctor can explore this area and truly appreciate its reality and its effects, the easier he will find it to attain that level when he is with his patient and to make use of it. In this manner he can learn to use the dialogue at this other level for diagnostic and therapeutic purposes, and may develop a perception and an intuition for this sphere which are bound to become more acute as time goes on.

We have now reached what I consider to be the gate to the specificity of Balint-work, for this open dialogue which goes beyond stereotyped rôle-behaviour and steers clear of the well-trodden paths of generalities, leads us into an area where each one of us goes his own way, and indeed must go his own way. One can now gain access to the specific, the individual, the subjective, but again this access itself is of a special nature in that it is individual and subjective, or rather intersubjective. The group's questions do not seek out all that is striking and personal in the doctor/patient relationship simply so as to be able to place those elements into predetermined categories, but rather an attempt is made to analyze what the doctor has heard during the consultation. What is important in this respect — and here in my view lies the most specific aspect of this approach — is that all that is communicated by the patient, including all the personal and subjective elements however they may be ascertained, are not simply removed from him but, on the contrary, are given back to the patient as his own.

The thrust of my argument is that we have been forced through our Balint-work to completely reappraise our basic attitudes. For me the paradigm of this reappraisal remains the 'flash',[5] that sudden relational phenomenon which one can neither actively plan nor create; the only thing that can be done is simply to observe and use it whenever it appears. What we are dealing with is an event beyond the control of our conscious powers — which explains why I have never really liked the idea of a flash technique. The 'flash' happens at a moment of its own choosing, and what it does and what it changes are equally unpredictable and, at first, only comprehensible through one's experiencing it. But it is precisely this characteristic which makes it a paradigm for the reappraisal of our premises.

It is only when we achieve this reappraisal that we can see what is so specific about Balint-work. Of course we begin to scrutinize our basic ideas even before we develop an interest in the 'flash'; that moment comes when we realise that we can learn much more by listening to our patients than by questioning them. Our changed attitudes show through in our interest in, and greater perception of what we see and what happens. What we should be attempting to do is not to introduce into general medical practice something akin to a good psychiatric interview — as Balint originally thought — nor are we so much concerned with 'long discussions', focal therapy or any other psychotherapeutic technique. Through the reappraisal of our original premisses we learn the importance of a new perspective which we can only attain in practice and which we consider today as the most adequate form of 'psychotherapy' for the practitioner.

It is both more and less than other psychotherapeutic 'techniques'. There is a qualitative difference in that we wish to provide our patients with a vis-a-vis who can respond to them. This vis-a-vis never seeks to squeeze secrets out of the patient, but knows the virtue of waiting and the importance of allowing the other to choose. It can also be surprised by others and allow that surprise to show.

Perspectives

I should now like to address myself to the perspectives of Balint-work. I hope to have made it clear that I cannot endorse the idea that the Balint perspective is to be seen as an *'unité de doctrine'*. In the final analysis, it is up to each doctor to learn how to develop and to use his own insight, and it is this perspective, which is specific to each individual, that Balint-work tries to convey. And yet we should attempt to describe this individuality so that we can conceive it as a different type of cognitive approach which is accessible to any doctor.

Over the last few years we have grown accustomed to calling this particular and individual path of access to the patient the relational perspective, and to contrast this cognitive approach to practice with our usual 'objective, scientific view' of things. When we studied medicine we were so trained to think in these patterns that it became almost impossible for us to see just how our desire to consider our patients as objects had caused us to lose our bearings and to develop this wretched one-sided vision of humanity. We did not see how presumptuous it was of us to try and adapt our ideas of ourselves as doctors to this vision.

In the 20th century, psychoanalysis and all the therapies which it has inspired have brought fresh ideas and greater complexity to the medical profession. As far as political medicine is concerned, I believe it is Balint-work that has opened up our horizons. It is through it that we learn to see the health and sickness of the individual, not just as part of an impersonal cross-section; we re-learn to use the words 'healthy' and 'sick' as adjectives which apply to human beings, ie, the qualities of an individual at a given moment in time. *Homo sapiens* turns out to be more than just a zoological being with a psychology and sociology typical of his species, more than just a *res extensa,* even where his illnesses are concerned.

Of course, doctors have always known that considering their patients as objects in the name of science was not a wholly satisfactory approach, and so they had to rely on what one human being can perceive of another one. What Balint-work seeks to do is merely to shed a bit more light on this automatic response and, at the same time, to make it possible for doctors to use this ability and to develop it in their own special way. The relational cognitive perspective thus becomes a specific tool to be used in day-to-day medical practice; it is not psychiatry, psychology or even psychotherapy for the non-specialist. It is totally practice-orientated and hardly lends itself to the traditional type of research. Even the standard vocabulary used by the researcher proves unwieldy when it comes to expressing relational discoveries, which explains why we have such difficulty in trying to describe unusual insights in the language that is familiar to us.

Unusual insights are afforded, for example, the traditional — and therefore institutionalized — distinction that is made between psychological and organic disorders, ie, between the psychogenic and the somatogenic causes of an illness. In the traditional approach, the doctor's questioning must always steer towards a 'yes' or 'no' answer. In other words, he only thinks of the psychological aspects and dimensions when there is no identifiable organic evidence. If he does detect a physical pathological deviation, then for him the illness must lie in that deviation alone. Any other attendant symptoms are deemed irrelevant.

Things are quite different from the relational perspective. Here the doctor is always confronted with the same personality, irrespective of whether this takes the form of a bodily symptom, a state of excitement, breathing difficulties or a depressive mood. From the relational point of view, the doctor is able to concern himself with all the elements of his patient's complaint just as they are presented to him; in other words, he can think simultaneously of a somatic disorder and a psychological one. If his patient prefers to take up the dialogue in a particular register, then he may answer him in that same register, just as he can switch communication levels according to needs. He will also be able to listen to what his patient has to say while he conducts an abdominal examination; if a patient loses his voice, the doctor can concentrate immediately on the specific interactions rather than looking first for an explanation in the larynx and then trying to determine scientifically what is happening in the patient's psyche. But things do not stop there: from the relational perspective, even clearly objective findings, be they of somatic or psychological origin, can also contain a piece of communicative information. For example, vaginal bleeding can be indicative of something other than just a change in the condition of the endometrium; a sudden stupor

or a state of semi-consciousness can be more than just a symptom of a given disease. We have become aware of this through Balint-work and it seems to me that we have learned to focus our attention on two aspects which are relevant to the whole of medicine: first, in our Western culture most of our emotional sufferings cannot be expressed verbally and so appear in what we term a somatic form; second, there is no doubt that a review of our entire scientific psyche/soma model is long overdue since it is no longer able to cope with the reality of our day-to-day practice.

An understanding of these two aspects can only be obtained in practice. This makes it necessary, in my view, for practitioners who have learned to work with the relational perspective to express what new insights they have gained and to promote the appropriate practice-oriented *research*.

Prospects for the Future

I should now like to come back to the change in the doctor and to suggest a rather audacious prospect for the future. I have already tried to explain that, to my way of thinking, it is above all our desire to create an open relationship, a space where nothing is determined in advance, that is the decisive principle of Balint-work. This allows a change to take place within the doctor, who in turn feels that he has become more flexible and open. Such new-found flexibility in his relationship with himself and with his patients will make it possible for the doctor to work on a one-to-one basis at 'the other level' which, once integrated into daily practice, opens up the relational perspective. As a result, the doctor will develop a much deeper understanding not only of the human psyche, but also of the body in all its complex ramifications.

Michael Sapir referred to this special aspect of the relational perspective in his ideas on the *'corps-a-corps'*. What he wrote at the time about the subject drew my attention to the fact that 'relational' and 'psyche' are not necessarily synonymous and that somatic evidence does not preclude a relational approach.[6] It dawned on me that the relational perspective in both spheres of experience had, or at least could have, the same meaning, provided of course that the change which the doctor has experienced allows him to see the body/soul problem with new eyes.

The traditional view of things, where the psyche is seen as separate from, and the body devoid of a soul, so that although they can influence one another they nevertheless remain incommensurable entities, would be replaced by another vision of man which accepts the existence of several dimensions of reality at the somatic and psychological levels and therefore considers that access to the various levels for therapeutic purposes is totally conceivable. This means that the doctor could still use his awareness of the relational links, or at least his understanding of relational processes, when his is concerned with a somatic disorder in his patient without losing sight of what can be expressed in objective terms.

To be able to do this, however, the doctor must be 'incorporated' in such a way as to perceive in himself the corresponding emotions and bodily feelings, the somatic fantasies and ideas, and to be able to use them. The *vis-a-vis* figure I was referring to previously in the dyadic situation is one such physical reality, ie, everything that could be said about it would thus acquire a bodily dimension. At the physical level it would be conceivable for there to be a reciprocal relationship which would not be of the usual subject/object type but something more complete.

I believe that all this is already implied in Sapir's ideas about the *'corps-a-corps'* and the specific experiences it can convey. Sapir, as is well known, tried to attain, or at least to prepare for, the necessary 'incorporation' of the doctor with his relaxation method. Of course it is in this sphere, that is to say the bodily one, that the boundary between the doctor and his patient assumes an even greater significance than elsewhere. However, there is no reason why a doctor who has to treat somatic disorders and who is in daily physical contact with his patients, should not also learn how to use this mode of communication in a relational perspective. Instead of just treating the body of his patient according to the subject/object pattern, as we are wont to do when dealing with inanimate objects, the doctor here might discover an area of 'intersubjectivity' and pursue a dialogue at this level. But there can only be a dialogue between two different subjects that have a clearly defined boundary between them; there can be no dialogue between two worlds of experience that have either merged or become bound together. For this to take place what is needed, once again, is the conscious focussing on oneself, and in this particular case on one's own physical experiences.

No hypnotic fusion is called for, nor any other suggestive tricks; the only thing that is necessary is a well-defined interlocutor so that a bipolar relationship can come into being. Michael Sapir spoke of heterogeneity in this connection, and by that he meant an inner distance which is close enough to permit an exchange, but large enough so as not to limit one's own mobility and self-determination. In my view this polarised and yet dynamic form of relationship, this 'heterogeneity', carries with a very high degree of therapeutic power in so far as it provides the patient with a *vis-a-vis* who can offer him encouragement without trying to engulf him at the same time. We are capable of maintaining that inner distance and remaining attuned to the patient provided that we can focus on ourselves and create a self-identity that can be preserved throughout our dailly professional lives. If we do not manage to do that, we run the risk of misusing our patients to bolster our own egos, or allowing ourselves to be sucked into a vacuum created by the patient. In both cases a situation arises, which I have described as fusion or a clinch which simply neuters the relationship.

My experience has shown that adopting a technical approach and acting accordingly will only provide a limited amount of protection against such mutual entanglement. Even the psychoanalytical transferral and counter-transferral concept is only of

help if we do not simply talk and think about it, but actually apply it to a real, 'earthed' dyadic situation. If we remember this, and do not allow ourselves to be blinded by the ever increasing number of theories, concepts, methods, schools and all the temptations that they give rise to, the *'limited,* but essential change' that Balint described will take on a very special significance. Here 'limited' means that the change can create a different type of relationship in a dyadic situation, but not a change which is divorced from this basic situation. Let us not seek to swap a 'limited' change can free us for a more far-reaching change in the final analysis will hold us prisoner once again.

Balint-work is a holistic approach and must therefore be protected against any attempts to annex parts of this *'terrain vague'* so that they can be turned into a schoolroom. Fortunately it concerns itself not with just one focal point but with several. Even the change in the doctor which is one of its aims can be seen from a number of different angles. Each individual possesses his own focus of attention, and it is my personal focus to make sure that this remains just so.

But to focus on some things necessarily implies that one is blind to others. I have already told you where my attention is focussed; through the eyes of others I can discover where my blindness lies.

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SIXTH INTERNATIONAL BALINT CONGRESS

The Proceedings of the Sixth International Balint Confernence held in Montreux, in October 1984, have been published as a paper-back book by the Swiss Society of Psychosomatic Medicines. Each paper is printed in the language in which it was delivered.

The Proceedings are available from: Dr méd. Jacques Dufey, 24 Rue des Fortifications, 1844 Villeneuve, Switzerland. Price 50 Swiss francs. (£7.00 plus postage).

INTERNATIONAL BALINT MEMORIAL CONGRESS: BUDAPEST, HUNGARY

29-31 May 1986

A preliminary announcement has been received, inviting enquiries from all those who might be interested in visiting Michael Balint's birth-place, and to attend a Congress to commemorate his 90th birthday.

The proposed main topics of the Congress are:

1. Balint Memorial Lecture.
2. The management of neurosis in general practice.
3. The treatment of psychosomatic disorders.
4. The Balint-method as a tool for self-education.
5. Work in Balint-groups will also be organised.

Simultaneous translation into English, French, German and Hungarian, is foreseen at the plenary sessions.
The group-work will be organised according to different languages.
Accommodation and the Congress-site will be in the Study Centre TOT. H-1121 Budapest, Normafa ut 54., Hungary.

Requests for further detailed information about the Congress should be addressed to the organizers:
MOTESZ Congress Bureau,
H-1361 Budapest,
P.O.B. 32. Hungary.

They — Us — and Him*

by Max Mayer

Were it nor for my vanity and your generosity you could have spent the evening more profitably elsewhere but now that you are here, let me first of all thank you for conferring an Honorary Life Membership on me which I know I don't deserve and for having asked me to address you which serves me right.

Having been denied a quiet burial I felt most vindictive at first but mellowed sufficiently in consequence to think of something to say which would not offend you. I hope that it is proper to have taken my cues for what follows from remarks overheard at recent meetings — they are therefore unlikely to be regarded as privileged communcations and I trust the following list does not breach the code of medical ethics.

'It has become more a of a club, a church even'
'It is more stodgy now — the early years are unrepeatable'
'We have been overtaken by events'
'We must lose our complacency'
'Are we better for being Balint-trained?'
'Are our patients better off or just ourselves?'
'It is such a never ending slog, drudgery and hard work,
'Why do we go round in circles?'

It is but a small sample but it will do to provide a starting point for my thesis that there is a crisis situation within our Society. Much as it may be related to the events outside our surgeries it concerns us deeply because it constitutes a kind of betrayal of Michael's work, more than a hint of regarding him as passé or at best submerged by a culture that does not deserve him any more. I could not let it go at that. But it may perhaps surprise you that the phenomenon had not gone unnoticed.

Dr Louis Goldman, editor of the Medical Digest, wrote in March 1984 under the heading *Balint in Decline,* irony sometimes carries a wry tinge. Searching through the last 5 years' British Medical Journal and the Lancet, Balint's name occurred only once and that was in a note about a £250.00 prize for the best essay on 'How Balint training has affected medical practice.'[1]

Dr Goldman did not attempt to explain this spectacular lack of interest which followed Michael's death in 1970 at the age of 74 but concludes his editorial stating that 'much of GP research these days seems to concentrate on epidemiology, audit, vocational training methods and organisation. Perhaps the time is ripe for a revival of interest in Balint-type medicine'.

Whether the time is *ripe* I dare not say but the time is *now*. It must have been obvious to those who attended the recent Oxford Balint weekend there are strong currents into which to launch our long becalmed ship. We must take advantage of them.

The laments referred to took place in London and those present at the meeting were, with all too few exceptions, the same people who had been present at the birth of the Society in 1969. Nevertheless they represented 10 per cent of our membership which, I am told, stands at 170 plus 80 associates, having remained fairly static over the years with new members about to balance the loss through death and resignations. So what about the rest?

One of my most vivid memories concerns the desperately angry yet defiant cry of one of our colleagues who shouted three times in succession '. . . *but Balint is dead!*' — and I began to wonder whether we too, like our friend, had not completed our mourning? Might this explain at least part of our lethargy?

It is possible that many of those who took part in his seminars or, like myself, sat with his lieutenants, may not have come to terms with the loss they sustained 14 years ago. Many of us cannot doubt that our preparation was not complete, fate intervening before we had learned fully to adjust to the demands doctoring makes on those who had been made conscious of their extended rôle by him. We knew that we had to achieve a degree of maturity which his presence might ultimately confer on us but that day never came. We met Michael when we were a lot younger. He instilled in us ideals which all too often proved individually to be an elusive goal. He made us feel immensely powerful but also issued stern warnings against the unjustifiable use of such powers. He sent us forth before experience had caught up with experiment. He left us before we had settled into a pattern which he might have approved of and, in view of this, is it really surprising that gloom and despondence should have descended upon us?

But why does it continue? Why do we huddle together like waifs? Why are the early years (I quote) 'unrepeatable'?

Some of us must have read what the Senior Lecturer in General Practice at the University of Nottingham, Dr Michael Sheldon, said at the spring meeting of the Royal College of General Practitioners entitled 'Living with Big Brother' when he mentioned that 55 per cent of patients present with minor, self-limiting conditions and asked 'why not let the chemist see them? It would cut the general practitioner's workload by half overnight',[2] but I am not aware that anyone, individually or as a member of our Society, stood up and flew the flag. Are we going to leave it to the Goldmans to do so?

You will no doubt remember that Michael thought that it was no coincidence that word doctor meant teacher and had said that 'we doctors are doctors for good reason, which is that we do indeed teach something highly important to patients while

*Paper presented at a meeting of the Balint Society on 27 November 1984.

attending to them', and continued: 'during the course of teaching, some patients may even be cured but unfortunately this does not happen in every case. Not so seldom the patient has to learn to be ill, how to live with his illness, how to adjust his life to it; and to tolerate all the uneasiness, fear, apprehension, discomfort, pain and even disability'.

Perhaps it was not only patients he was thinking of but of us as well. One day we would lose him, when we would have to apply to ourselves the teachings we were teaching; when he would have wished us to stop looking over our shoulders to see whether he was still with us; to stop feeling that he had pushed us out into the world before we were ready for it; that we would falter without his continued guidance; or suspecting that he had taken secrets into his grave which he ought to have revealed in time; and that while exhorting us to grow up he had failed to hand us the curriculum on how to go about it.

Some of the roots of our languor may well be found here. If this were true and went to work on ourselves, a resurgence of our previous vigour may not be long in coming about.

The first thing would be to resolve to walk out from under Michael's shadow, take a good look at the landscape and begin to speculate how he would have dealt with the profound changes affecting medical practice; how he might have modified his approach to to-day's patient who decidedly is not the same as he was in his time, and, consequently to adapt his vision and practice to the present.

But before we can contemplate any action we shall have to survey our resources. We shall have to find out whether there is a potential for renewal and if so, go about making some rought calculations. We shall have to find out whether there is a potential for renewal and if so, go about making some rough calculations. We shall have to find out what the other 150 members of our Society are doing and thinking. Are they still practising Balint-type medicine? If so, have they developed or modified their approach? Are they passing on their experience to the next generation of doctors? Are they prepared to take an active part in the re-birth of Balint-type medicine? Do they need support from the centre or do they wish to occupy the centre? Or, indeed, is there a centre which is recognisable and likely to be recognised?

There are at least two ways of going about it which we should avoid: a questionnaire or a plenary meeting. My own suggestion is to base the survey on personal interviews conducted by one of us. We need of course to be clear about the information we want to collect and the briefing of the Grand Interviewer, not to say the Grand Inquisitor, should be thorough and in keeping with our objective so that we may in the end formulate a program which will re-establish Balint in the vanguard of medical thought and concurrently prevent this Society from dying of ennui.

It would require a great deal of earnest preparatory work but at the conclusion of the exercise we ought to have a good idea of the professional pool and human resources from which to engineer our revival.

With any luck we should arrive at a plan which is both firm and flexible — a plan which must be more than a declaration of intent and outline actions as well as aims and ideas.

Michael borrowed from medical practice the rules of the day so that he might apply his principles for the good of the patients we were likely to see in his time. Throughout his writings he was at pains to look at his efforts as being tentative solutions, and he would welcome us to re-think his teachings. He recognised the tenuous basis of our operations and insisted that his approach implied that the patient would become an active partner in all transactions affecting the doctor/patient relationship. But he could hardly have foreseen that such a process can also arise outside the surgery and be brought into the therapeutic situation as of right. More of that later.

The dilemma of the innovator is that he will somewhat obsessively strive for objective proof that his system is beneficial, and Michael called for more and more verifications which would confirm the soundness of his edifice. You will remember that the call for 'more research' echoes also around our Society at frequent intervals but, to be provocative, I see in it a chimera more closely related to a yearning for respectability than objectivity.

Michael knew how impossible it would be to erect a doctrine around his teachings and I shall only cite one example. Reflecting on the advisability or otherwise of deliberate interventions and interpretations during the interview he said 'there are no criteria to determine what is sufficient or satisfactory, and what is not' and that the 'innumerable facets' of the situation make 'systematic discussion' impossible.[3]

Nevertheless, he, like us, was moved by a gut feeling and an over-riding conviction in the goodness — (I use the word deliberately) of his attitude to patients and he knew that the ethical and moral basis of his work was unassailable. That will also have to be our strength and if we do not feel likewise we shall have to cease paying lipservice to him. Of course we would like to be seen to be doing the right thing by our patients and have the means to prove it, but in the context of the intricate interactions which are taking place in the doctor/patient relationship in a given cultural setting data analysis will remain an elusive goal. What is more, it would have little predictive value because each interaction changes the outcome of the next one. We must be firm in accepting these restrictions and not be paralysed by them. Some of our malice may well be related to this conundrum.

We must also not be dismayed by the awareness that we dispense Balintian principles and care only to a restricted number of our patients, namely to those with whom we can establish rapport. It is unrealistic to expect that it can be otherwise. We need instead to carry on our work with insightful confidence and the willingness to forge the ultimate proof of doing right. It would make us feel more at ease with ourselves if we were to accept what that kindly cynic Dr Richard Asher

whom Michael might have invented had he not been a real person, once expressed in the following way: 'If you can believe fervently in your treatment, even though controlled trials show that it is quite useless, then your results are much better, your patients are much better and your income is much better, too. I believe that this accounts for the remarkable success of the less gifted but more credulous members of our profession, and also for the violent dislike of statistics and controlled tests which fashionable and successful doctors are accustomed to display. It is an almost insoluble problem and the majority of worthwhile doctors are driven to a compromise in which they muster enough genuine belief in their treatment to keep their patients happy and maintain their own self-respect, while preserving enough doubt to admit their inadequacy during transient bouts of uncomfortable honesty.'[3]

Let us take heart — and reflect there *have* been profound changes in our society and indeed in the whole of the Western world since Balint investigated our rôle, drew his conclusions and established his format.

In 1959 Harold Macmillan won the election with the slogan 'You Never Had It So Good', and his 'Wind of Change' was meant to blow away the cobwebs. Although I know nothing of Michael's political views I assume that he shared some of the optimism of his time and I believe that this is reflected in his teachings. His is an inherently optimistic picture, peppered as it may be with scepticism and self-doubt. He thought that doctors must concern themselves not just with the preservation but also the flowering of the human personality — words which recur in his writings. Fifteen years later it is doubtful whether he would have thought it fair to lumber us with such a mission.

Nor can we overlook that an aim so loftly cannot be separated from the apostolic function against which he so rightly put us on guard.

There are unresolved problems in his teaching which belong to *his* personality rather than our own. They are even hinted at in the title he chose for his bombshell of a book: *The Doctor, his Patient and the Illness.*[4] Our patients have long taught us that we have no proprietary rights in them. In the days of Patient Participation groups and the emergence of the British Holistic Medical Association he might have been tempted, somewhat impishly no doubt, to change it to. 'The Doctor, his Illness and the Patient.'

He knew of course that all was not well with us, and constantly admonished us to question our motives, hoping perhaps to prevent the present tableau from arising.

It is neither his fault that the task proved beyond his powers, nor do we have to feel guilty ourselves although it may be hard not to. Society has evolved on somewhat unexpected lines and imposed on us a different scale of values to be applied in our interventions, in our no longer private consulting rooms. What would Michael have made of the dilution of the doctor/patient relationship through the innumerable agencies both statutory and voluntary which not only involve the patient in more relationships than a sane person can expect him or her to handle, especially in times of stress, but also directly counteract his aim to restore to the patient his independence within a framework of responsibilities as well as privileges?

Michael was determined to make the patient retrieve the freedoms previously surrendered in unsuccessful dealings with the world around him and would quickly see the connection between being handled as an object and parcelled out to different agencies, and the seemingly unfulfillable demands made on those whose help is being sought. As you know, it is not all that easy to keep one's cool when involved in such a scenario.

We also have to accommodate Balint-type interactions within the setting of group-practices, deputising services and the approaching shadow of a salaried service and find ways and means to redress the balance in favour of the caring doctor whose existence is now widely believed to be anecdotal.

Michael might have pointed out that doctors tend to become unpopular in hard times because, like lawyers, bankers and undertakers, they are seen to do relatively well while others are doing badly. But he would not have looked with favour on those who believe 'that we have been overtaken by events'. We may be weary and a little overawed and thus get the feeling that we are no longer in the mainstream (if such a thing exists) but with a few courageous strokes we could cast off from our safe anchorages and hoist our sail once more.

Balint's philosophy has also a profound bearing on the ethical questions which the progress of medical science and skills has produced in its wake. We need to think very carefully about the issues involved and strive to come up with something a little more substantial than individual and idiosyncratic views of which there is a surfeit. It is not a matter of a simple balancing out the legitimate interests between the parties involved — doctors, patients and society — but of remaining faithful to his concept that every human experience may uncover hidden potentials; and that it is our duty to sense such a development in our patients, and to lead them to the solution that is proper for them in life or in death.

Nowhere is such a task more obvious than in training young doctors. What would Michael have said to our colleague who wrote that trainees had added a 'new dimension' to his practice so that he could no longer be content with a 'less than definite diagnosis or a treatment that was not completely up-to-date'. Mind you he was not speaking of overall diagnosis, Michael's promised land, but of the criteria which would have satisfied is professor who, having made his point, would swiftly go over to the next case. Having read the confession of him who now found himself in a new dimension should we not have written to the Journal in question and given our version? Would it be proper for our Society to have a letter-writing panel to remind the fraternity that one can approach patients differently without

foresaking one's clinical acument, whenever similar wisdom is offered?

Furthermore we must find an answer to the blandishments of Information Technology. If it be true that general practitioners find it hard to communicate with as many as one in four of their patients and that the problem is largely due to tension in the doctor, do we think with Dr David Pendleton, Managerial Psychologist from the King's Fund Centre in London, speaking to delegates from the British Association for the Advancement of Science, that the remedy lies in video-recordings of consultations and making a critical analysis of them so that general practitioners could be induced to delegate some of the decision-making to the patient? Admittedly a trendy and not at all anti-Balintian statement — but what a way of going about it?

No, we have not been overtaken by events but it could be said that some of use have not reacted to them as we should.

It is somewhat of a puzzle to me that whilst we never found it difficult in our rôle as 'proper' doctors to adjust to new ways of treating old diseases we have preferred to sit in ivory towers when it came to be Balint-followers. It is of course possible that Balint had neither the time nor the opportunity to teach us to develop means of coping with rapid change, but it is also possible that we are looking at an inherent weakness in his edifice. We should have acquired the ability to be harbingers of change instead of becoming its victims, real or imagined. Perhaps it is true that he created an elite and as such we may echo, albeit subconsciously, the sentiments of a well known army general who remarked that 'conscription may have been good for the country but it damn near killed the army'. If that were so we better had a good look at ourselves before going any further.

To be sure Balint's way is not the alpha and omega of patient-centred medicine. Although it is no doubt the most complete and, dare I say, the most rational form of it, should we not at least examine the possibility that some patients may be more profitably helped by different techniques? Do we have secretly to snigger at the behaviouristic approach, at operant conditioning, cognitive therapy, meditation and the like?

Is it not an intriguing thought that there might be methods which open up the prospect of help without implicating the personality at a deeper level than we are used to do? Michael might have disbelieved the claims of practitioners who report on effective treatments which did not involve the doctor and the patient in the not inconsiderable problems of transference and counter-transference, but it can hardly be doubted that many of them can look back on considerable success.

It may be that we have to acquire a less prejudiced stance towards such methods and, yes, even learn to use them as we have learned other aids to treatment which were not dreamed of when we were young doctors. Having, besides Balint, an enlarged armamentarium at our disposal from which to select the most suitable one for an individual patient, can only make us into better doctors.

If this is anathema to you, you may want to remember that Balint, though continuing to be a formal psychoanalyst, considered the method inappropriate in the context of general practice and substituted not a dilute version but a radical re-think of psychoanalysis which raised his fraternity's hackles and deeply offended the purists.

Conversely I would not like you to forget the writing on the wall which reads: *no more section 63 for you boys!* Instead this privilege was liberally accorded to the British Holistic Medical Association whose programme of quaint and not so quaint courses was amalgamated with that of the British Postgraduate Medical Federation.

With regard this breast-beating group whose official motto is 'Physician Heal Thyself', I will limit myself to the observation that I see the principal danger for this laudable enterprise in the creation of specialist diversions as numerous as the ones which have beset, and indeed bedevilled, hospital-orientated practitioners. Neither fraction seems prepared to take the patient under their own wing in the endeavour to solve the dis-ease which brought him to the doctor. To which I hastily add that if anyone ever advocated a holistic approach in medicine it was Michael Balint but we need to say this a little more loudly and insistently than we do at present, and not watch his crown being snatched from his head.

The trouble with Balint is the setting of vastly increased pressures on doctors is that there is no yardstick, nor will there ever be one, which would allow us to concentrate our considerable investment of time and skill on the kind of person capable of growth instead of offering it on a fail-safe basis. That being so, Balint is a hard sell these days and although I am not entirely behind the one of us who said that it was a never-ending slog, we all know that it is hard work. To coin an aphorism: kismet with a dash of sour grapes.

What then can we do to re-direct the attention of the profession and of the public towards a form of patient-centred medicine which does not relegate the unfortunate client to the fringes of the right and the left, but goes straight to the core and which is designed to change the climate from one of doing nothing worse to one of achieving positive good?

The recent Oxford meeting demonstrated beyond a shade of doubt that Balint's proclamation still echoes among the young generation of doctors who exhibited a degree of insight, fervor and sophistication which almost shocked us old-timers and quickly made us focus on the important issues before us.[7]

Self-selected as our colleagues may have been they might conceivably be the representatives of a vast pool of young doctors willing to experiment with better patient-care on the lines we try to follow. The greater the pity that these young men and women would have to return to their relative wildernesses and make the best of a single encounter with the custodians of a system of care to which they had spontaneously gravitated.

Is it not our duty to provide them with the opportunities to grow and develop so that they in turn might become the nucleus of a continuously evolving application of Balint's thoughts?

If we agree that he has left us a desirable inheritance, would it not be an obligation on us to create an accessible place where it can be shared with the profession and indeed with all those who have an interest in patient-care?

It may not be beyond our means to create such a place: a *Balint College*. The least we can do is to explore the possibility. It was this thought which earlier on led me to stress the importance of a survey among our members. If as a result we found enough strength and resourcefulness we could gather it up and make it the foundation on which to build our College. Otherwise we must muddle on in the hope that something survives to create another impetus for Balint's ideas to flower at some time in the future when the more esoteric systems of medicine have had their day. By which time, alas, most of us here would probably no longer be there.

A College would overcome the conundrum of whether to insert a taste of Balint (it could hardly be more than that) into the undergraduate curriculum of an already overburdened student who would find it difficult to see what relevance it had to passing his exams. But he would find later a ready-made source of insightful illumination waiting for him.

It would fit in very well with the vocational training schemes which are here to stay. On the other hand I do not think that, a few 'naturals' excepted, Balint's approach to patient-care can be appreciated, not to say effectively practised, by someone who has not been exposed to the crossfire and trench warfare of general practice for some time at least.

It is an even more urgent necessity in the face of student selection on the basis of A-level results which might produce graduates with attitudes several orders of magnitude removed from the compassionate doctor all patients need and whom we are trying to promote.

As a College we should guard ourselves from any medico-political allegiances or affiliations, and that would include the Royal College of General Practitioners as well as the newly created College of Health, whatever our sympathies. Of course we should have spies in both. But we should have a hard look at ourselves and think about the shape of association we should form with that vigorous offshot of Michael's credo, the Institute of Psychosexual Medicine which can look back on 10 years' active work, and having so far trained 1400 doctors. Their membership equals ours but they far exceed us in their enthusiasm.

By producing the kind of doctor we would like to see, the College might go a long way to stop the drift of the public towards alternative sources of comfort which none would deny them in the present circumstances. If that came about we might again be directly approached by some of our patients before they were slung back at us disappointed, disillusioned and with their original problems unsolved, perhaps increased, and a few nasty medical conditions thrown in for good measure.

Whilst we all wish Bishop Morris Maddocks, the Adviser for Health and Healing to the Archbishop of Canterbury, luck in passing on to his vicars some of the 50 per cent of patients of guilt, anxiety and stress, we should also remember there are many documented cases of clergymen who have failed to handle their personal problems appropriately, and these same problems have reached the National Press after botching up a funeral, swearing at the mourners and clinging to the gravestone for support. 'To tolerate the bores, accommodate the obsessional, solve the problems of the inadequate, (wrote one newspaper columist), 'they (the vicars) have at all times to be either saintly or hearty. They can never be cross, tired or shout 'go to hell'.' Indeed, they had no Balint but with the College that situation would be changing.

As we all know, Colleges are congenitally constituted to rear an elite and we must be very careful not to fall into that trap. We must be at pains to explain that its aim would be to make us all into very ordinary doctors, the kind most people are taught to think of as museum pieces under pressure from the faddists.

It should make it clear that it is out to create the doctor who is *not* among the 87 per cent of a sample who go through episodes when they feel exhausted physically, emotionally or intellectually; or the 72 per cent who find the conditions under which they work stressful; or among the 50 per cent who suffer from enduring boredom, according to Dr James Morrice writing in the Bulletin of the Royal College of Psychiatrists,[5] and whose only remedy is the proposal of fuller use of sabbatical leave which he considers to be cost-effective in terms of renewed skills and motivation. Once we have a College we could arrange for their sabbatical to good effect.

The tasks for the College are many indeed. It would want to look, for example, at the adaptation of Balint-type medicine in the setting of group-practices and health-centres, always bearing in mind that graduates of the College must not be regarded by their partners as specialists good at sorting out the patients who are dropped into their lap across the coffee table at practice meetings. This is a difficult area which requires a lot of thinking as well as tact so as to equip Balintians with the skill to treat their professional colleagues as well as their patients.

The College might well find a profitable area of research in supplying some of the answers sought by Professor Neil Kessel who, when writing about medical education, described medical schools as 'black boxes': 'We know what goes in and what comes out, we learn little about how the intervening mechanism works.'[8]

The College's students are more than likely to have the kind of information Professor Kessel needs to press the Government into pressing the Universities to change the curriculum in a direction which we, too, would find desirable. Something

which he opened offered to do if he was given the means to do it. Can we ask for a better incentive?

Another challenge to which we must rise concerns the use of Balint techniques to patients coming from other cultures. Those of us who were at the Oxford meeting will have noticed what a thorny subject this is. Balint did not have to contend with it, but Balintians we are and as Balintians we must cope. To be called to mediate between cultures and to help in the process of adaptation, we have to learn a great deal from our overseas colleagues who will have to instruct us about functioning as doctors in milieus different from those in which most of us habitually move. It is, to my mind, a daunting prospective.

I could go on finding more good reasons why we should seriously think of a College but I shall not try your patience any longer.

Once, in an early seminar, a colleague presented us with a different case. His patient was very unhappy with his small stature and had pinned all his problems on his unfortunate handicap. There was a great deal of sympathy flowing towards the doctor who could not turn his patient into an effigy of Napoleon until one day he turned up, rather shamefacedly, and told us that, in a flash of anger and frustration, he had actually measured his patient's height and found him to be 5 feet 10 inches tall.

Whilst I would not expect, in Sam Goldwyn's words, our story to begin with an earthquake and work itself up to a climax, I would also hope that it may not be said us — as of certain members of Her Majesty's regiments — that you can always tell a guards officer — but you cannot tell him much.

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Psychotherapy in General Practice*

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The Setting

Specialist psychotherapy is concerned with the treatment of patients in a highly organised setting. The treatment of patients in general practice is very different. The surgery doors open on to the everyday world. In general practice the doctor is not set at such a careful distance, monitoring the various aspects of transference and projection; but enmeshed, a fellow traveller, more involved with his patients and their illnesses. It is High Street medicine. This difference gives rise to many of the difficulties of the setting, but also to some of its unique advantages for psychotherapeutic work.

In general practice the doctor is not concerned with the application of any particular therapeutic philosophy, but more with whatever psychotherapeutic use he can make of the opportunities that arise as part of his everyday work. He is an *opportunist*. He carries with him whatever skills and awareness he possesses in whatever he is called on to do, visiting a dying patient at home, dealing with a 'minor' illness in the surgery, responding to an emotional crisis, or a problem concealed in a 'While I'm here, Doctor'. The general practitioner's psychotherapy is dressed in ordinary clothing.

Psychoanalytic theory gives us an essentially developmental view of human life, placing 'each individual in his own unique cultural and developmental context',[1] and lays great emphasis on the quality of the human relationships that enable the individual's development from the earliest moments of life. Difficulties and conflicts as well as satisfactions and achievements, are constantly present and may build up in such a way that a crisis, or an illness, develops. For a few patients this may lead to formal psychotherapy, but for the overwhelming majority it is neither sought nor appropriate. The doctor in general practice, however, is often already present at first hand, helping his patients with many of these experiences that are some of the psychological determinants of people's lives: the problems of birth and early childhood, sexual development and marriage, illnesses, death and losses of one sort or another. Morbidity and presentations to the doctor are known to increase when people are negotiating these major transitions of life, or life events. This means that the doctor is often involved when psychic history is being made. He can therefore influence this process, a little, both for better and for worse.

Listening

In this chapter I shall often refer to listening and hearing when describing the need for doctors to 'listen' to their patients and 'hear' what they are saying. This does not mean a passive process of sitting back and listening to someone talk. It refers to the quality and intensity of the listening to feelings that lie behind the patient's words, and the sensitivity with which things are heard that the patient is only half saying. This requires considerable attention to detail; how the patient looks and behaves, his mood, what words he chooses, when he falters and changes track and what is left unsaid; it involves respecting the patient's needs to express emotion in his own way, and hearing what thoughts and feelings all these things, and many more, elicit in the doctor's own mind.

Most communication from which something new may be learnt by the person communicating, exists in a half-lit world of things that are only 'almost known' to that person. This is true of the patient communicating to his doctor, and also true of the doctor when he attempts any change in his understanding of his patients or his involvement with them. Both worlds, the patient's and doctor's, are changing. It is the relationship between the two, referred to in this chapter as the doctor/patient relationship, that is of central importance.

Incidence

It is commonplace that the incidence of emotional or psychiatric disorders seen in general practice is high. Figures vary widely; the problems of definition are great and the diagnoses made in general practice consultations depend as much on the doctor's own characteristics and attitudes, as on the patient's presentation. In a practice with a special interest in psychological disorders, forty-three per cent of all patients seen had symptoms which were regarded as being of emotional origin; eleven per cent suffered from formal psychiatric illnesses and thirty-two per cent from a variety of stress disorders.[2] In another survey,[3] a general practitioner who was again described as having a particular interest in psychiatric disorders, only recorded an incidence of twenty per cent of consecutive attenders as having evidence of psychiatric morbidity. It may be that another doctor steadfastly physical in his approach, and determined not to notice his patients' emotional problems, could achieve a significantly lower incidence still. Doctors are as variable as their patients.

Despite these differences in the doctors' diagnostic thresholds, it seems that the average general practitioner in this country is likely to have a significant number of his consultations, probably averaging around thirty per cent (4), with people who have been propelled towards the surgery by apparent psychiatric symptomatology of one sort or another. This figure may rise to sixty per cent or more if

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consultations are included in which the doctor feels there is a significant element of emotional difficulty being presented.

Some people consult their general practitioners much more often than others. Approximately fifty per cent of the general practitioner's workload is generated by ten per cent of his patients.[5] The members of each doctor's ten per cent group may have more psychological characteristics in common with each other than with less frequently consulting patients who may nevertheless belong to the same diagnostic category; for instance migraine, dysmenorrhoea or depression. Amongst the population who do not go to the doctor often, are individuals who have similar symptoms as those who do.[6] It is not the possession of the symptom or the disorder that characterises the patients who more frequently come to the surgery, but the fact that they come, while others do not. This realisation is vital to the general practitioner's work.

What kind of diagnosis?

Although the results of these surveys give us something of a statistical background to the general practitioner's work, they do so in misleading terms. Diagnoses of this sort belong to a psychiatric classification derived from what is often called the medical model. The doctor presides, uninvolved with his patient, and diagnoses the patient's illness according to certain symptoms and signs. Such a model encourages the doctor to think only about making the 'right' diagnosis and not about the patient, and inclines both the patient and the doctor to define the problem outside themselves, thus discouraging the doctor from thinking about his relationship with the patient. It is a model much used in hospital thinking, but it transfers very uneasily into general practice, where the emphasis is shifted more to people and away from illnesses; more to a longer term perspective rather than a two-dimensional view at one moment. It makes little sense to place two totally different consultations with people of different personalities and backgrounds with different problems and expectations into a single category called, say, anxiety state.

> A large woman in her sixties who always has a timid look about her, comes to see the doctor about her painful neck which prevents her from sleeping. She is a bit overweight, tends to visit the doctor about once a month and is recently retired from her work as a cleaner. She comes to ask for a repeat of her arthritis tablets, and wonders of her blood pressure is up (which it is, slightly). She cries when the doctor asks about her brother who he knows she has been worried about and is now dying of cancer. She is single, rather shy and has always felt large and awkward.
>
> She has remained closely attached to her large number of brothers and sisters since their father died when she was nine. They mostly live a long way from her and she is constantly anxious about them. The doctor has got to know her and how she uses him. He is happy to see her and takes her blood pressure, listens to her and prescribes more tablets. The consultation lasts ten minutes, and will be repeated many times, in one form or another, as it already has been in the past.

Such a consultation is very typical of a general practitioner's work. Which diagnosis is the doctor to choose? Even sticking to traditional medical diagnoses, it would be difficult to choose between obesity, mild hypertension, cervical spondylosis, anxiety or depression. All play a part.

If we shift the emphasis from the medical diagnosis towards a more personal one, we immediately begin to include some life history, any important recent events, present tensions with other people, and something of the patient's relationship to herself; her self-esteem and confidence, and her capacity for change and adaptation. These things may help us learn more about her emotional needs and what she may require from a visit to the doctor. The single page becomes biography.

It does however still leave out any account of the doctor's own particular viewpoint. The importance of this omission increases as the patient's subjective world is taken more into account. The diagnoses has to broaden again to include something of the doctor's own reactions and how he sees the patient. Today's view may be different tomorrow and the same patient would be seen differently by different doctors.

Knocking on the doctor's door

Amongst the sea of people who come in and out of a doctor's surgery, some people will have a relatively clear idea of why they have come and what they can reasonably hope to gain. Others are propelled by a less well-differentiated urge; a more generalised need for understanding or help, which they initially transmit to the doctor through their symptoms. These may resolve quite quickly or continue until the doctor and patient eventually settle on a distance and a language that is acceptable to both of them. This is then the 'illness'. It is particularly important for the doctor in general practice to tolerate uncertainty, and not organise the patient's illness too soon. He may otherwise prevent important developments from emerging and contribute to what Illich has called the 'medicalisation of life'.[7] The groundswell of need which brings people to doctors is present in everyone.

For some it is more successfully met in life relationships than for others. The doctor is a relatively freely available figure. Maybe in previous times such a need sought its expression elsewhere, through the church of within the extended family, but in today's world it knocks on the doctor's door. Both the patient and the doctor contain numerous possibilities for the outcome of their consultation together. They each have the potential for many different directions and levels of contact with each other. Nothing is static. Patients alter their patterns to fit their doctors and seek out doctors who reflect their needs. For many patients it may be more important that there is a channel of communication

open to them when they need it, rather than its particular 'medical content'.

Doctors develop different ways of responding to this challenge. Each doctor's own approach may be valid for himself. There is a risk in too great a conformity. If a doctor does decide to undergo appropriate training and learn to make himself more accessible to his patient's emotional needs, he must first become aware of the history and development of the thought that has already gone into trying to understand the nature of the general practice setting for this kind of work.

History

The history of psychotherapy in general practice is essentially the history of the impact of two psychoanalysts, Michael and Enid Balint, and their work with general practitioners. The story begins with general practice at a low ebb in the early 1950s, very much the junior partner within the medical profession. There was 'widespread dissatisfaction amongst general practitioners',[8] who at that time lacked any specific training for their work. The mismatch between the skills acquired through undergraduate medical training and those needed by the general practitioner in his work, was even more acute than it is now. Apart from their heavily disease-centred training, those doctors had mainly their common sense and endless outpatient referrals to help them through.

In 1948 at the Tavistock Clinic in London, Enid Balint began leading a group of non-medical workers who were working with people having marital difficulties. Michael Balint, a Hungarian psychoanalyst whose father had been a doctor, became interested in applying this method to study the difficulties general practitioners were having, and to see if new techniques could be developed to help them in their work. In 1954 and 1955 the first reports of this work were published.[9, 10] It initiated far-reaching changes in the ways doctors and patients were subsequently to relate to each other. Much was learned from this early work and was eventually published in 1957 as *The Doctor, his Patient and the Illness,* [11] one of the masterpieces of medical literature.

From the beginning this work was a marriage between the psychoanalytical background of the Balints and the medical work and attitudes brought to the groups by those first general practitioners.

The Balints contributed the setting, the aims, the open-mindedness of their enquiry and a belief in the value of human beings (doctors as well as patients). They also contributed their understanding of the unconscious and a basic trust that from the ruminations of the doctors themselves, new patterns would emerge. They were non-moralising and non-teaching. They did not attempt to instruct the doctors in psychoanalytic theory or give them psychodynamic explanations of their patients' behaviour, or of the doctors' own behaviour for that matter. Through their own listening skills, enhanced by psychoanalytic training, they helped the doctors listen better to their patients.

Winnicott and others have shown how a mother can respond more sensitively to her child if she has herself received what he called 'good-enough mothering'.[12] By the same token doctors are better able to respond to their patients' problems if they have had the experience of being listened to sensitively themselves in their training. They are then able to learn more from the main source and stimulus to education for doctors, patients themselves.

The doctors also contributed a lot. They brought their openess and willingness to learn, which is never an easy process, and their preparedness to stick at a difficult task for a considerable length of time. They required what Balint came to call the *'Courage of their stupidity'*. This meant being prepared to use their minds imaginatively and contribute freely to the thinking of the group; not being too cautious and correct. This courage remains the main driving force for any group.

Training

The method of work and its aims have remained essentially the same over the years. A small group of general practitioners meet each week with a suitably trained leader and present cases that are giving them difficulty. They do so without notes which enables the doctor to give a more spontaneous presentation, disclosing to the group some of his own subjective reactions to the patient. With the help of the leader(s), the group then examines the doctor's and the patient's interactions over the whole of their relationship, and also focussing on the detail of a recent consultation:

'Why did you do that? . . .' 'How did she react? . . .' 'I feel that by prescribing for her at that moment, you were dismissing her . . .' 'I don't think this patient can get through to you . . .' 'I think you were caught in a difficult situation . . .' etc.

> 'The doctor comes to the group with the real burden of a difficult case. In reporting his case and joining in the discussion, he tests his own ideas against those of his colleagues. In a way, the reporting doctor takes on the rôle of his own patient, and the group becomes the doctor. They share his anxieties and may pick up what he has missed due to his blind spots . . .'[13]

The group process doesn't teach skills or manoeuvres, but aims at a *'limited but considerable change'* in the doctor's personality. It helps each participant to extend his range and methods or working by enabling him to use his own personal potential more fully. He gains additional understanding of his involvement with the patient, and over the years gains a greater understanding of himself too.

There are many aspects of a doctor's work. It is the integration of these various elements and their appropriate use that is the aim of successful training. If the training results in a doctor who carries on his general practice regardless but does what might be described as 'psychotherapy on Sundays', it has failed. And if it results in a doctor who becomes so

interested in pursuing his patients' psyches that he persecutes them with inappropriate curiosity, 'How's your sex life?', and becomes dissatisfied and neglectful of the rest of his medical work, then again the training has failed. A successful marriage produces a new individual, not just a chip off one or other of the old parental blocks.

It is the leader's job to preserve the aims of the group and help it remain focussed on its primary task. Groups often prefer to do almost anything other than this. They take refuge by flight into other preoccupations, and the leader has to watch out for these, steering a course between anecdotal chit-chat, journeys of psychological speculation into the patient's past, constant questioning of the presenting doctor, or drowning him with 'helpful' advice; at the same time avoiding anything that might be too personal or painful about the doctor.

This method is both a technique for training, still remaining the principal one for training general practitioners in this sort of work, and a technique for research. For research it can be used to study the present state of play in the general practitioner's world, like a sampling net lowered at a particular point to chart the changes and developments that are occurring as the wider medical and social culture evolves. Some groups have also met to research particular aspects of their work, such as marital problems,[14] repeat prescriptions[15] or abortions.[16]

Developments

An important change of emphasis and technique occurred in the 1970s. During the early years the doctors tended to become semi-psychotherapists, devoting long sessions to their patients with psychological problems. This was an inevitable side-effect of the training and reflected the doctors' need to model themselves on the work of the leaders, a defence against the real difficulty of achieving an independent and appropriate professional identity for themselves.

The doctors' psychotherapeutic work had to become better integrated with their everyday work, making it less of a foreign body. New techniques had to be discovered to fit the general practitioner's timescale. A research group, again with the Balints' leadership, began meeting in 1965 to study this problem. They published their findings in a book called *Six Minutes for the Patient* in 1973.[17] The change in thinking that lay behind this work was as significant as the original work itself. They described the change from a history-taking style of interview, which they called the *Detective Inspector* approach, with the doctor conducting a search of the patient's life for significant events and feelings, to one in which the doctor listens intently to the patient's presentation, trying to tune in to how the patient wants to use the doctor and what this means.

In this style of work more autonomy is left with the patient, who sets the pace, and the doctor has to be content to abandon his central rôle and follow the patient, being more aware of their relationship and less curious about secrets in the patient's inner world, or finding out what makes the patient tick. This is a more appropriate method for the brief encounters characteristic of general practice and leaves the patient's self-esteem intact. While working in this way *flash* interviews may occur, in which there is a sudden mutual awakening between doctor and patient with a consequent change in their relationship. 'Often the flash concerns the relationship between doctor and patient, but even if it does not, the relationship is changed by the flash'.[17] Relationships in general practice often seem to progress through these 'flashes' or 'important moments'.[13]

Balint had a considerable literary gift and used many mataphors which are still highly resonant. He described doctors as possessing an *apostolic function* by which he meant,

> 'the way in which every doctor demonstrates a vague but almost unshakeably firm idea of how a patient ought to behave when is ill. Although this idea is anything but explicit and concrete, it is immensely powerful, and influences the way in which the doctor not only talks to the patient and relates to him, but how he prescribes drugs, and the way in which he expects to be treated by the patient. It is almost as if every doctor had a revealed knowledge of what is right and what is wrong for patients to expect to endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and unbelieving amongst his patients'.[11]

A doctor's apostolic function is shaped mainly by his own personality and his personal attitudes to suffering and illness but it is also influenced by the social culture in which he lives. Every culture has powerful apostolic beliefs of its own about health as well as other things, and these are changing all the time. The apostolic attitudes of thirty years ago may no longer be relevant now. In our world we may expect people 'to work through their grief appropriately' or 'to take responsibility for their own health, not using alcohol, coffee or tablets but learning to meditate instead'. It is worth examining what is meant by such phrases and whose concerns they reflect, the patient's or the doctor's?

Balint also often referred to the doctor as the *drug doctor,* saying he was the most frequently used drug in medical practice and calling for further study of his uses and side-effects. Revealingly it is the most frequently misquoted of his aphorisms. Doctors usually describe the 'doctor' as 'the most powerful drug used in medical practice'! The apostolic function is alive and well.

General practice owes the Balints a debt of great gratitude. It is almost inconceivable to imagine people coming from positions of outside expertise, bringing the same painstaking willingness to study, listen and learn from the doctors as did the Balints, and not adopting a position of 'telling them what they ought to be doing' — an invitation only very exceptional people can refuse.

Wider changes

Since the 1950s there have been many developments which have influenced general practice; vocational training has become firmly established, a Royal College of General Practitioners has been founded, and departments for teaching general practice have been created in most medical schools. There has also been a rapid growth in the number of 'therapies' and 'techniques' of a broadly psychotherapeutic nature, and some of these have influenced psychotherapeutic work in general practice. Family therapy, counselling, and the different approaches to sex therapy all contribute to the ways in which a general practitioner can choose to develop this style of work. They are like articles of clothing for the general practitioner to try on, taking something from this one and other things from another one, adding to his range of techniques and skills alongside those acquired through his medical training. He has to find out, though, how well they fit his particular setting, and how well they fit his particular personality. None has yet been sufficiently studied from within the particular perspective of general practice.

Body and mind

The general practitioner has to try to achieve an integration in his work between those skills and attitudes that come from the more authoritarian traditions of the medical profession with those other quieter listening skills that come from the psychoanalytic tradition. When to ask questions and when to listen? He has to learn sufficient flexibility for the one to be part of the other.

> A young man comes to the doctor, looking rather sleepy, and complains of a heavy chest, wondering whether it could be his 'heart'. The doctor can find nothing obviously wrong. The consultation seems lifeless, but in an aside which the doctor easily might have overlooked, the patient mentions that his father died a year ago. His father had been less than sixty when he died of a heart attack, and his father's father had also died young, raising the question of a familial hyperlipidaemia. The patient expresses little grief and doesn't feel his father's death has affected his life much. He mentions that he now visits his mother more often and seems to resent this.

The doctor has to balance his medical responsibilities, such as defining the patient's lipid status, and giving him necessary advice about this, while also noticing his own reactions and the patient's appearance and listening for clues to this young man's heavy heart. The patient seems depressed without knowing, quite unconsciously bringing his complaint to the doctor. He doesn't seem to feel as much grief as the doctor first expects. But the doctor must allow the patient's own story to unfold, not superimposing his own expectations.

This is a typical brief encounter, where there is a balance between medicine and listening, both being part of each other, not an 'either/or'. The patient has had some limited but relevant help at a time when he presented himself for it. He may leave it there or return some time later. If he does come back, the first impressions have been laid, on both the doctor's and the patient's side.

The illness or health of an individual depends on a complex inter-relationship between the total person and his environment. Within the individual there is a constant interaction between the body, the mind with its powerful emotional world both conscious and unconscious, and whatever moral and spiritual life the person has and through which he relates his life to other people and the world at large.

The doctor has a relationship with the *whole person* and often with the whole of a family too. The body and the mind reflect and influence each other all the time. There is no such easy divide as people often make. The split between the two is a very common feature of illness, where a physical tension, an ache or a rash remain quite unconnected in the patient's mind to the conflicts that may be associated with them. Medical thinking is often also split in this way with physical illness being considered first, leaving the mind as a sort of remainder. The patient is put through a sieve marked physical in order to catch only those aspects that the doctor feels he understands and can do something about. The antagonism sometimes observed between medical consultants and psychiatrists is an expression of this divide, with the two seeming to inhabit different worlds, and psychoanalysis in isolating the mind for particular study, is also prone to accentuating this problem.

The general practitioner is uniquely placed for an understanding and healing of this relationship. He is working across the 'body/mind' boundary practically all the time. The whole spectrum of illness is brought to him, from the almost entirely physical to the almost entirely psychological. They reflect different densities of disturbance. At the most concrete end, serious physical illnesses like cancers and arterial diseases always have important psychological consequences; in the middle range there are large numbers of illnesses in which body and mind seem to be inextricably bound up with each other, like asthma, the irritable bowel syndrome, hypertension, migraine and abnormalities of menstruation; and at the lighter end there are the transient physical expressions of tension, odd pains, headaches and autonomic symptoms that come according to personal patterns of anxiety and depression.

The doctor handles, touches and listens through his stethoscope while also keeping alert and listening through his human ear as well. He examines the body at the same time as noticing the patient's reactions to this process.

Not everything has to be verbalised. If psychological tensions are expressed, which had been close to the surface anyway, their physical counterparts may resolve as well. But such connections are most often quite inaccessible. The doctor must learn to mediate his medicine through whatever language, be it largely physical or largely psychological, that the patient is using at that time.

Mr. C is a tall young banker in his late twenties, married to an attractive schoolteacher. They are expecting their first baby and Mrs. C comes regularly for her antenatal care. She is rather jolly and seems pleased to be pregnant. The doctor has only seen the husband once or twice before and on this occasion Mr. C seems rather more reserved than before and the two don't easily get on to the right track. He has been having intermittent diarrhoea and abdominal discomfort for some weeks. The doctor and patient fence around a bit but don't seem to get anywhere. Maybe this is the beginning of ulcerative colitis? The doctor sends for him for some tests that all turn out to be normal. Mr. C is still pretty unforthcoming when he comes again, but is perhaps a little keener for the doctor to get on to the right wavelength this time, and drops more of a hint. He describes his symptoms as 'blowing out' and says he's 'almost as big has his wife'. The doctor senses an important area, makes some exploratory remarks, and when he is more sure of his footing says 'You can look forward to the birth of babies but you can dread them too'. With doctor and patient now better tuned, the patient can express some of his feelings about the forthcoming baby, . . . 'he hates babies, they puke and make a noise, the smaller they are the worse they are, he can't stand his friends' babies because he has seen how they have changed them, ruining their lives . . .'

The patient seems to resent the intrusion of the pregnancy and is frightened by the changes that it may produce. He fears they may have to move, as there wont be enough space for the baby (or for himself?) and nowhere to retreat in peace, as he is someone dislikes displays of strong feelings. He is angry and fears the baby will change his life, leaving him left out of the relationship between the baby and his wife. It is possible that this strong feeling of the patient's was echoed in the doctor/patient relationship where he may have felt left out by the doctor and his wife, something that very often happens in antenatal care. Perhaps they had left him with an unfair amount of the negative resentful feelings attaches to the forthcoming birth? The patient afterwards felt that both sides of his experience, positive and negative (for he was also looking forward to the birth), had been accepted by the doctor, making him feel less of an outcast. He had earlier described the baby as a 'monster'. It is also possible (and there was some evidence from later joint antenatal visits) that after this consultation, Mr. and Mrs. C were able to communicate with each other about such an important change in their lives in a more open and balanced way.

Still within the psychosomatic sphere, the body may literally almost break under a psychological strain.

Mr. J, an earnest young man of twenty-six had been sent to his doctor by his employer because he had collapsed with back pain six weeks earlier and had still not fully recovered. The doctor had not seen him before but he gave the history of his back pain clearly. He was an only child who had always done well academically. He had 'passed everything' until recently failing some exams to become a solicitor. He had been working hard to retake them and his parents had suggested he went away with them for a Bank Holiday weekend. He was pleased he went, but returned home earlier than his parents, in order to continue his studies.

After he left, his mother had suddenly died. Normally he would have phoned them on his safe arrival, but that night he didn't. He was devastated. He had always found emotion less easy to share with his father, and he adopted a rôle of 'carrying on', throwing himself into hard work, redoubling his efforts to do well in his retake exams. These he passed. As the pressure began to relax, only a few days later he 'collapsed' with back pain and was taken to a hospital casualty department, where he was sent home with analgesics and told to rest, advice which his firm's doctor had later repeated.

During the consultation described, in which this history emerged, the patient's emotions also emerged at the same time. He was able to break down in tears, particularly when reliving the bitter anguish he felt that his mother had not been able to share in his examination success. What had it all been for?

The patient had himself half-known that his back had cracked as a result of the tension and strain of his suppressed feelings after his mother's funeral. But he needed a doctor who could allow him to make the connection more confidently and who could help him express some of the full-hearted emotions which he had bottled up inside his body in order to carry on with his work.

'The helping him express' is often written about as 'allowing the patient to express'. It is more than that. It is the doctor experiencing some aspects of the patient's predicament and feelings, and giving them back through his words and reactions as a rightful experience for the patient to be having. It is a re-inforced or positive echo returning to the patient from the doctor. The patient leaves feeling 'Yes, *that is* what I feel'. His authenticity as an individual is strengthened. This is of course helpful only if the experience does have the feeling of *truth for the patient*. Otherwise it may be that the feeling of conviction belongs more to the doctor's end. This is an ever present danger.

Living in the present

Patients often apologise when they take the doctor's time. 'I'm sorry to take your time (again?) doctor'. 'I won't keep you a moment, doctor'. Sentences which can carry many different emphases and meanings, and which most often the doctor

hardly notices. *The way* in which patients ask for the doctor's attention *matters*. Why does this patient always seem unsatisfied or unable to tolerate other patients in the waiting room? Why is this one over-apologetic and another anxiously over-friendly? *How* people present their problems to the doctor may reveal important patterns in their relationships and these may be closely related to their current difficulties. The doctor must allow such patterns to develop, being careful not to do so only to gratify his own needs, say, for patients to be appreciative or friendly. He may sense when he is with a particular patient, that he is perceived as a parent who has to be appeased, or a lover who must not come too close, an old friend or somebody the patient always has to do battle with, but never completely defeat.

The doctor has to try and recognise, *there and then,* when one of these characteristic patterns of relating is being enacted with him, and whether or not it is relevant. His listening must be efficient, hearing what is important at that moment.

> A young woman in her thirties, Miss E, seems to the doctor prematurely grey and burdened. She has a likeable seriousness about her and is depressed. She had what she describes as a 'big emotional breakdown' three years ago and has been depressed on and off since. She has a strong sense of duty and seems to live in a predominantly female world. She has a responsible job which she does very conscientiously, but feels that her supervisors do not take her work with sufficient seriousness. She is new to this doctor who can feel how heavily depressed she is, but also how difficult it is for her to do anything with this, other than to worthily endure it. He is content to let her communicate in her own way and has to remain in the dark about many of the details of various relationships she hints at as current difficulties. If he does ask or enquire, he appears to add to her burden and she says 'Oh, it would take such a long time, it's all so complicated anyway'.
>
> She comes seldom. On this occasion she had not been for some time, but clearly had been very depressed. The doctor felt that he wanted her to realise that he was available for her as her doctor, and finished the consultation by saying that she was able to come and see him if she felt depressed, and that it was legitimate to make an appointment if she felt dreadful. It was not breaking any rules. At this point she conveyed that he had enough to deal with already and would not want to be burdened or spend more of his time seeing her. This was said genuinely, not evasively. She said it in such a way that she seemed to be making *herself* responsible for *his* burden. He pointed this out to her, suggesting that she had enough to carry already, without also having to worry about his decisions in allocating his time and energy. He would look after that himself.

The doctor could feel her conflict. It was not just that she did not want to burden him. If it had been, his remarks would have made no impact. It was that she desperately wanted to burden him, but also could not allow herself to do so, and that in part her depression was related to her habit of carrying other people's responsibilities as well as her own, a pattern perhaps originally established with her parents, but certainly persisting into the present as well.

This was a crystallising point in the relationship and clearly meant something significant to her. It had arisen with the doctor, but it was important in her difficulties all round. The same or a similar point may often have come up, after all such a problem is not uncommon, but it seemed *particularly true* at that *particular moment,* and was intimately related to the problems the patient was suffering in her current life. It has much of its impact for the patient because of the feelings contained in the doctor/patient encounter in which it is spoken.

Miss E did return after quite a short interval and this time was able to talk to the doctor more about her distress, initiating a series of appointments with him at a time when she needed help.

It is worth noting that the doctor at this stage knows nothing about the patient's father, her mother or her siblings and very little of her present relationships. He does not know about her sex-life, whether she has a boyfriend, a girlfriend or no friends. If he had asked her, he would have been unable to help her in the way he did. He had to be prepared to follow the patient, trying to make sense of whatever patterns emerged.

Time

It is very often said that general practitioners do not have enough time to listen to their patients. This is far from the truth. The general practitioner's timescale is one of his setting's great strengths. He builds his knowledge of his patients and their families, through repeated short contacts, sometimes over many years. It is his use of the time that matters. His appointment system is flexible. He can see a patient for five minutes on one occasion, twenty minutes another. He can see people frequently for a short time and then not need to again for months. Of course, if listening is simply a process of letting people talk, then indeed he does not have enough time. But it is not. It is the accuracy of attention to the moment that counts and an ear that 'hears' what is being said in the echoes and resonances behind the patient's words. No long preamble and fact finding is needed. The doctor and patient can get to the point quickly. Much of what is important will already be known.

> Mr. R, a widower in his sixties, seldom comes to the doctor, but does one evening about two years after his wife's death. She had been a frequent attender who the doctor knew well, an incessant talker with a great many complaints. Mr. R is dressed in dull clothes, near Christmas and comes with a 'croaky cold'. No time is needed for his own

doctor who has known his whole situation over the years, to understand his croaky (tearful) cold (ness) and the lack of warmth he has felt in his life since his wife's death. The doctor gives him simple treatment for his cold and a few minutes of time, tears and some memories of the unexpectedness of her death, the shock . . .

This is all that is necessary. A brief consultation not necessarily requiring any follow-up.

For some patients the doctor remains one of the few fixed points. They may not come often, but know that he is there, as a reference point.

Most important is the patient's pattern of use over time. Is there a change? Is the patient coming more often, or less often? One axis of the doctor's timescale is long-term, but the rhythm of use along the way can be very variable. This reflects the distance the patient may feel he needs at different times. Sometimes coming to the doctor for quite intense help, and then staying away. This pattern itself may have important echoes.

Miss J. is a slim twenty-three year old student. She is a northerner and often comes to the surgery with a friend who stays in the waiting room. When she joined the doctor's list she came for a repeat prescription of her pill, a routine visit in which no problems were mentioned. She returned a month later to tell the doctor she was having a difficult time with sex with her present boyfriend. She felt dry and was put off by the thought of intercourse. She was shy and embarrassed with the doctor, but told him that she had known Robert for two years, that he had been prepared to build up their relationship slowly which had been important for her as she had easily felt pushed into bed by men previously. She had recently changed digs, and so was new to the doctor's area, but felt her present 'home' would suit her better. She had felt tense with her past family and feared that someone might walk in to her bedroom at any moment if she had her boyfriend there.

The doctor and Miss J managed to establish enough contact and Miss J would come every few weeks, sometimes more often, sometimes less, to talk to the doctor, and report progress in her relationship with Robert. The doctor had suggested seeing them together as a couple and had discussed referring them for specialist psychosexual help. Neither of these suggestions had worked out. During this time she also talked a little about her family background and other relationships. Her mother and she were 'peas in a pod'. Her father, in fact her stepfather, had been very strict but she was his 'favourite'.

The doctor felt he had to be careful not to undermine the patient's relationship with Robert, hoping instead to help Miss J become more receptive to him.

The doctor was careful to let her dictate the pattern and frequency of her attendance, as she had clearly signalled that this was important to her in her relations with men. She did not like to be pushed. It seemed to be the doctor's task to respect this aspect of her, but not too much. He had also to push her a bit as well, towards examining some of her reactions and possible reasons for them; gently steering a course between 'too much' and 'too little'. On one occasion the doctor finished an interview feeling he had probably overdone it and gone into things more deeply than was comfortable for the patient. However, on the next occasion she returned she looked more feminine and said she had a confession to make. They had successfully made love. On that occasion her friend had not accompanied her to the waiting room.

This kind of work tends to progress, then run into new difficulties. Backwards and forwards. Miss J seemed to keep attending when she wanted to, and the doctor continued to try and balance his encouragement with allowing her to set the pace.

This work goes on amidst all the other demands that are made on a doctor's attention. He has many other difficult tasks to perform and his mind may often be far from being tuned in to his patients. The doctor will need to find a balance for himself between engaging and identifying with his patients on the one hand, and gaining sufficient distance from them on the other for thoughtful professional reflection. He will need both if he is to remain useful to his patients, and not either to become too defensive and distant or 'clinical', or be too close to think clearly and see his patients from a different angle than the one from which they see themselves. He can then show respect for his patient's own way of living, and treat the patient as another human being and not only as the bearer of a diagnosis for the doctor to discover.

I have isolated some aspects of the general practitioner's work in order to draw attention to the possibilities his setting offers for psychotherapeutic work of a certain sort. I hope that some of the characteristics of this work can be seen from the cases I have discussed, all taken from a general practitioner's everyday work; the doctor's relatively easy personal accessability; his involvement with patients at times of need and change; his 'being there' for people (regardless of how often consulted) for long periods of time, often for many years; his relationship with the *whole* patient; that the patient holds the key and can therefore dictate the pace, coming at a time of his own making (*why now?* what is important to *this* patient at *this* time?); listening all round the patient as well as to echoes in himself; being content to do *just enough,* and not more, so that the patient may leave feeling free to use the doctor at another time, or in a different way, without having to bare his sould more than he wants or having his life interpreted to him. The patient remains in charge of his own life and hopefully is strengthened by his contact with the doctor, and not undermined.

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The Balint Society Prize Essay, 1986

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the theme 'Who needs Balint? . . .'

Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with two copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.

Length of essay is not critical.

Entry is open to all, except for members of the Balint Society Council.

Where case histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in medical journals.

Essays should be signed with a *nom de plume,* and should be accompanied by a sealed envelope containing the writer's identity.

The judges will consist of the Balint Society Council and their decision is final.

All entries will be considered for publication in the Journal of the Balint Society.

Entries must be received by 1st April, 1986, and sent to:

Dr. P. Graham,
149 Altmore Avenue,
London, E.6.

Please tell your colleagues.

From the Annual General Meeting held on 4th June, 1985

Presidential Address

My contribution this evening is going to take the form of personal reflections on the work of our Society, and the very briefest glimpse into its future. Before speculating on where we might be going, it may be helpful to recall where we once were.

The Balint movement took life, and has continued to develop for more than 30 years, mainly for two reasons. First, the need was felt to fill an enormous gap in our care of patients. Second, because there was nothing else remotely adequate to fill that gap.

The void to which I refer relates to the handling of patients variously described as having emotional problems, psychological difficulties, or psychiatric disturbance. They include those known as 'the worried well'; troubled, as well as troublesome patients; and also those many patients who come to us and reveal — not necessarily in words — how

> 'they grow weary,
> and sick of trying;
> tired of living
> and scared of dying.'

What help was available to us, as doctors, from conventional specialists and teachers? How were general practitioners being guided by those experts? Well I can tell you, because I have been looking up some of the book reviews I did a decade ago. The following excerpts will give you a taste of the sort of things which were offered then.

Psychiatry in Primary Care: 1974
Good descriptions, in the conventional mode, of depression, mania, schizophrenia and schizophreniform syndromes; but poor on anxiety and personality problems. Any text designed fo primary care must stand or fall by its adequacy in the bread-and-butter stuff of general practice: the rag-bag of tension state, neurotic depression, inadequate personality — call it what you will. Yet this is precisely where the book opts out. This may be psychiatry, but it is decidedly not primary care.

Psychological Disorders of Children: A Handbook for Primary Care Physicians: 1978
The authors make no secret of their motive to keep up with the Jones's in adult psychiatry; hoping by presenting 'hard information' in the field of child psychiatry to acquire scientific respectability for it. General practitioners may well blink at the following stipulation: 'at least 18 medically unexplained symptoms for a diagnosis of definite hysteria; 16 or 17 for probably hysteria.'

Currents in Psychoanalysis: 1971
The following serves an an example of the tortured writing and jargon terms, the final phrase providing unintended humour: 'Why do I not simply speak of the externalisation of unconscious conflicts, of acting out as an adolescent-specific modality of behaviour, as a defence against a depressive core and object loss, as a symbolic repliction of the past — and let it go at that?'

Structuring the Therapeutic Process: 1978
The general practitioner is seen as engaging the patient 'within a more variegated, heavily contoured, therapeutic space' — a fair sample of the author's style. The latter can get even more taxing, as when 'shared laughter' becomes: 'involved with cognitive-affective re-encounter and reactivation of his patient's introjected past.' Such gobbledegook is apt to give this discipline a bad name.

And References to 'rich seam' remind us of that other Holy Grail, 'the root of the trouble', with which general practitioners are understandably disenchanted. Our encounters with patients are more to do with peeling off successive layers of an onion; no one layer being truer, more real, or more meaningful than the one before.

Lastly, *Treatment of Sexual Problems*: 1976
A married man presented, wanting help for his impotence of three months' duration. He was seen regularly, first alone, then jointly with his wife, and finally in a couples' group. For 12 months, feelings were worked through, relationships explored, and communication skills taught; with great improvement all round, especially in the quality of their family life, their openness with each other, and in the husband's career prospects. When about to leave the area, they came to express someone to help with the impotence.

For all our disdain for 'mere symptomatic treatment', it is salutary to be reminded that this is precisely what most patients want. Understanding, yes; health education, perhaps; but above all, relief.

These are a few samples of the atmosphere prevailing in the 1970s. Have things changes? Have they changed for the better? I wouldn't be too sure. Fresh theories are being propagated, ideologies are being canvassed; and newly-formed associations are proclaiming whole-person medicine as if they invented it.

Consider the following: 'Dealing with the Emotionally Disturbed Patient', which appeared 18 months ago in a magazine circulated to vocational trainees and their trainers. First, let me quote the concluding sentence of that article. 'Seeing a patient change from a recurrently anxious and depressed human being to one who is living more effectively is a most rewarding experience, and well worth the effort of acquiring the necessary skills.' And so say all of us. But what precisely are these skills? Counselling skills; but not just lending an interested and sympathetic ear and giving time to patients. No, actually helping patients to think their way through problems.

What problems? I'm glad you asked. Basically, people upset themselves about things by evaluating them in an irrational way; they hold

irrational beliefs about these things, and it is important for these ideas to be disputed. For example, an irrational belief such as 'It is awful that I failed my exam', is changed to the more rational 'It is sad that I failed the exam'. The latter is less likely to provoke anxiety or depression but only sadness and regret.

A case-history is supplied to illustrate the theory: A 14-year old girl with recurrent headaches and feelings of worthlessness was unable to supply any real proof of being useless, ugly, unintelligent and so on. Every time she brought up one of these negative ideas during the consultation she was encouraged to hit herself on the head with a rubber hammer, called a 'disputing hammer'. She lost her headache after six sessions and had not been back a year later.

We Balint doctors were formerly regarded as being on the fringe of general practice. Now, many of our ideas are recognised implicitly, if not explicitly, as belonging to the mainstream of current thinking. So now there may be other contenders for the status of 'fringe'; or even, 'lunatic fringe'. But what is happening in orthodox psychiatry?

Last month I received an invitation to attend a conference offering 'Continuing Medical Education in Psychiatry for Family Doctors' on the subject of Suicide. The programme contained the following introductory statement: 'The vast majority of people who commit suicide have consulted their family doctors in the preceding few weeks. Only a small majority have ever consulted a psychiatrist.' Make of that what you will.

A year ago I took part in a study in which several experienced general practitioners were shown video-tapes of consultations with psychiatrically disturbed patients. We were invited to list the symptoms observed, and to assign each patient to a diagnosis, using the International Classification of Disease. The general practitioners included Balint doctors, academics, and senior officers of the Royal College of General Practitioners.

The psychiatrist who organised the survey is quoted as saying later that 'the general practitioners had wildly different notions of what constituted a psychiatric symptom. About the only symptom they agreed on was when the patient cried. They could not agree on a simple diagnosis. They gave almost as many diagnoses as there were doctors. Indeed, each doctor had his own 'signature' in the way he used the symptom tables.'

Does this mean, I wonder, that the message has finally got through to some of our academic psychiatrist colleagues? Do they now recognise the uniqueness of one individual patient relating to one individual doctor, and the limited relevance to general practice of lists of conventional psychiatric diagnoses? As well as the futility of trying to categorise patients after viewing them as if on a slide under a microscope? Do they realise these things? I shouldn't bank on it. Their attitude still seems to be a million miles away from the understanding which Balint doctors have gradually and painfully acquired; and I am afraid we cannot look to them for the sort of help we need.

We general practitioners must press on, but we have the great good fortune to be able to call on the expertise and generous help of other professional colleagues, three of whom we are delighted to have here this evening as guests of our Society. Our Honorary Member, Enid; Antonia Shooter of the Derbyshire Department of Psychotherapy; and Dr Alexis Brook of the Tavistock Clinic. These true friends represent, between them, the range of valued, specialist contribution to what has become an essentially general practice activity. Without such help it would not have been possible to undertake our training activities on anything like the present scale; nor to have achieved anything like our present level of understanding. We are grateful to them, and to their many colleagues similarly engaged in helping general practitioners to broaden their horizons and to become more self-sufficient in the care of their patients.

The presence here of the President of the Royal College of General Practitioners, Dr John Lawson, is both a source of pleasure and of special significance. It reflects more than closeness of purpose, for the fact is that the College and the Balint movement are virtually twins. They were born at the same time, in 1951, in the most unpromising circumstances, and at the lowest point in the fortunes of general practice in this country.

Their separate emergence in those dark days signalled what has come to be recognised as the renaissance of general practice. In their different ways they laboured to restore our relevance and effectiveness as general practitioners so that we could once more take pride in what we are doing and face our challenges in good spirit.

From the very beginning, the College recognised the need for rehumanising medicine, and has steadily incorporated much of the Balint philosophy into its own policies on such things as clinical management, postgraduate education, and auditing practice activities by peer review.

John Lawson is a practising family doctor in Dundee, from where he has just flown here after doing a surgery. He is also postgraduate adviser for the Tayside region of East Scotland. But it was in his capacity as chairman of College Council that we first met a dozen years ago, when he interviewed me for the post of Dean of Studies. We will not ask him what he now thinks about that appointment; but we have worked together on a number of projects: notably, on standards for vocational training; and general practitioners mutually assessing each other in the setting of their practices. The latter is coming out as a report entitled *What Sort of Doctor?,* and we have high hopes for the adoption of its principles among all our general practitioner colleagues, and not only College members.

But of all the many College activities in which I have been engaged, none has given me more pleasure or filled me with more pride than when I was responsible for formally introducing Enid when she was awarded the College's Honorary Fellowship.[1] This great privilege was conferred on

me by the then President of the College, and distinguished founder member of our own Society, Dr John Horder, who I am so pleased has managed to be here, with his wife, Elizabeth, this evening. I am forever indebted to John for that opportunity, which meant a great deal to me personally. I have never spoken to him about this, but now I should like publically to express my thanks, and the thanks of our Society, for that privilege.

I used that occasion to remind College people of the origin of many of the principles they now took for granted, and of the great debt owed to the Balints. It was a long overdue acknowledgement, and I put everything I had into it. I believe it went down well; and I recall Enid glowed with pleasure. But for me it is memorable for a somewhat different reason; because, come to think of it, it is probably the only time I have ever said anything nice about anyone. Though I did manage to pull myself together, and redressed the balance in my William Pickles lecture last year.[2]

But for all I was able to say about Enid on the occasion of her Fellowship, so much remained unsaid. How do you say those things? Even now? Easy to be formal, and to say that Enid honours us by her presence here. Or being a bit more forthcoming that we rejoice to see her and are so grateful for her continuing relationship with our Society, and for our working contacts with her.

But to be really human, I would have to speak of the enormous affection we all feel for her. My only alibi for not even attempting to express this adequately is that Enid, being a psychoanalyst, and a woman, she knows darn well how much we love her.

Some of our guests here may not realise that Enid virtually invented the style of group-work that is now identified with the name of our Society. That was back in the late 1940's. Soon afterwards it was acquired by Michael Balint for use with general practitioners, because Michael Balint recognised a good thing when he saw one.

During all those years Enid had continued to work closely with general practitioners, inspiring fresh progress, and to this day breathing new life into our research activities. I am privileged to be a member of the small group she is leading at the moment, which is looking at aspects of the doctor/patient relationship; or more correctly, not any doctor/patient, but the unique general practitioner/patient relationship. In particular, the fascinating but rarely alluded to changes in such relationships. And it was Enid who reminded us of the significance of the physical illness factor in our relationships with patients and their families. Easy enough to be body technician, *or* guide-philosopher-and-friend; but how to be adequate at both simultaneously?: that is the challenge which has stirred our interest and which will now be occupying our attention, along with other topics.

Long ago, Enid saw that the real potential strength of general practice, the unique contribution which we general practitioners could make to the health of our patients, was not in trying to emulate specialists and performing brilliant psychotherapeutic feats with highly selected patients reserved for a sort of Sunday best, but in our everyday, every patient contacts.

Although, usually, Enid is eventually shown to be right, her messages have not always had an easy passage, being sometimes greeted with incomprehension, scepticism or frank disbelief. But she is a patient woman; she has to be. Now, if I had a hand in her training (what a fantasy!), if I had been responsible for her supervision, I think I might have sent her on a course for assertion-training so that she could deal with us haughty doctors.

Well now, what of the future? The main thing I want to say is that I am more optimistic about it now than I was this time last year. To me, things seem more healthy, more hopeful, and more purposeful. There have been a number of experiences contributing to this change of heart; I shall recount just three.

I remember many years ago reporting a case in a group led by Michael Balint. When he queried an aspect of the patient's behaviour and wondered what it meant. I shrugged my shoulders and said rather dismissively that we general practitioners had to accept such things in our patients. Yes, agreed Michael, but we should try to understand what it is we are accepting. Touché. Or in my case, Ouch!

He was absolutely right of course. Without proper understanding, so-called acceptance is superficial. It is merely tolerance, not acceptance. Well, if we need to understand properly before we can truly accept, should we not try to understand those things which we propose to reject? I am not suggesting that this should apply to political issues or religious matters: that would be asking too much. But with professional topics, especially those felt to be rivalling or threatening us in some way, we are surely secure enough to listen carefully to their proponents. After all, observing something which you then find you cannot identify with is one way of knowing what you are and what you really stand for.

The Balint Society has recently shown a willingness to hear at first hand about a number of neighbouring activities with which it has not always been totally sympathetic. Speakers on holistic medicine, the counter-transference, and psychosexual medicine, have not had an entirely rapturous reception; but it is to the credit of this Society that they were invited to put their case. (I hasten to add that I take no credit personally: these things were arranged before my time, under the presidency of my predecessor, Aaron Lask.) So, this is one encouraging thing.

A couple of months ago, as you have heard, I accompanied your vice-president, Erica Jones, to Ascona to attend the 13th International Balint Meeting. It was quite an experience. Proceedings at Ascona are generally conducted in German; but the organiser promised to arrange an English-speaking group if I turned up, and he was as good as his word. He managed to recruit well over a dozen people from half-a-dozen non-English speaking countries, including Finland, Yugoslavia and Japan. It was

most humbling to someone like me, a narrow specialist in just one language.

There was a high proportion of youngsters at that Meeting: medical students, junior hospital doctors, and recent graduates with little or no experience of general practice as we understand it. So as you can imagine, I had little expectation of a particularly productive group-session. I could not have been more wrong. Everyone's ready identification with the reporting doctor, their perceptive group cohesion, were truly amazing and defied all our conventional ideas about the subtleties and nuances of language, and the necessity for comparable experience among the members of each Balint-group.

Under Erica Jones's leadership our group performed its task splendidly and with great enthusiasm. Despite my initial reservations I felt completely at home and relaxed in that atmosphere. I became myself. With consequences which you may readily predict. Yes, I caused laughter; and also. I regret, some upset. It was all very instructive.

At the first session, after a short preamble, Erica gently asked who had a case? There was a long silence. And I mean, long. They went on looking at each other, and I realised that there was no way in which anyone was going to speak up. It was expecting a lot from these good people to stick their necks out like that, so I dug into my memory and came up with a case I had seen in the surgery a few days before.

It was a woman in her late twenties who I had first met a year ago, just after she had given birth to twins in hospital; a boy and a girl. There were feeding problems when they got home. I described her as attractive, well-dressed, nicely made-up, intelligent and educated. But she did seem to be making heavy weather over managing the two babies. We were repeatedly called to the home, but could not find anything the matter; and this went on. I was frankly puzzled, and then rather disappointed in her; and eventually I suppose, a little annoyed.

Things settled after a while, and I did not see her again until the twins were nearly a year old when she turned up at the surgery for herself. I asked how things were at home? It appeared that the boy was no trouble at all, but the little girl had become dreadfully dependent. She screamed every time her mother tried to lay her down, and even stopped her going to the cinema because she would refuse to settle down with the baby-sitter.

As the mother related all this, my attitude towards her changed completely. I was furious at the way this poor woman was being tyrannised by that little brat. We discussed possible ways of dealing with the situation, like leaving her to cry; but this would just upset the boy — they only had a small flat. We then got talking about how easy it was to understand the amount of baby-battering that goes on in the world. She clearly had my sympathy. I asked her to come back again.

So this is what I reported to the group. I told it as it happened, just as I would have done — and did do with other cases — 25 years ago; no clever insights, no convenient alibis. The group got to work on it extraordinary well. Remember, they had literally never worked together before.

For most of them, English was not their first language; and many had no experience of family practice. Yet they rapidly got the feel of the case, and then began to discuss the things I had possibly missed: like, what was the mother's part in creating the child's dependency?; did the little girl's misery reflect the mother's inner feelings which she had successfully hidden from the doctor?

Then an American woman doctor asked, 'Why doesn't Dr Norell speak to her man to man? Forget she's an attractive woman, and behave to her as you would another patient.' Silence. 'What!', I exclaimed, 'Are you suggesting I should treat her like an ordinary human being?' The ensuing laughter gave me time to lick my wounds. I believe it helped that group to observe that someone fairly senior could learn, and accept, and acknowledge.

After this, the group really took off, and we had a succession of most interesting cases. Not cases where the patient has some terrific problem, usually totally insoluble, as in common in newly-formed groups over here. No, these were about problems the doctor was having with his patient: the doctor's problems. A common theme was patients who seemed to refuse to behave as their doctors expected them to. Not all the cases were from general practice, but the reporting doctors, despite their hesitant English, were able to convey most eloquently the feelings aroused in them by their patients: whether deep concern, hope, compassion, irritation, distaste, or guilt; and we had examples of all these. Furthermore, these revelations did not have to be dragged out of them; they emerged in a natural and moving way.

There was a single exception, and it was this which produced the unfortunate outcome to which I alluded earlier. At the second session, on the following day, a woman psychiatrist presented a patient who had originally been referred to her by a physician. It concerned a man suffering from unexplained chest pain at night. The recounting of this case was totally different from all the other ones we had listened to: formal, conventional stuff; questions and answers, symptoms, facts, dreams; but scarcely anything about any interpersonal relationship, about what was happening between doctor and patient. We were being presented with a diagnostic puzzle.

As this went on, I wondered what difference it would have made if this patient had fed the information into a computer instead of the doctor. Unfortunately, I thought aloud. And that was my mistake; because the next thing I knew, the leader sprang to the defence of the reporting doctor, and I should have realised then that something was up.

At this point I should explain that because of the oddly shaped room we were in, the group was not sitting in a perfect circle; so I was not able to see the reporting doctor without leaning forward a good bit. Consequently, I missed what was very evident to the leader who was sitting next to her, namely that

she was considerably stressed from the very beginning. Minutes later she was in tears.

Something else that I had overlooked was that this psychiatrist had not been present at our first session. Now, this may sound ridiculous: how on earth can one session make all that difference? All I can do is to testify to the astonishing cohesiveness of that group; and how they all seemed in tune with each other, and to have a common 'language', by the end of that first session, under Erica's skilled leadership.

So my comment, which led to the psychiatrist's distress, was literally blind and insensitive: I could not see her, nor could I identify with the way she was handling the patient. The chief lessons there, are that it is not enough to listen to people, they need to be observed also; and our imagination ought to be given freer rein. Everyone knows this.

Overall, I found the most valuable contributions at the Ascona meeting came from the relatively inexperienced. There is no reason to be really surprised at this. It is legendary how, in the old days, when we used continually to beseech Michael Balint to give us the answers we desperately needed, he would smile and his eyes would gleam behind those thick spectacles of his. Not because he was holding out on us in a teasing way, but because he did indeed know something we did not: namely, that he was going to learn the answers from us.

Now lastly, the third experience; something completely different. In the William Pickles lecture last year, I challenged the notion that the College's membership examination could be a 'proper test of a general practitioner'. This reference was of course to the Gilbert and Sullivan character who proclaimed that his prowess as a major-general was based not on practical soldiering but on academic militarism.

This idea of the model general practitioner was picked up by another of our guests here this evening: Dr James Willis, a general practitioner and course organiser in Hampshire, from where he has just come to be with us. He produced a satirical version entitled 'The Model Member's Song' which was published in the College Journal earlier this year.[3] Some of you may have seen it. I must say I was tremendously impressed by it: I found it totally in line with our thinking. But you must judge for yourselves.

I should love to sing it to you, only I do not have the voice. More importantly, I do not have the nerve. But I shall attempt to recite part of it. First though, so that you can pick up the tempo and the rhythym, here's a snatch of the Gilbert and Sullivan original.

The Model Member's Song

I am a model member of the Royal College of GPs
I'm lacking no accomplishment to rid my patients of disease.
I did the OK house-jobs in a range of specialties —
(I'm good with a retractor and I've done a few appendices).
My practice is a business and efficiency is everything.
I ridicule the fossils who persist in chronic visiting.

I analyse my patients on a scale from one to forty-two,
They're broken down by age and sex and height and weight and size of shoe.
I tape my consultations to admire communication skills.
Oh yes, I am the very thing the patients need for all their ills!

In fact I sometimes wonder if my training *was* vocational —
It had a sort of relevance, but nothing too sensational.
My teachers taught me arrogance but now I need the common touch —
My practised pompous strutting and carnation haven't helped me much.
I find myself let down by all those bright ideas that we were taught,
The customers refuse to need the sort of help we thought they ought!

In fact when I'm available as freely as I ought to be —
When I can understand the reasons patients really come to me,
And when the things I know and those I don't know I begin to see —
You'll say a better general practitioner could never be!

That I submit, is the true Balint spirit.

If, as appears, the Balint influence has spread beyond our Society — whether acknowledged or not — then that to me is ample justification for continuing our efforts to achieve a better understanding of the essentials of our approach to patients; and to make this understanding available to all our colleagues in general practice who show an interest.

I said at the beginning that I would be offering personal reflections. Let me conclude then, by saying that it is my personal belief that there may be two sorts of general practitioner: those who from time to time experience self-doubt; and those who don't, but ought to.

With that, and until this time next year, dear colleagues, and dear friends, my warmest thanks and sincerest good wishes to you all.

JACK NORELL

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2. Norell, J. S. (1984) *J. Roy. Coll. Gen. Pract.*, **34**,417-424.
3. Wills, J. (1985) The model member's song. *J. Roy. Coll. Gen. Pract.* **35**,11.

Secretary's Report

The Balint Society continues to work to promote the original ideas of the late Michael, and Enid Balint.

Last September (1984) we held our annual Residential Weekend at Pembroke College, Oxford. Dr. Jack Norell led the initial demonstration group and chaired the final plenary session.

Fifty-two general practitioners and trainees attended and we formed four groups which coalesced and worked well for four sessions.

In October 1984 several members of the Society flew to Montreux for the 6th Congress of the International Balint Federation. The warm Swiss climate and lakeside views together with the enjoyable polyglot company made for an exciting weekend. There were many highlights but for me the best were the contrasting styles of leadership of the demonstration groups led by Professor Guyotat in French and by Dr. Werner Stücke in German.

In November we began our series of meetings at the Royal College of General Practitioners with Dr. Max Mayer who was awarded Honorary Life Membership. He spoke on the subject 'They, Us and Him'. He found only one reference to the name Balint in the last five years in the Lancet and the British Medical Journal. He asked, is there a crisis in our Society?

In January 1985 at the Royal College of General Practitioners, Dr. Patrick Pietroni addressed us on 'Aspects of Holistic Medicine'. He asked, would Michael Balint have joined the British Holistic Medical Association? A great deal of his argument was derivative without even a gratuitous reference.

In February at the Royal Society of Medicine, Dr. Cyril Gill gave the Michael Balint Memorial Lecture entitled 'Tensions in General Practice' (see page 10).

In March at the Royal College of General Practitioners, Dr. Michael Pokorny led a group demonstration entitled 'Grasping the Counter-Transference' in which he exhibited modern bahavioural techniques for understanding the doctor's overt and unconscious reactions.

Throughout the year the Balint Group-Leaders' Workshop met every other month at the Royal College of General Practitioners to discuss transcripts of group case-presentations in order to illuminate and encourage the rôle of the Group-leader both in Balint-groups and Trainee-groups.

The Council of the Society has met regularly throughout the year with good attendance to discuss the various issues and practical problems. Perhaps the most important of these is the diminishing membership. A working party was formed and a report appended below.

For the future we are planning to hold another Residential Weekend of Balint groups at Pembroke College, Oxford, on September 27th. This year we are fortunate again to have the sponsorship of Stuart Pharmaceuticals who have printed the excellent programme.

Finally we are offering another Prize Essay Competition to be judged in April 1986. This year the title is 'Who needs Balint?' and the winner will receive £250.

PETER GRAHAM

Report of Ad Hoc Working Party

Remit: To consider future membership options

Is membership a token of achievement?

Are we an exclusive or inclusive club? Are we a catalyst or are we stagnating?

Is there a difference between Trainee-groups and Balint-groups?

Can we supply the means of training to only insiders or outsiders?

As there are no trained group-leaders in your Region, how can we help you?

Do we agree that what we have to offer is of universal application to general practice?

The only principle with which we work is that we know that we do not know the answers.

Most people learn about Balint second-hand through hearsay or newspapers; very few have the two years in a Balint group.

Is there any demand for membership?

Why are we afraid to take people who have had no group-experience? Perhaps if we admitted potential members it may give the Society new dynamism.

The Working Party considered these questions and concluded that the real action in general practice is taking place in Trainee-groups. Therefore we propose that a change in the constitution which would allow general practitioners to become full members of the Society after only one year's experience in a group, rather than two years as at present, should be considered.

Jack Norell
Erica Jones
John Salinsky
Sally Hull
Heather Suckling
Peter Graham

Balint in Ascona, 1985

The theme of the 13th International Meeting held in Ascona, 28-31 March, 1985, was The Chronically Ill Patient and his Doctor. There were also talks and discussions, as well as the familiar group-work on reported case-histories.

There were a number of striking features to the British visitors. Firstly there was the truly international flavour. The participants came from a dozen different countries, including Austria, Belgium, Britain, Finland, Germany, Holland, Hungary, Japan, Portugal, United States of America and Yugoslavia, as well as the host country, Switzerland, some of which have not yet formed their own national Balint Societies (or equivalents).

The proceedings were mostly conducted in German, but an English-speaking group, whose members had come from countries as far apart as Finland, Japan and the United States of America, was convened and met each day.

In addition to the wide range of nationalities in that particular group, there was great variation in the amount of experience possessed by the individual members.

There were family doctors, internists and psychiatrists, as well as medical students and recently qualified doctors.

Despite these potential drawbacks, everyone joined in the group-discussion which was marked by good understanding and perceptive comments.

Evidently, language barriers and the problem of mixed ability can be overcome if there is commitment to a common task, and respect for the contribution of each individual member of the group.

The actual case-histories presented in the English-speaking group proved to be fascinating. They all touched on an important aspect of our work: not so much the patient's particular problem, but the problem the doctor was having with that patient. In other words, the doctor's problem.

In nearly every case, the patient seemed to refuse to act as the doctor expected, so that not only did the patient's behaviour puzzle the doctor, it also disappointed him.

The focus of the group discussion was very clearly on the doctor/patient relationship, but the remarkable thing was that this should have been achieved so early and so well in a mixed group.

Another notable feature of the meeting was the large contingent of medical students and junior doctors, who could have had little or no first-hand experience of family medicine — the traditional field of Balint-work. This suggests that the Balint principles have wider application than is conventionally thought.

The sustained interest displayed by everyone at the meeting was very impressive. There was enthusiasm for the whole programme, as well as eagerness to rejoin the groups for further work on reported case-histories.

Finally, the undoubted success of the Ascona Meeting is both a tribute to the organizational skills or Professor Boris Luban-Plozza, and a reflection of the personal contribution made to the proceedings by that charismatic medical man.

J.S.N.

The Balint Documentation Centre, Ascona

The municipality of Ascona, always sympathetic to the international Balint meetings which have been held in this town since 1972, has now made possible — with the cooperation of the Ascona Library — the establishment of a Balint Documentation Centre. It has seemed that a Centre of this kind would correspond to the need for contacts, at an international level.

This institution is directed primarily to interested professionals, students and those who are preparing scientific works regarding the doctor/patient relationship and psychological training. Despite its modest dimensions, the Centre is able to make available to physicians as well as students books, journals excerpts and programs concerning psychological, psychosomatic and patient-centred medicine in the tradition of Michael Balint-work.

The material is sent out free of charge; return postage will be appreciated. Those who wish to make use of the Centre's facilities for their research or study purposes are invited to send in their requests in writing.

The Centre, for its part, will be grateful for any support, especially for receiving pertinent material suited to enrich and expand the bibliographical and documentary collection of the Institution.

The Balint Documentation is guided by a *scientific council*, presided over by Mrs. Enid Balint-Edmonds, London.

The secretariat is in the hands of Prof. Dr. med. Boris Luban-Plozza, CH — 6600 Locarno (Plazza Fontana Pedrazzini).

P.H.

Correspondence

The Editor,
Journal of the Balint Society.

An even better than usual Journal arrived this morning!

However, I would be grateful if you would correct an error in Michael Courtenay's excellent contributiion (Vol. 12, p. 8) — I have already drawn his attention to it.

Advanced seminars of the Institute of Psychosexual Medicine do not always have a psychoanalyst group-leader. They have been, and still are, led by specially selected leaders of ordinary seminars.

Indeed to my knowledge, Tom Main has been the only psychoanalyst to lead advanced seminars for the Institute.

I ask for this correction because this practice has facilitated the spread of Institute seminars over a very wide area. Of course, I realize that there are strong arguments against — but as long as the limits of aims are accepted, it has its uses.

Jean Pasmore,

South Cottage,
Ham Gate Avenue,
Richmond,
Surrey, TW10 5HB.

Book Review

Children's Problems: A parents' guide to understanding and tackling them. By Bryan Lask. 1985. London. Martin Dunitz. (Pp. 124. £3.95 paperback.)

The aim of **Children's Problems** is to establish reciprocal contact between parents and their children, and to encourage the active discussion of problems rather than burying them under embarrassment and misunderstanding.

Bryan Lask is consultant psychiatrist at the Hospital for Sick Children at Great Ormond Street, London. Apart from being the son of Dr Aaron Lask, past-president of the Balint Society, he is internationally famous for his clinical and research work into childhood behavioural problems. He is a father of two young children himself.

The problems of two to five-year-olds such as feeding, sleeping, toilet-training are tackled, as well as teenage subjects such as sex and drug-abuse.

The role of the family and the good-enough parent are strongly emphasised, and Dr. Lask recommends parents to use a positive approach at all times, particularly in their communication with their children.

This is an excellent book to recommend to patients, and to serve as a basis for discussion with them; it is refreshingly free of over-theoretical statements, and any patronising tone.

The style is very easy and readable, and indeed could well be read by doctors and others who are concerned about the welfare and health of the family.

PHILIP HOPKINS

Obituary

Dr GERDA TINTNER (Née Lewin), MRCS.(Eng.). LRCP.(Lond.)

Gerda Tintner was born in Berlin, the daughter of a well-known urologist and venerologist, a man of exceptional personality, greatly gifted in many fields, who had a great influence on Gerda's development and thinking.

She started her medical studies at the Medical Faculty of the Berlin University, but had to leave in 1936. After gaining her first MB she came to London, but was only able to continue her studies in medicine at the end of the war, qualifying at the Royal Free Hospital, in 1948, on the same day as her husband. In 1953 they started their own practice in Roehampton.

All along her main interest was the study of the whole patient, the whole psychology of the individual and the inter-relationship of the family. When Michael Balint started his groups, she was among the first of the doctors to take part, was one of his outstanding pupils and contributed two case histories for *The Doctor, his Patient, and the Illness.*

Her own practice rapidly developed to a group of four partners, with whom she had a very good relationship. There were 9000 patients of varied social and ethnic backgrounds, to all of whom she tried to give of her best. They regarded her not only as a doctor but as a friend or parent.

After her death, her husband was approached by many people who wanted to give donations in her name to charity. He decided to start a Scholarship Fund in Psychological Medicine in the Medical School of the Ben Gurion University in Beersheba, which has a unique programme in medical education, and attempts to use a holistic approach in Balint-style. The target figure has nearly been reached but contributions would still be greatly appreciated.*

J.T.

* Contributions, made payable to Dr. J. Tintner, may be sent c/o The Editor, The Journal of the Balint Society.

Balint Weekend at Oxford 27th-29th September, 1985

The ninth annual meeting for general practitioners and others who want to sample the work of a Balint-group, again took place this year at Oxford's Pembroke College.

Like the beautifully unseasonable, warm and sunny weather, the meeting was better than ever before.

Several doctors came from France, Norway and Switzerland, and a few from as far afield as South Africa, but the majority of the one hundred and seven participants were British general practitioners, trainees and principals in equal numbers, in spite of the persistent reduction of Section 63 funds.

One clinical psychologist, two paediatricians, (one French, one British), and a sprinkling of psychiatrists, added to the usual enthusiastic, and often highly emotionally charged discussions in the nine small groups, each with two co-leaders, for three sessions.

After registration on the Friday evening, and a simple meal in the lofty, oak-panelled dining hall, nine doctors (who had not had previous Balint-group experience), volunteered to form the 'fish-bowl group' to be skilfully led by Mrs Enid Balint-Edmonds, with the rest of us sitting around in a crowded, irregular circle.

At past Balint Weekends, some doctors reluctantly listened in enforced silence, and with mounting frustration, which later burst out angrily at the final plenary sessions. This year, all were invited to join in the discussion after the first case-history was presented — and they did!

Predictably, at the final plenary session there were again angry outbursts by some who now complained that they had not witnessed a 'proper demonstration' of a Balint-group! Proving yet again that old adage not being able to please all the people all the time!

Enid's amazing group-leadership not only showed how well even a large group can work together, but it also helped to weld us all together, so that the success of the weekend was guaranteed.

I always find it quite remarkable to experience the ease with which a group of doctors, mostly unknown to each other can, in such a short time, produce an array of what at first seem to be such bafflingly difficult problems, in both clinical or medical, as well as in psychological terms, and then work as though they have been meeting together every week for months!

Mike Courtnay, who was co-leader with me, and I were delighted to see how wonderfully well and quickly our group worked together, and how supportive they were when two of the group members revealed how emotionally moved they were, when they recounted their reactions to the dying and death of the patients they were reporting.

All were agreed that this is a very important function of a Balint-group that may not be sufficiently well recognised.

It was specially interesting that one member of the group was not a doctor, but a psychologist involved in treating patients in conjunction with general practitioners. It turned out that the need for the opportunity to discuss problem-cases with colleagues is as great for psychologists as it is for doctors — and for social workers too, as was proved by Michael and Enid Balint by their early work together at the Tavistock Clinic with groups for social workers.

Once again, at the final plenary session on Sunday morning, many questions were asked — but there were not even any answers . . .

The discussion showed how great is the anger felt by many doctors who came to the Oxford Weekends to experience working in a Balint-group, and who are then highly frustrated by savouring their stimulating effects; only to discover that it is not easy to find a Balint-group outside London. The need is there and our Society must find ways of meeting it.

It may be that we must not only continue to hold the annual Oxford Balint Weekend, but perhaps we should also consider offering Balint Weekends for potential group-leaders (or, as has been suggested, group-conductors) from those parts north of Watford who so desperately are clamouring for Balint-groups.

P.H.

Programme of Meetings for the Sixteenth Session

1985-6

All meetings will take place at the Royal College of General Practitioners, 14, Princes Gate, London, SW7, on Tuesday evenings, at 8.30 p.m., preceded by coffee at 8.15 p.m.

DR. DAVID SIGMOND:
Dialogue, Dialectic and Didacticism: 29 October 1985.

DR. MARK SUNDLE:
Another View . . . Video of the Consultation: 26 November 1985.

DR. MICHAEL COURTENAY:
Rôle of the Balint Group-leader:
A Critical Re-appraisal: 18 February 1986.

CLARE RAYNER:
The Agony Column and the General Practitioner: 25 March 1986.

DR. DEIDRE PAULLEY:
Sensitivity Groups: 24 April 1986.

THE ANNUAL GENERAL MEETING and DINNER will take place on 10th June 1986. Details of the venue will be announced later.

THE OXFORD RESIDENTIAL BALINT WEEK-END will be arranged for September 1986. Details will be announced later.

BALINT-SEMINARS FOR GENERAL PRACTITIONERS WILL BE ARRANGED AND DETAILS WILL BE ANNOUNCED LATER.

The Balint Society Council 1985-86

(Founded 1969)

President:	Dr. Jack Norell	*Hon. Secretary:*	Dr. Peter Graham 149 Altmore Avenue East Ham London E6 2BT Tel.: 01-472 4822 01-505 1520
Vice-President:	Dr. Erica Jones		
Hon. Treasurer:	Dr. John Salinsky	*Members of Council:*	Dr. S. Hull Dr. P. Julian Dr. P. Monk Dr. J. R. Scott Dr. L. Speight Dr. H. Suckling Dr. M. Sundle
Hon. Editor:	Dr. Philip Hopkins 249 Haverstock Hill London NW3 4PS Tel.: 01-794 3759		

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

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

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.

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