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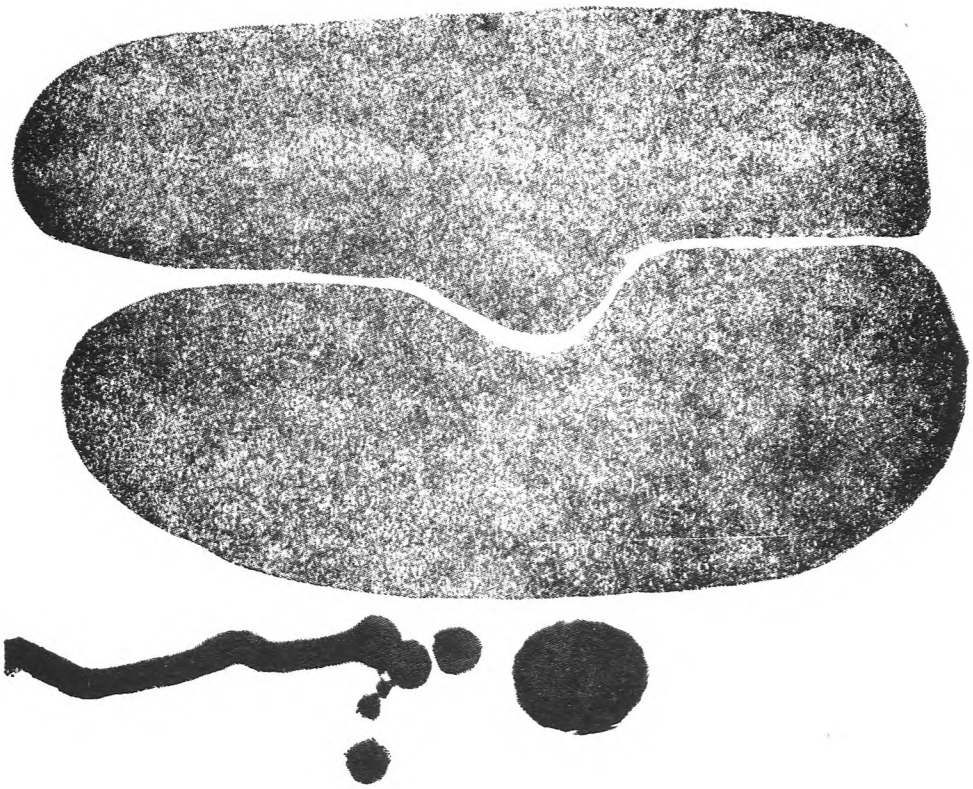

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Editor: Philip Hopkins

Michael and Enid Balint above Lake Lugarno, Summer, 1970

Editorial

Time was one of the recurring topics mentioned and discussed over and over again at the highly successful International Balint Memorial Congress recently held in Budapest (see page 26). Not only the average time allowed for each patient, which is remarkably constant at about five or six minutes in almost all the countries represented at the congress was discussed, but also what use the patient makes of his doctor in that five or six minutes.

Also discussed was the question what can the doctor usefully say or do for the patient in that short time; that is, what can be said and done in those all too few minutes?

Underlying the obvious concern shown by most doctors who want to do more for their patients, there is the realization that apart from the possibility of a 'spot diagnosis' or a 'flash' occurring in this all too short a consultation, not a lot can be achieved in any one such meeting between doctor and patient. On one occasion Balint suggested during a group discussion in 1967 that it may not always be appropriate to 'strike when the iron is hot', but better to allow a few weeks cooling off period.

So the average time allowed for a consultation might well be adequate for the patient who cannot stand the intensity of the long interview, as it came to be called, or tolerate too fast a pace in dealing with his problems.

Indeed, one of the saving graces of general practice is said to be the fact that even though each consultation may be fleeting in terms of time, there are many of them. In theory, therefore, relevant points may be taken up repeatedly, albeit briefly, and pursued as and when required. If, of course, the patient can be sure of seeing the same doctor each time he attends, so there is the continuity of care required for this technique.

Then there are those who very much appreciate and do want more time in which to work through their problems. Undoubtedly these are the patients who benefit when we are able to offer them the time they need to ventilate their problems and feelings in their own way. Anyone who has used this technique must know that this is not easily done in the average five or six minutes!

Perhaps some doctors may feel frustrated by the limitation forced upon them by the lack of time. Could it be that in turn this creates in the doctor a strong feeling of dissatisfaction and discontent, and could this explain why so many doctors are now looking forward to the earlier retirement which may well be imposed upon them in the near future?

Was Balint under some false impression perhaps — and were we not always clear in our definition of what is the 'average' consultation time in general practice? We always talked about the 'average five minute' consultation, yet on one occasion in 1966, Balint spoke of the 'normal five-ten minute period that is available for any patient in general practice'. During another discussion in 1967 he spoke of the 'normal routine which means five to fifteen minutes of work at any one occasion'.[1]

That could well have been the expression of some unconscious wish, because on another occasion in that same year, Balint severely chastised a doctor in the group for stopping a consultation when it was taking more than the ten minutes which we had agreed was a necessary criterion if the case-history was to be presented to the group. He said very sternly, 'Sorry, ten minutes should be discarded if it hampers your style . . .' (see page 3).

Certainly many of our patients have been expressing their very conscious wish to have more time to discuss their problems. We have quite recently been told how patients prefer to see the modern British version of the old Soviet idea of the *feldsher* — the practice nurse. The reason quoted by one such lady, 'Instead of offering women Mogadon I offered them my time.'[2]

It is interesting to consider what our text books have had to say about the use of time in medical practice — it will not take long! One of the earliest references to the problem of *physical time* occurred as recently as 1961, in Michael and Enid Balint's *Psychotherapeutic Techniques in Medicine*,[3] a book that sadly has not engendered the interest it warrants. They 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 need.'

In the light of our not inconsiderable experience over the past 38 years, we must now add that the time most of us can offer our patients must also be dependent on the organisation of the health service in which we work.

Even though it was reported that some doctors had said at another medical gathering that if they had to spend more than five minutes with a patient they would not know what to do, we cannot accept the view that there is no evidence to show that a patient benefits more if the doctor spends more time with him. We must point out that it is not simply a matter of the doctor spending more time with a patient, but also *what he is able to do in that time.*

There is a great deal that our Society can and should be doing in order to continue the work started by the Balints, not only in terms of providing and encouraging the formation of more Balint-groups. Should we perhaps be preparing a statement of our views about the Green Paper[4] that is about to revolutionise general practice in our National Health Service yet again?

As our president, Jack Norell, has said, 'Michael Balint did so much to transform our profession that we doctors in Britain are immensely proud — and awed — to have been colleagues of his . . .' (see page 13). Now surely is the time for us to develop his work further, and do all we can to ensure that Balint's concepts are put into practice more widely.

This would not only be of enormous benefit to our patients, and give doctors the boost to their morale that they very sorely need — it would also result in immeasurable savings for the National Health Service.

P.H.

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The Doctor's Therapeutic Function*

by Michael Balint
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This paper is a short historical summary of one aspect of some research carried out during the past fifteen years, first at the Tavistock Clinic and recently at University College Hospital in London.

The original aim was to devise a training scheme for practising doctors which would help them to understand their patients' emotional problems, and so to use this understanding that it would have a therapeutic effect not only on the illness of the patients, but on the patients themselves. As so often happens in science, our research gradually encroached on neighbouring fields: epidemiology, therapeutics, the place of psychotherapy in medicine.

The object of our studies is not psychotherapy, but therapy: not an isolated or specialised medical skill, but the doctor's whole professional activity regardless of whether he is a specialist or a general practitioner. The word "function" in the title emphasises my concern with everything that the doctor does with therapeutic intent or that may have a therapeutic effect.

If my account seems unsystematic, that is because I have thought it best to present our findings in the order in which they revealed themselves to the ignorant and unprepared observers that we were when we started out on our research.

Listening to the Patient

What we first discovered was that the doctor must learn *to learn* in such a way as to avoid superimposing on the material produced by the patient his own preconceived ideas about the causes and nature of the illness, and thereby moulding the patient's complaints to fit these ideas. This danger is as great in organic as in psychological medicine. We epitomised the difference between this new attitude and the traditional way of taking a medical history in the phrase *he who asks questions will get answers, but not much else.*

A price had, of course, to be paid for this innovation. A properly taken medical history is orderly, neat, and tidy; there seem to be no holes in it. The result of listening is, as a rule, an untidy picture, with loose ends, frayed edges, and many holes in it. But these very loose ends and holes, if properly understood, tell at least as revealing a tale as a traditional medical history. So we coined a second phrase: *negative findings must be explicity stated, and evaluated* — instead of asking questions to cover them up.

To take an everyday example of this attitude: during a consultation the patient does not say a word about his father: most doctors will treat this as an oversight and try to put it right by asking questions — instead of recognising it as an important communication or even a symptom, and evaluating it as a pointer to the patient's emotional problems with his father.

Intellectual and Emotional Understanding

Mere listening is not, of course, enough. It enables the doctor to assimilate the patient's material with the least possible distortion by his own preconceived ideas; but this material, with all its holes and loose ends, must be understood both intellectually and emotionally.

Intellectual understanding presents no special problem and needs no discussion. But emotional understanding must be considered further. It is important in every human relationship, whether between two lovers, between the public and a new work of art, between the parents and their newly arrived baby, or between the different members of a working team. In medicine we have to do with a special form of emotional understanding — understanding people in a professional capacity — which we may call clinical understanding. I have discussed this in detail elsewhere (Balint and Balint 1962). The doctor must learn not only to understand the emotional problem presented by his patient, but also to express to himself his understanding, primarily in terms of areas of conflict and secondarily in terms of areas of no solutions, or of false ones. The following short case-history illustrates all these points.

A young man of 23 appeared at a dermatological outpatient department, with a letter from his doctor to say that for 3 years he had had irritation of his lips which did not respond to any kind of ointment, even cortisone. Various tests for allergens, including patch tests, were negative. A girl student was taking the history when a male student arrived, and from that moment the patient completely ignored the girl and answered only the questions put by the man. Then a registrar — another woman — arrived and she too was ignored.

The male student, "listening" not only to the medical history but also to all these details, asked the patient whether the patch tests included lipstick. At this the patient pulled himself up indignantly and said: "That was unnecessary because it was impossible."

Having thus established the main theme, the student quickly obtained the following details: (1) the patient had left home, to be nearer his office, about 3 years before (that is, when his illness started); (2) his father died when he was only 5; (3) he was the youngest son of nine or ten siblings, mostly girls; (4) ever since leaving his mother's house he had lived in a family with two children aged 10 and 8 (that is, as the eldest son); (5) he had no girl friends, and felt

* Based on a short address to the Second International Conference on Training of General Practitioners at Versailles. March 22, 1964.

inhibited in their presence "because of the condition of his lips". The rest of the case-history is irrelevant; the illness was diagnosed as exfoliative cheilitis.

This case-history shows how the student listened, and noticed two loose ends: the patient's behaviour during the examination and the absence of any reference to a girl friend. A well-aimed question clinched the diagnosis. The area of conflict in this case was the patient's relationship to women, and in this area he could reach only a false solution: close proximity to any woman became impossible — because of the state of his lips.

The Patient's Offers

Another discovery was that if the doctor is able and willing to listen to his patient he nearly always finds that the patient offers various complaints, or illnesses. To these the doctor then responds with various examinations and treatments — according to his professional knowledge and skill, prejudices, and preconceived ideas. This interplay between offers and responses continues until eventually an agreement is reached, then doctor and patient settle down to treat the illness — or, in some cases, the agreement.

Something of this kind happened in our case, too. The patient offered at least four different conditions, complaints, or perhaps even illness: (1) the condition of his lips, the cheilitis; (2) his inability to kiss a girl; (3) his wish to live in a close knit family as the eldest son; and (4) his preference for men. Apart from my two students, the medical profession responded by neglecting or even ignoring offers 2, 3 and 4 and concentrating exclusively on offer 1 — the exfoliative cheilitis.

These four discoveries — listening instead of taking a medical history, recording and evaluating the negative findings instead of covering them up by asking questions, recognising the dynamic interplay between the patient's offers and the doctor's responses which results eventually in an "agreement", and expressing these findings in terms of areas of conflicts on the one hand and areas of false solution, or none, on the other — have been tested on a fairly large scale in general practice and have proved their worth. In consequence, especially among the doctors who participated in our training-cum-research seminars, these four functions are in constant use. The situation is somewhat different with the next two of our discoveries although there would have been ample time to integrate them into everyday medical practice.

"Organisation" of Illness

We noticed fairly early in our research that during the interplay between the patient's offers and the doctor's responses two distinct phases could be differentiated; either may be very short, or may occupy almost the whole duration of the illness. One of these phases occupies as a rule, though not necessarily, the initial stages. During this phase *the illness as yet is unorganised;* "unorganised" is used here in the psychological sense in the first instance, but I would not object if it were taken in its full equivocal meaning which refers to the organic as well as to the psychological sphere of illnesses. The patient offers various symptoms and complaints to his doctor, changes them in the light of the doctor's responses, and in particular to the results of the clinical examinations, the various tests, or the treatments prescribed. The doctor is keen, inquisitive, and interested. The roles of the two actors are not yet settled, definitely not running in a rut.

In the other phase *the illness is organised;* both patient and doctor then *know* what the "trouble" is. Before the organisation the patient was living with his *un*organised illness, which meant vague but harassing worries, uncertainties, and fears often so hazy that he could not describe or name them. The organisation of the illness in a way relieved his state; something was settled for him. He knows now what his "trouble" is. However unpleasant the implications may be, they have none of the horrors of the unknown; they have a name. For the doctor, too, there is some relief, he knows now where he stands and what he can and cannot do for his patient. But the roles of patient and doctor are settled, and being settled are difficult to alter, because any change may seem a step back to the unorganised state of worry, fear, and uncertainty. This threat creates rigidity because both the "trouble" and the roles are strictly prescribed by the illness that has been diagnosed — or perhaps only "agreed upon".

Returning to the same case-history, the agreed illness was exfoliative cheilitis. This then determined the roles; the only thing that the doctor could do was to prescribe ointments, while the patient had to show his lips but not his other fears and inhibitions, especially not those about women.

It is obvious that patients are more willing to be approached in the unorganised phase of their illnesses. The secondary psychological process, which may create such rigidity that the doctor can do nothing but let the patient have his accustomed treatment, have not yet had time to take charge. In consequence it is vitally important for every doctor, especially if he is dealing with a chronic case, to watch for signs which would enable him to recognise the coming of an unorganised state. Fortunately, even in the most chronic cases swings towards the unorganised phase may occur from time to time. These give the perceptive doctor badly needed opportunities for therapeutic interventions, which would be impossible during the organised phase.

Autogenous and Iatrogenous Illness

One last discovery to be mentioned here is the existence of two illnesses, or more correctly of two pictures of illnesses, in each case. We have found that a patient comes to a doctor only after having reached a certain point. The external characteristic of this point is a newly won capacity: he can now complain. This means that he has now created out of his new sensations, fears, suspicions, pains, and discomfort a more or less stable structure which I propose to call *the autogenous illness.* It is this that he offers to his doctor, but of course only in very vague and uncertain terms.

The doctor then, on the basis of his medical history and his examinations, also creates a more or less stable structure which I propose to call — *sit venia verbo — the iatrogenous illness.* It is more realistic and more scientific than the autogenous illness; and,

especially if it leads to a real diagnosis, it may be more easily treatable. However, I think we doctors ought to admit that not so seldom the iatrogenous picture of the illness leads only to a spurious diagnosis: to a sort of mimicry, or caricature, of a real diagnosis.

An all-too-common attitude in the medical profession is that the iatrogenous illness is the real thing which the doctor can and must treat, while the autogenous illness, though its existence cannot be denied, is only an irritating, irrelevant nuisance because the doctor has no idea how to treat it. Admittedly, all this is true in some cases, in particular of acute illnesses described by saying that an otherwise normal patient was struck by an illness. Yet too often it is untrue, especially in cases described by saying that the whole patient is ill. It is in these latter cases that the iatrogenous picture of the illness proves of very limited help in devising an efficient therapy. For a safe prognosis and efficient therapy it is essential to recognise both pictures of illness, diagnose their nature, and treat them properly.

This has been our last important discovery and as yet we have not done much to train the doctors to use it in practice. Even in our most advanced research projects, which are carried out at the moment in the Staunton Clinic in Pittsburgh, at the Tavistock Clinic, and at University College Hospital, we have gone only so far as to train the doctors to make a traditional diagnosis and in addition what we call on overall diagnosis, using the first four discoveries enumerated above. However, as soon as the present group of doctors become familiar with these ideas I intend to introduce a tripartite diagnosis which will integrate the traditional or iatrogenous diagnosis, the autogenous diagnosis, and the overall diagnosis.

Treatment before Diagnosis?

So far, I have said hardly anything about therapy. This in a way is right and wrong at the same time. It is right because in principle no therapy should be started without prior diagnosis. But often a partial diagnosis is followed by a partial therapy which then leads to a more detailed and more reliable diagnosis. In these cases diagnosis must *follow* some sort of therapy. Exactly this happened during our research. It was on the basis of the observed therapeutic results that we were able to make the discoveries described in this paper. Since with each discovery the doctor's function changed — a little or even a great deal — it would be most difficult to give a true picture of the whole historical development. Instead of it I shall try to describe the doctor's therapeutic function as it appears today.

At present, that is at the stage that we have reached, we think that the doctor must: (*a*) listen and ask only the right questions and not too many of them; (*b*) allow his patient to develop the picture of his autogenous illness with as little interference from the doctor as possible: and (c) watch especially for negative findings and evaluate them properly.

While doing all this he must try to recognise: (*a*) which *areas* of the patient's illness are still unorganised; (*b*) the conflict or conflicts hidden behind these areas, and probably expressed by them; and (c) the possible connections between the patient's offers of illnesses or symptoms, the unorganised areas, and the areas of conflict. In certain cases it may be important to reach a differential diagnosis between areas of false solution and those of none. On the whole, no solution and unorganised illness are connected on the one hand, and false solution and organised illness on the other. This differential diagnosis is important in psychosomatic medicine, because the two conditions need somewhat different treatment. On the one hand, the doctor may restrict his diagnosis solely to the organised illness, such as asthma, peptic ulcer, enuresis; and many neglect the need to understand the difference between the areas of no solution and those of an attempted false solution. If, on the other hand, the doctor is psychosomatically minded he may be tempted to concentrate on the conflicts and not evaluate properly the sometimes considerable benefits of a false solution.

The Doctor's Therapeutic Function

So much for the doctor's diagnostic function, which is a sort of pre-condition for any therapy. His therapeutic function may be defined as responding to the patient's offers so that his responses have a therapeutic effect both on the illness and on the patient. The doctor's first aim should be to avoid any further costly organising of illnesses. This, however, is only a negative aim; in a positive sense he must try to open ways to the patient for choosing better alternatives — for instance, by accepting some of his conflicts and doing something about them in reality.

A well-known example is the conflict often found with duodenal ulcer. It arises from anger, which may be conditioned by the excessive demands of a hard employer or by the patient's own conscience. The false solution is to defeat the over demanding authority, external or internal, by becoming ill from time to time; the alternative would be to revolt against him and fight out in reality an acceptable compromise solution. All this may be fairly clear, especially to an uninvolved observer, as the doctor is; but the patient, even if he is aware of the alternatives, cannot move because of his pathological emotional involvement. If the doctor has the requisite skills he may help his patient to explore his feelings in order to find out whether in fact he is holding on to them unnecessarily through pathological fear.

The doctor has therefore a twofold task, corresponding to the traditional twofold task of diagnosis and therapy. We emphasise the slight change of accent by calling the first understanding people in a professional capacity, and the second helping people to understand themselves.

The Part and the Whole

Should this new version of the old twofold task be called psychotherapy? The answer depends on how the practice of medicine is viewed at the given moment. If the chief emphasis is laid on the patient's body, seen as a very complex, fine, and subtle machine made up of parts, each part with its specific structure and function, then each part will need a specialist to keep it in running order. The patient's feelings and emotions will be seen as functions of some part, and this part, too, will be turned over for care and treatment to a

specialist — namely, to a psychiatrist. If a human being becomes a patient — that is, complains of an illness — the first idea of a doctor trained in this spirit is that something must have gone wrong with one of the man parts of the complex machine; this part must be identified and put right. I hasten to add that this, the working principle of what is called scientific medicine, has proved most valuable. On the basis of it medicine achieved the spectacular successes of the past one and a half centuries.

Because of its undeniable success it is not easy to recognise that this way of thinking also has its drawbacks. But once this can be accepted, it is not too difficult to see that each "offer" by the patient, such as ulcer pains, sleeplessness, or palpitation, may be understood not just as a pointer to disturbed structure or function of some part, but also a communication by the whole patient, the person. But more often than scientific medicine cares to admit it is not with a part, but with the whole man that something has gone wrong. In these cases, then, it is pointless to examine, even with the most sensitive physical or chemical methods, the structure or function of any one part, and still more so to prescribe any physical or chemical method of treatment. Yet enormous amounts of time, energy, and money are spent in fruitless attempts to identify in these cases some faulty part, in the hope that repairing or readjusting it will help the whole patient — whereas not one part but the whole man must be examined.

When, as so often happens, both conditions are present, diagnosis and treatment are all too likely to be focused on the pathologically altered part, neglecting or completely ignoring the whole person. It is a tragic consequence of present-day medical thinking that the greater the share of the whole person's illness in the "offers", the easier it is to lose the whole person in the maze of parts examined by the many specialists consulted by a conscientious and painstaking doctor. The badly needed *real* examination — which understands the patient's "offers" both as pointers to some disturbed part and as meaningful communications by the whole person — can be performed more easily and more reliably by one man than by several, even though they may include a psychiatrist.

Conclusion

Unfortunately, all the highly efficient and sophisticated methods in medicine can examine only structure or function of parts, but never the whole human being. The only method that can tell us anything about the *man* is the observation of his individual ways of relating to others. The two areas of this relating to others which readily lend themselves to observation are the ways he behaves towards others and the ways he talks to others — above all to his doctor during the medical examination. For the time being the data observed in these areas can be expressed only in terms of the reference system created by the various psychological schools. The same applies to any systematic study of the doctor's therapeutic interventions. Therefore, for the time being, the doctor needs help from one or the other of the psychological schools, if he wants to talk or even to think systematically about his diagnostic or therapeutic functions as described in this paper. To this extent, these two functions belong to psychotherapy.

Must it always be so? Once we have learned what the psychologists and psychiatrists can teach us, we doctors, and first among us the general practitioners, must take advantage of the opportunities offered by the intimate and specific relationship between us and our patients. Close study of this unique relationship will surely produce results. It will not only make medicine independent from psychotherapy, but will almost certainly enable us doctors to repay all we owe, and more, to psychotherapy, psychiatry, and psychology.

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Michael Balint in London: 1948-1970

by Enid Balint-Edmonds, F.R.C.G.P.
Psychoanalyst, London

It is a great honour to be asked to give this address in Budapest in honour of Michael Balint, whose life I was lucky enough to share from 1948 when we first met at the Tavistock Clinic until his death in 1970. We came to Budapest together only once when his book, *The Doctor, his Patient, and the Illness*,[1] was published here, but otherwise my only knowledge of your city is from Michael's endless talks about it and his life here before the War.

I will not talk about his memories of Budapest but rather tell you a little about how Michael's ideas grew in London — because it is about his ideas that I want to talk.

His way of thinking, and his way of relation to people, led him quite logically from the field of psychoanalysis to the field of general practice and back again, and he was "used" — "made use of" in both fields. A wide variety of people in other disciplines also turned to him for guidance or help, and Michael would invariably compose a long and careful letter in reply and/or ask the writer to come and see him to discuss the matter. I sometimes was impatient about some of these interruptions because there was always so much to do, so much to discuss, so much to write about, that the heavy correspondence seemed unnecessary. However, it was clearly not unnecessary, and his life was full with other people's work and ideas as well as his own, and his genius in his ability to evaluate other people's work, even when it cut across his own ideas.

When I first knew Michael Balint, he was working almost full time in private practice as a psychoanalyst in London, having moved from Manchester a few years before. he had just started working at the Tavistock Clinic where we were to start the training cum-research-seminars for general practitioners. Towards the end of his life the doctors who were trained in the seminars, formed the Balint Societies (not the psychoanalyst leaders who trained them), and in due course, the International Federation of Balint Societies was created. This conference grew out of this work.

Right up until he died, Michael continued his once-a-week seminars with general practitioners at University College Hospital, and he also continued seeing five or six analytic patients four or five times a week in his consulting rooms in the house where we lived in Park Square West in Regents Park, London. he also continued to write books, clarifying and extending his ideas about the human mind and human relationships.

Balint's work both as a psychoanalyst and as a leader of general practitioner seminars required that he should form hypotheses and concepts. These were needed if work was to proceed in a useful way. He never used his work to prove that his ideas, concepts and hypotheses were right; but created his concepts to enable his work to continue. Neither did he ever try to prove that his ideas and concepts were right in one field by applying them to another. His driving force came from the continually exciting discoveries which arose out of the study of human relationships in the different settings of his choice. He never ceased to be amazed by the events of each day's work in his clinical practice. Our evenings, our weekends, our holidays, our walks in Regents Park and on Hampstead Heath and in the Alps were filled by our discussions about exciting discoveries which we thought we had made and which we proposed to write about.

Like Freud and other scientists, Michael would often contradict himself and go ahead with ideas irrespective of whether or not he had taken a different view of the same problem on another occasion. He was not frightened of being found inconsistent. He studied his relationships with his patients and with the doctors with whom he worked, and why he was in difficulties or why he had succeeded at different times. He was not interested in trying to fit these observations into theories unless, like any other scientist, he needed them to continue his work. Furthermore, having formulated the theories in order to continue the work, he did not (although we often thought that he should) try to see in what way the different ideas fed one into the other. I perhaps have been able to do this a little more clearly since he died, but the need during his lifetime was to go ahead with his early studies made in the 30's, which had been principally about 'regressed' analytic patients, and about what he called Primary Love and the New Beginning. I will not go into the ideas and theories arising out of general practitioners' seminars, as they will be well known to you.

I have made a good deal about Michael Balint's ability and wish to let his ideas remain fluid, to form hypotheses and theories, and to re-examine them, in order to be able to describe briefly what I think is happening now in 1986 in Balint-groups, to tell you what kind of research we are now interested in, what kind of hypotheses we are now formulating, and to see how much the work has changed over the years.

Before proceeding, I will describe briefly how the Balint-groups arose out of some work that Michael and I started in 1949, when Michael led a group of non-medical professional workers at the Tavistock Clinic which I started in 1948, with the aim of trying to understand and work with people with marital difficulties.

We then decided to start working with general practitioners, using the same techniques we had developed during the previous work and also some of

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the techniques Michael had used in Budapest, in groups with general practitioners.

In 1949 Michael put advertisements in the medical journals, offering seminars to general practitioners who wished to study their work with their patients, particularly their psychological problems (we soon dropped the term 'psychological problems' because it was clear we wished to study all kinds of patients with all kinds of problems). The idea was that Michael, a psychoanalyst, together with me and other psychoanalysts, would see whether our particular insights, our particular way of looking at things (not our theories) would throw any light on any of the problems facing general practitioners at that time.

This was a courageous idea and could only have been undertaken by a clear-headed scientist with insight, and who was prepared to venture into dark places in order to throw light on them.

The aim of Balint-groups has changed very little, if at all, over the last twenty years in Britain, although it may have changed in other parts of the world. Great changes, however, have occurred in the techniques which general practitioners now study in the groups and in their approach to their patients' problems.

I, and perhaps many of you, will be surprised at how little our structure has changed; we still meet once a week during the academic year; we still think that if doctors wish to learn to make better diagnoses, and to develop skills to treat them, they need at least two years in such a group. The leaders of the groups are still psychoanalysts and have been trained by them; we still base our work on the presentation of cases and the study of the doctor/patient relationship.

I do not think that the fact that our structure has changed so little is due to any lack of flexibility in us. Michael and I continually discussed the need for change and made some experiments, and I have continued to do so since he died. However, I repeat, there is little doubt that the techniques and the skills that we are studying, and the way we look at the problems and at the doctors as well as the changes that occur in the doctors while they are working with us have changed a lot.

The aim of the Balint-groups is clear from their title, namely, research-cum-training groups. We had to find out at the beginning what general practitioners like; we also wished to find out whether psychoanalysts with our particular way of looking at human relationships and with our inward-looking experience in working with the unconscious mind would help to throw any light on the subject. We needed also to know at the beginning whether new techniques and methods of working might have to develop in general practice: new skills which could be used by the general practitioners. We now think that new skills are necessary, but it is difficult to describe them, and many of us think that the particular input, the particular contribution of the psychoanalyst, or somebody who has worked very closely with psychoanalysts, brings a different dimension to the work and that, without this different dimension, the work is no doubt rewarding and interesting but has a different flavour. It is rare that two disciplines can work together in such harmony or with so much mutual benefit, but this was the case for Michael and me during the twenty years we worked together in Balint-groups and has been true for me during the last fifteen years since he died.

It was in 1966 that a new appraisal of the work that had been done since the early 50's was made. It started when a research team consisting of ten general practitioners — some of whom are here — and two, sometimes three, psychoanalyst leaders met at University College Hospital under the leadership of Michael and myself. This group ended in 1971, a year after Michael died, and was the material for a book which was published in 1973.[2]

The ideas, however, that were in this book had been in the minds of both of us for some time. Michael wrote a chapter for this book before he died, and he said, and I quote, 'In spite of our efforts so far to create a technique suited particularly to the setting of medical practice, the long interview has remained a sort of foreign body in the general practitioner's normal routine.'

I should add for those of you who do not know it that during the first fifteen years of our work we had taken particular cases that seemed to need special attention, so to speak, out of the ordinary routine of the general practice, and the general practitioners had given the patients who were selected for this kind of treatment a special long consultation. We realised that this was a bad idea, so we examined what could be done during the ordinary, what we call 'six minutes' of a morning 'surgery' (which is the time given to an ordinary patient during an ordinary 'surgery').

It is also important that we realised at that time that the kind of diagnoses we were making, which led to the work which was to follow, were too static, were not fluid enough. We started talking about processes and less about states. We encountered great difficulties in this group because the doctors did not like to give up their old methods and seemed somehow to lose out on the change. Their authority seemed less strong, and they had to go along with their patients more and be used more by their patients.

I referred earlier to one of the marvellous things about Michael was the way he let himself be used by a number of people in a number of ways. Perhaps this quality in him was passed on to the doctors with whom he worked, so that they were able to give up some of the authority that they had previously had and let the patients show them what they wanted, rather than that the doctor should take the lead without listening to the patient.

The therapist's role was to tune in to the patient and see what it was like both for the doctor and for the patient, and what changes occurred and how varied and inconsistent were the feelings and the stories that he obtained. The need here to identify and then to withdraw from the identification was paramount. The technique which originally emerged from these ideas was unfortunately called the 'flash' technique (although it was never really a technique), but it consisted of a moment of mutual understanding between a doctor and his patient which was communicated by the doctor to his patient.

Since then, others in other groups have studied the same kind of event, but now the doctor does not necessarily communicate to the patient what he thinks.

In another group of doctors with whom I am now working, we are studying 'surprises'. I prefer this word to others we have used because the ability to be surprised seems to be an absolute necessity for any worker in any scientific field. Once one gives up the ability to be surprised, one might as well stop altogether. Michael had an infinite ability to be surprised and delighted by his discoveries, as I have already said.

I would like to end on this note because I feel it was Michael's ability to be surprised, to go about the world and see what he could find: to develop theories and have ideas but never to be stuck in them. To be delighted when he found something new which even though it might, as it often did, change to some extent his previous ideas or the ideas on which he based previous work.

He himself never changed altogether. The early ideas which he developed with his first wife, Alice Balint, and with Ferenczi, never needed to be replaced by others. They were sound, and they were fruitful, and his work in Budapest was, in the main, continued in London and blossomed there in, I hope, much the same way in which it would have blossomed in Hungary had it had the opportunity to do so.

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Balint in Britain*

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I was honoured to have been invited to speak at the International Balint Memorial Congress in Budapest about Balint in Britain: but it would take more courage than I possess to claim that I was representing the ideas and thoughts of our entire Society, even though I happen to be its President. Medicine is a very individualistic profession, and British general practice is no exception.

I must add that it takes some courage to stand up and talk before any Balint audience. In the early days of my career, I used to complain that nobody understood me. Then, to my horror, I discovered that Balint-trained colleagues understood me only too well!

This contribution is based on experience as a general practitioner in Balint-groups, spanning a period of nearly thirty years. I shall be referring mainly to personal reflection, but of course this is the Balint tradition: personal accounts and revelations are the essence of our approach.

The Beginning

In Britain, we are naturally delighted that our country should have been the birthplace of the Balint movement. An accident of history?; or should I say, geography? Perhaps, and yet there were certain factors which helped to make it possible for the Balint ideal to take life in Britain, and develop and spread far beyond its country of origin. Let me refer to some of them.

Balint-work in Britain has always been concerned with general practice, almost exclusively. It began as a mission among well-established family doctors, and today it is available also to doctors at the start of their training. When Michael Balint first encountered general practice in Britain 35 years ago, it was at a very low point indeed. The new Natonal Health Service seemed to be depriving general practitioners of some of their traditional functions. It was as if we were being left to deal only with coughs and colds. There was confusion and uncertainty about the family doctor's proper role. Above all, we felt totally ill-equipped to cope with the troubled and troublesome patients who seemed to be besieging us.

But there were also some positive features. General practitioners in Britain give front-line, first contact, primary medical care, at no immediate cost to the patient; and access is open and informal. Their practices are largely family-based; and they have a contractual obligation to a defined community of patients — 'the list' — which ensures some degree of continuity of care. This then was the background against which Michael Balint initiated his programme at the Tavistock Clinic in London, that resulted in his famous book, *The Doctor, his Patient, and the Illness.*[1] It was intended to help general practitioners to become more responsive to a wider range of their needful patients. Not only the patients with whom they got on well, or had a feeling for; but those others, with unrealistic expectations and unreasonable demands; the aggressive, the resentful, the non-compliant, the helpless and the hopeless.

The following years saw an extension of the Balint programme which gradually influenced a significant part of British general practice, and including many doctors who had never even heard of Balint. And of course it spread to Europe and further abroad. At this point I should draw attention to the fact that for twenty years we in Britain had the good fortune to be members of a two-parent family. That is to say, we had Enid Balint as well as Michael. This had an extremely favourable effect on our upbringing, as I shall explain later.

The original aim of Balint training was to impart psychotherapeutic skills to general practitioners so that they could employ these techniques where appropriate. The outcome of this was that a very small minority of family doctors were able to treat a very small minority of their own patients. Many of us automatically assumed that we had to imitate the psychoanalysts whom we know as leaders. So much so, that Bob Gosling, one of the early leaders at the Tavistock Clinic, described our behaviour as 'a grotesque parody'. We would set aside 30 or 40 minutes regularly for highly selected patients; delve into their backgrounds; search for significant material, preferably of a sexual nature, or even better, genital; struggle to find the correct interpretation to make; and finally, exclaim triumphantly, 'Ah ha!'

Michael Balint himself referred to general practice as a 'gold mine' of interesting cases; and we were fascinated by analytic concepts, psycho-sexual theories, the unconscious, transference and counter-transference. We were determined to get to the root of the patient's problem, to discover the underlying cause of the trouble. In our quest for a deeper understanding of our patients, we sought more knowledge about them, more facts, more information. We would act as 'detective-inspectors'; probing, confronting, breaking down defences, uncovering secrets. It was words, words, words. There was a pathetic belief that our patients could be talked out of their troubles. So-called 'non-directive' and 'non-judgemental' techniques were employed to bestow our patients with insight; in other words, to persuade them what their 'real' problem was. The aim of our work was supposed to be patient-orientated; but it often seemed as if we were more concerned with our own problem of trying to make sense of the data we had amassed, rather than noticing what was happening to the patient in the 'here and now'.

*Paper read at the International Balint Memorial Congress, Budapest, Hungary. 29-31 May 1986.

It is perfectly understandable that our approach should have been dominated by the medical model. After all, we believe in cause and effect. We try to explain all symptoms — physical and psychological — in terms of a disorder, a fault, an abnormality; something to put right; that needs correcting before the patient can be restored to normal health. This is the way we doctors were brought up. And so was Michael Balint. And so was Sigmund Freud. But now we are beginning to wonder whether the medical model is always appropriate for dealing with every single problem presented by our patients.

We are also recognising the significance of Michael Balint's reference to 'selective attention', which is totally in keeping with the realistic approach to general practice. We have only brief glimpses of the problems offered by patients, and have to make decisions on which aspect to take up and which to leave alone for the time being. This is rather different from our original ambitious aim of 'overall diagnosis' and total understanding of the whole patient.

Changing Course

The truth is that over the years, we have had to undergo a degree of unlearning; abandoning some of the classical techniques adopted as a result of earlier Balint training. Michael Balint himself recognised these as incongruous, referring to them as 'a foreign body' in general practice. And with Enid's help, he began to revise his original ideas. This eventually led to the concept of getting on to the patient's wavelength; tuning in to the patient — every single patient, not just the favoured few. In turn, this restored attention to the doctor/patient relationship; to which of course lip-service was always being paid, but which was frequently overlooked because of our greater interest in the cause of the patient's particular disorder.

Something else that was new, and introduced by Enid, was the notion of the patient making use of the doctor. The suggestion that the doctor might be used, seemed to us derogatory. After all, the doctor is supposed to be the expert, he is in charge, he gives the instructions. And yet Enid's idea recognised the reality of the patient's initiative; not only in seeking help in the first place, but in defining the area of concern, and limiting the territory to be explored. Being available to be used by patients, emerges as one of the most significant contributions we can make as doctors. It also relates to something that has frequently puzzled us; patients who seem to benefit from their consultations with us although we have not the faintest idea what the problem was really about. Every doctor must have experienced this baffling and frustrating situation.

This surely means that the patient has been able to gain something from the doctor/patient relationship, at a different level from that which the doctor himself has expected. Not from intellectual explanation, or reasoning, or reassurance, or insight, or even shared understanding. But something stemming from an accurately tuned-in relationship, where the patient senses that the doctor is with him. Amazingly, this sometimes seems to be enough.

We have always suspected that what many of our patients were seeking from us was not just professional skill, expertise, diagnostic ability, or clever interpretations; but to be befriended. They want not only a body technician, but 'a guide, philosopher and friend'. We are reminded of the message,

> 'Understand your patients, if you can;
> love them, if you must;
> but for Heaven's sake, notice them; let them feel that they matter, that they are being taken seriously, and treated as human beings.'

It would seem that what really matters is not what we doctors say to our patients, but how we behave towards them. Actions speak louder than words.

Michael Balint alluded to this at the very end of the very last seminar he held with us. We had been discussing the 'Flash', about which there was some confusion. Was it a sudden new perception by the doctor? Or was it a changed mutual understanding, shared by patient and doctor together? Balint felt that the 'Flash' should consist not only of sensing and understanding what is happening, but responding appropriately. Only if it led to a change in the doctor's behaviour towards the patient could it be called a 'Flash'.

Recent Developments

These, then, were some of the things that influenced the development of Balint work in Britain, under Michael's leadership. What has been happening in the last 15 years? Nothing really dramatic. The membership of our Society has not grown recently, although there are larger numbers of what are called 'Balint-type groups'. These adopt the principle of open discussion of reported cases, but do not necessarily focus on the doctor/patient relationship. We have recently opened membership of our Society to doctors who may not have had long experience of Balint-work, but who express interest and a commitment to its principles. Some new recruits want their groups to discuss the doctor's own problems, not just his professional problems.

There has been an increase in the number of our groups which are led by Balint-trained general practitioners; some of these groups have a psychologist as co-leader, most do not. Again, this has been a gradual development, not a dramatic one. We greatly value the continued contribution of our analyst colleagues, but we are not totally convinced that leadership of groups by psychoanalysts is absolutely necessary today.

I should perhaps remind everyone here that in Britain we do not go in for revolution, but evolution; and so there is no question of cutting the umbilical cord; instead, allowing it to shrivel. We were very surprised that some European psychoanalyst colleagues should have expressed such consternation over this. Cutting an umbilical cord does not necessarily terminate a relationship. On the contrary, it can generate one. While the umbilical cord exists, the foetus is merely an appendage, a parasite. There can be no proper relationship. Only after it is removed can there be the possibility of a genuine relationship. Initially, it is true, a very dependent relationship; but later on, becoming interdependent. For there is much that we can learn from each other. It is known that

Michael Balint's own ideas about psychoanalysis were modified as a result of his work with general practitioners.

The Future

So what should be the trends for the future? We have no need to look beyond Michael Balint's own principles. He made an enormous contribution to the renaissance of general practice in our country. He was a total person; but for us in Britain he was, above all, a medical man; a doctor imbued with the scientific spirit, and properly inquisitive; one who fully understood the plight of his general practitioner colleagues who are unable (unlike some fortunate psychoanalysts) to indulge in the luxury of discarding patients labelled as unsuitable, unco-operative, non-compliant or resistant.

Balint called his programme 'training-cum-research'. From now on there should be less emphasis on training, and much more on research. For one thing, the term 'training' is now a complete misnomer. You can be trained to listen and to keep quiet, but you cannot be trained to hear, to tune in, to identify with your patient. These things are learned gradually, through trial and error; not through instruction, nor example; but from experience — daily experience with patients. Because patients are the only true teachers. The role of leaders, tutors, trainers, experts, and fellow group members, is to assist us to hear what the patient is saying, so that we can contribute to the doctor/patient relationship in the most appropriate way.

The more research we do, the more we shall learn. There is still much that we do not understand about the doctor/patient relationship. Only recently, with Enid's guidance, have we paid any attention to the fact that such relationships are not static, but dynamic. They can undergo change. We need more research into the effects of what we do; the outcome for the patient. And why it is that vastly different techniques seem to give similar results. We also need to become more disciplined, to avoid the temptation to juggle with reported material so that it can be fitted into existing hypotheses; or just trimming our theories. Instead, we should re-examine what happened, recast our ideas, and then test them out again. This was Michael Balint's style. He must surely have been a disciple of John Hunter, that famous pioneer of British medicine, who proclaimed: 'Why speculate? Why not try the experiment?'

In the early days of the Balint movement there was very great emphasis on feelings; the doctor's feelings as well as the patient's feelings. Understandably so, because of previous neglect. But today there is no shortage of attention to feelings. What we are really short of is sensible thinking about these feelings, a friendly scrutiny of our ideas about them.

The way groups are conducted should also come under more scrutiny. Some group-leaders are easily seduced into attempting to unravel the patient's problem and to offer a solution; instead of concentrating on the difficulties which the reporting doctor has been experiencing, and on those aspects of the doctor/patient relationship which he may not have taken fully into account. The doctor should not be seeking an answer from his group, but a fresh perspective. Doctor and patient will eventually work out their own solution, jointly. Their encounters will fit into some sort of pattern, which the doctor may discern; but he must accept that the grand design really belongs to the patient, and that the doctor may never fully understand it.

All these things are a far cry from the early, well-intentioned ideas about structured, deliberate, systematic procedures in Balint-training. But it should not be considered a retreat to show due regard for 'the art of medicine'. We all agree that the sort of medicine we are practising is not a science. But that is no reason why we should not adopt a scientific approach towards it. For instance, we need to be more explicit about those things we feel to be true; and have the courage to submit them to testing. Balint would certainly have agreed with Alvan Feinstein who said that 'the best way of promoting and preserving the art of medicine in an age of burgeoning technology is to make the art more scientific'.[2]

Finally, in Britain our Society has recently been challenged with a question: 'Would Michael Balint have wished to become a member of the Balint Society?' Some question! It will certainly stimulate us to develop our work along the lines Michael set out, and to embody the fine principles of that amazing man; who displayed wisdom, concern, eagerness, curiosity, humour, and an insatiable appetite to learn from anybody. He was a marvellous teacher; and the most effective way he taught was not by telling, or instructing, or informing, or demonstrating; but by inspiring. He has provided us with a model for every level of activity in Medicine; including our behaviour with individual patients, and the way we conduct our groups, and wider aims for our national and international Balint Societies.

Michael Balint did so much to transform our profession that we doctors in Britain are immensely proud — and awed — to have been medical colleagues of his, in his adopted country. But we know that his message is for everyone, everywhere.

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Personal Memories of Michael Balint*

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One of the greatest social experiments in Britain started on July 1948 with the inception of the National Health Service. On that day, every man, woman and child was able to obtain medical attention without payment at the time it was needed.

The Second World War had ended not long before, and many of the doctors working in this new service had only recently been demobilised from the medical branches of the armed services.

It soon became clear that neither our medical training, nor our war-time experience, had prepared us for the overwhelming demands made by the huge numbers of patients who presented with illnesses which could not easily be matched with the pathological states or the diagnostic headings so well described in our text-books.

Nor, we discovered all too painfully, were our patients helped by being told that we could find 'nothing wrong' with them.[1]

It is not surprising therefore, that in April 1952, our attention was attracted to a small announcement in the Lancet, inviting doctors to attend a 'Discussion Group Seminar or Psychological Problems in General Practice.'

My enquiring letter resulted in a reply from the Training Secretary of the Tavistock Clinic accepting me for a 'course of eight to ten discussion meetings' to start on 1 October 1952. The fee was ten shillings — and, on reflection, that was about the best ten shillings I ever spent!

Michael Balint welcomed us in a friendly way, and invited us to say something about ourselves. He said little more, except to encourage us to present any current case-histories with that question which later was to become so very familiar, 'So, who has a case?'. He soon showed his intense interest in all the problems to be found in patients seen in the general practice setting, and particularly in the way we handled them, and clearly this was one of the main reasons for our being there.

Those early group meetings must have been exploratory in nature, because not a lot happened as those few weeks passed by, apart from my coming to realize just how much I needed help to learn how to deal with my problem patients.

The next letter I received was dated 16 December 1952, and was signed by Michael Balint who explained that, '. . . it had been decided to start a two-year course in psychotherapy for general practitioners early in the New Year.'

This entailed twice-weekly visits to the Tavistock Clinic, . . . one from 2-4 p.m. on Wednesday afternoons for weekly case conferences, and other for individual supervision (of my own cases) at a mutually convenient time.'

After dealing with some practical points, Balint stated that, '. . . the fee for the course is not yet settled, but will be between five and ten guineas per term', he went on to ask whether the proposed arrangement was acceptable, and to say, '. . . if you have any other suggestions I shall be very glad to hear about them.'

So here, at the very beginning of my long association with Michael Balint, the friendly concern and consideration of the needs of anyone he had dealings with, came through in these courteous phrases. Again, there was an indication of how he made those who worked with him feel that he was always interested in their views and ideas.

Of course, he may not have agreed with us and, as the group-leader, he could be very authoritative, confining our discussion strictly to the relevant topic of what was going on between the presenting doctor and his patient. When he felt that we had exhausted the subject under discussion, he would stop us with a sudden, 'thank you very much. Now who has the next case? . . .'

I well remember an early meeting, during which I was quite startled when Balint sternly rebuked me because I referred to my case-notes. We quickly learned one of his very few 'rules' — that it is better to describe what we remember and *feel* about that patients whose problems we presented to the group, rather than to read from our notes.

Balint helped us to see how this reflected our reactions when a patient came to us with a written list of symptoms or other matters, which could be used to conceal his feelings. Indeed, this must be one of the main distinguishing features of a Balint-group. He always emphasised that we should learn by discovering from our own feelings as we described our case-histories to the group, and during all that followed in the ensuing discussions.

I can remember now how angry I felt when I first realized that attending this 'course' was not providing any answer to my questions, 'what should I do for this patient? Or, 'how should I treat that patient?' After all, that is what I had been trained to expect, and what previous medical courses had always provide.

I must add that I was not alone in feeling angry — I later discovered that most doctors attending a Balint-group pass through this phase! It is as though we feel the group-leader has some special, superior knowledge which he will not impart to us!

In a letter dated 9 April 1953, Balint wrote to tell us, '. . . it has been considered advisable to publish an article on our scheme at its present stage, and I enclose a paper on it herewith.' In his usual way, he invited us to '. . . bring any comments or criticisms . . .' we might have for discussion at our next meeting.

Balint insisted that he did not 'teach', and he emphasised the '. . . limited value of 'teaching' psychotherapy . . .' in that first paper about *training*

*Paper read at the International Balint Memorial Congress in Budapest, Hungary, 29-31 May 1986.

general practitioners in psychotherapy. He went on to explain that, '. . . a new approach has been tried — namely, to shift the emphasis from *'teaching'* to *'training'*, using group-methods.'[2]

He later expressed his views about this even more strongly in his paper on the structure of the training-cum-research-seminars, which was how he later came to describe his groups.[3] 'The intention of the teachers is always to hand over some of their superior knowledge and some of their consummate skills to the pupils . . . the teachers are always *active*, while the pupil's role is more or less passive . . . we psychiatrists do not teach — at any rate we try very hard not to behave like teachers. Instead, we try to establish the spirit of a research team.'[3]

It took me some time to realize that Balint used his role as group-leader to create an atmosphere to enable us to feel free to express our own feelings, as well as those of our patients, and so to learn something about ourselves as well as about our patients, and, indeed, about our colleagues by now friends, in the group.

Balint later described this as achieving 'the courage of one's own stupidity' — which meant not only learning how to accept the often severe criticisms of the other group-members, but also learning how to free ourselves from our automatic responses, so that we could 'click', or fit in more easily with our patients' responses in order to provide more effective treatment.[3]

He made it clear that his aim was to help us to develop a new skill — to listen to things in our patients which are hardly said, and then to listen to the same things in ourselves, so that we can better use the doctor/patient relationship. Balint described very clearly that this '. . . inevitably also entails a limited, though considerable change in the doctor's personality,'[4] although he always maintained that his were not 'treatment'-groups.

Bacal subsequently discussed this fully, and concluded that this does not '. . . involve psychotherapy in the traditional sense, but it could well be described as an intensive 'treatment' for the doctor's functioning in the area of his professional ego, the aim of which is to effect a shift in him in the direction of becoming able to use more of himself in the service of his patient.'[5]

There were many occasions when Balint could be what he called 'very severe' with us. For example, in the later research group which produced the book on the 'flash'.[6] We had been discussing one of the problems relating to the difficulty of how we were to choose patients to present to the group. For various reasons it had been reluctantly accepted that only those patients whose therapy took less than ten minutes, should be presented.

One doctor, Dr G, reported a case-history, where he had stopped a consultation and prescribed anti-depressant tablets when he realized he had gone on for more than the prescribed ten minutes. He was therefore not allowed to continue with her story. The sharp interchange of words that resulted, and recorded in the transcript of the meeting on 1 August 1967 (Reference No. UCH/4/63/10), follows:

Dr G: . . . There are some cases you feel you can help, she was simply shouting for help . . . I would have presented this case as I felt I had done some good.

BALINT: What is 'the good'? Can I now be very severe with you? What is 'the good' you have done?

Dr G: Well I feel . . . I don't know . . .

BALINT: 'I don't know' is not enough.

Dr. G: It's actually a hunch . . .

BALINT: Hunch is not an answer.

Dr G: Only by seeing this person as a follow-up can you really know, but I do feel you know whether you've done something or not. I felt this was a very ongoing interview, and the fact that she was able to talk must have done her some good . . .

BALINT: But she didn't, Dr G. If our hunches are more or less correct, one hunch is that . . . and another hunch is that . . . or something of the sort . . .

Will you allow me again to use your case because it's quite fresh for this sort of discussion? . . . Why is it that at a really propitious moment, when the girl has tears in her eyes and is willing to talk about losing a baby, it would have been so easy to make her realize that you are on her side, and you are interested in how much she was suffering then and is the present situation in any way reminiscent of it — or something of that sort. I don't know why you stopped it and gave her amitryptiline?

Dr G: I think the answer is it's this ten minutes business . . .

BALINT: Sorry, ten minutes should then be discarded if it hampers your style . . .

Dr A: We said 'in normal surgery time' . . .

Dr E: So that means, doesn't it that when we fear that it's going to get out of control . . .

Dr A: When the floodgates are opened . . .

Dr E: . . . and you're not going to be able to control . . .

BALINT: Then you go back to your bad habits and prescribe amitryptiline or something . . .

Dr E: Then they're all right till next week . . .

BALINT: Yes. Here are seven or ten pills and come back next week.

Dr G: Just imagine the whole of this group out of control . . .

BALINT: Do you remember the German word *konfessionszwang* . . . It's the compulsion to confess.

Dr E: Perhaps, but we think . . .

BALINT: Dr E, please don't say no, because you started your report last week with the request, 'please beat me up hard.' If anything is confession this is it.

It is not entirely by chance that out of the many possible examples of the way in which Michael behaved as group-leader, I chose one concerning the use of time. I have always regarded time as one of the crucial factors

in the consultation, and at the present moment, it is again the centre of much debate in Britain.

It is also an area where Balint made it abundantly clear how flexible he was in his thinking, and where he showed his enthusiasm for constant review and development of his ideas and attitudes. In the early stages of our work, the 'long interview' came to be regarded as a 'foreign body' in the general practice consultation. Later, arising from this, Michael and Enid decided to form a group to explore possible ways in which this could be modified and improved.

In what was probably one of the last papers he wrote, Michael described in the book based on the findings of this group, how '. . . right from the start we recognised the differences between the psychiatric interview and the new technique that was needed in general practice, and emphasized it by referring to the latter as 'listening' or 'long' interview . . .'[6]

But, Michael was not only concerned about helping general practitioners to treat their patients more efficiently, he was also genuinely interested in wanting to find out more about what actually happens in that unique relationship which develops between a patient and his doctor.

As he said many times, his groups were two-way. That is, as he readily admitted, not only did we learn from him, but he also learned from the many case-histories we brought to him.

In addition, Michael's keen sense of humour also comes through in the interview I recorded with him on 27th November 1970,[7,8] without knowing, of course, that in little more than a month, he would no longer be with us.

(Extract from recorded interview with Dr Michael Balint on 27 November 1970):

> BALINT: One of the high-ups of the Postgraduate Federation came and sat in on the seminars — it was about the second or third years of my experiments; before the 'old guard' got together — and then disappeared, never to be seen again.
>
> But we heard on the grapevine that he had said that he is very uncertain whether the doctors learn anything from Dr Balint but it is quite certain that Dr Balint learns a lot from the doctors. And I think this is the greatest praise I ever received. It was absolutely true; I learned an enormous amount and all my papers and books that I have written about it are the consequences of the results of this learning process.

After nearly three years of my learning process in Balint's first group, I began to feel more relaxed with certain types of patients who previously had made me feel nervous, incompetent and angry, and indeed incapable of helping them. So that I felt almost as much at ease with these difficult patients, as I was with those less commonly seen, who actually had text-book diseases!

I can never cease to be grateful to Michael Balint for this, and indeed for so much more — but this is not the place for eulogies. In any case, I do not think that Michael would have wanted that. Instead, what follows are Michael's own words in answer to my first question in the recorded interview mentioned above, about his personal background, and how he became interested in psychosomatic medicine:

(Extracts from recorded interview on 27 November 1970):

> MICHAEL BALINT: First, my father was a general practitioner for about 50 years in Budapest until his death, so I grew up in this atmosphere. I knew quite a lot about what general practice was by watching it from outside, and later when I qualified, I had to stand in for my father and so had some understanding of what general practice was.
>
> But all this was not really known by me consciously, because my training, my real training, which was consciously accepted and I was really interested in, was almost entirely scientific: right through school, my main interests were chemistry, physics and mathematics, exactly as befits a . . .
>
> P.H. . . . a proper doctor?!
>
> M.B. . . . a proper doctor, to the extent that I almost became an electrical engineer; it was really touch and go. But anyhow at the end I decided to become a doctor and started my medical training, which was much more liberal in Hungary than it was in England so I could study everything I wanted. So I went to lectures on comparative law, comparative religion, anthropology, what you want . . .
>
> Of course my main interest was physics and chemistry. We had a little booklet in which to write all our lectures and we committed ourselves to listen. When there were various examinations, one had to produce this booklet — and the examiners always asked, 'What are you? Are you a medical student or what!' Anyhow, in my later years I became assistant, first in the department of physical chemistry, then in the department of hygiene, biochemistry, and what you want . . .
>
> When I graduated as an M.D. I decided to go on and study biochemistry. At the same time, just the opposite, I got interested in psychoanalysis, and I did the two together in Berlin. I went into analysis and took my Ph.D. in chemistry and physics.
>
> That was the turning point in my career, because I then began to think how to utilise all this knowledge that I had got together, and skills and so on. So I decided to study what is called now psychosomatic illnesses. Really I am one of the pioneers — I started in about 1922 and published a few papers about it.[9, 10, 11]
>
> Then I came back to Budapest, and first I was completely taken up by my gradually developing practice and had to give up all these side interests — I wanted to become a proper analyst and worked very hard, very long hours and so on. Then gradually when we decided to start a psychoanalytic

institute in Budapest, there was the question of how to get more doctors interested in it, and I was asked to run seminars for general practitioners, on exactly the same sort of psychological understanding.

P.H. In Budapest?

M.B. In Budapest — that was before the war . .

P.H. What year was that?

M.B. Recently I dug out an entry in the International Journal of Psychoanalysis, according to which in 1926 it is recorded that I gave a lecture on psychological problems in general practice, in one of the provincial towns in Hungary, at the request of the local, what shall we call it, B.M.A. [12]

P.H. Was general practice the same as we understand it here? Family medicine?

M.B. Absolutely. So that was the first official thing . . . Then I came to Manchester when the war broke out, and all this had to finish.

Then at the end of the war, in 1945, I got a job in London as Director of a Child Guidance Clinic and came to London and started my practice here. A few years later the Tavistock Clinic invited me to help train social workers . . . and that was how we worked out, Enid and I, the technique, but of course not yet for medicine, but for social workers.

Then I heard that The Tavistock had tried several times to run courses for general practitioners. You know, postgraduate courses with lectures about psychopathology and psychodynamics, which were all singularly unsuccessful; everybody came for a few lectures and then it was packed up. And then it came to my mind it would be worthwhile starting on the same lines what I did already in Budapest. That's described in *The Doctor, his Patient and the Illness.* [4] That was in 1950.

Then, in *A Study of Doctors,* [13] is how it was developed; what sort of mistakes we made and so on: and how gradually, in about 1954 we got fourteen of you doctors, seven in each group, and this was the main experiment where this method was worked out.

P.H. The main point, of course is that it was *training and research* . . .

M.B.: Yes, right from the start. And training and research came in two directions: Training and research of the general practitioners to understand psychological problems, and of the psychiatrists to understand general practice, and again extend their point of view far beyond the narrow field of the one-to-one relationship in the analytic consulting room, quite different work.

Now what have we learned? First that the two worlds of the general practitioner and the psychiatrist, psychoanalyst, are utterly different. What can happen in one, cannot happen in the other, and *vice versa.*

Of course there are overlaps and so on, but the essence of it is quite different. Also the psychoanalyst's world is very intense and in this intensity all sorts of things can happen which cannot happen in general practice because they haven't got this white hot intensity.

On the other hand, the general practitioner's work is ongoing, it lasts sometimes for generations, as you well know, and it is not broken off when the patient gets better. On the contrary, that is an impetus . . . every illness is an impetus to make the relationship still more intense and still more meaningful for both of them, and the better the relationship is, the better the doctor can help his patient.

The comparative thing is that at the end of a good psychoanalysis the ideal thing is that the analyst and patient say goodbye to each other and never meet again: they had enough of each other and the relationship served its purpose and now it's finished for good.

Now this would be an enormous loss in general practice . . .

P.H.: . . . because the patient invests so much of his . . .

BALINT: And the doctor invests . . . so this is an utterly different world and has different rules and possibilities. Now this was the first thing that we learned.

Then, extending from it, what we discovered was that each medical setting has its own rules, possibilities and potentials, and what one has to do is study this individual setting and develop the psychological skills, or psychotherapeutic skills — it doesn't matter what you call it — which are adapted to this setting and use the possibilities inherent in it.

M.B.: To come back to the problem, what is Medicine? . . . there are a number of conditions, we call them Class 1 conditions, which you can diagnose fairly adequately, using modern techniques, x-rays, chemical methods, what you want . . . This is the ideal of medicine, and this what is taught in hospitals . . . what we call 'illness-centred medicine'.

The other great branch of medicine started with the recognition that when a patient comes to a doctor, especially to a family doctor, then it is not quite so certain that he will have an identifiable illness. In fact, only a small percentage will have one, you have written about it, it looks as if over 30%, probably much higher, of patients consulting the family doctor, not the hospital doctor, are suffering from what we call Class 2 conditions, in which there is no identifiable, diagnosable illness.

P.H. . . . in traditional medical terms?

M.B.: Absolutely none . . . however hard you try, you can't find any identifiable illness. And now the great problem starts: what to do? And what usually is done, is that the patient is forced into some sort of category, doctor and patient then agree what the trouble is about — and *this agreement* is treated — and we have learned what an enormous price is paid for it; and the enormous drug bill for the National Health Service, and the enormously wasted time, and so on . . . everybody knows about it, but nobody really wants to take it seriously . . .

Recently we did the study of the repeat prescription, [14] which is one aspect of this non-illness, or fake-illness, or organised illness situation. There are many more, and if I live long enough, that will be the next ten years' research . . .

(End of extracts from recorded interview with Dr Michael Balint)

I was very interested to hear about his earlier work as Director of a Child Guidance Clinic in that interview, because of the contents of a letter he had written to me only a few days before, on 12 November 1970.

It was about a patient he had referred to me for obstetric care. She had been in analysis with him, and was subsequently happy to have become pregnant. In spite of some mild depressive symptoms during the last few weeks of her pregnancy, she had a remarkably short and uncomplicated labour. In answer to my letter informing him of her safe and uneventful delivery, Michael wrote to say that he had not yet heard anything from her, which he interpreted as a good sign.

He added that he hoped she would, ' . . not hurry to resume treatment in the first period of her relationship with her son. To my mind,' he wrote, 'these initial phases should not be interfered with by anybody from outside.'

Like so many of us, our mutual patient was all but devastated when she heard of Michael's death on the last day of December 1970, but no doubt due to the care and skill of her analysis by him, she was able to deal with her intense feelings and focus her attention on her new role of mother.

I will always remember with gratitude, the influence which Michael Balint had on me, and indeed there must be very many doctors all over the world who feel the same, even though they have never worked with him, nor even met him. As the late Lord Rosenheim has written so eloquently:

'By all reckoning, Michael Balint was a remarkable doctor and psychoanalyst, a man for all time, whose impact on general practice and on the understanding of the doctor/patient relationship has been felt all round the world.'[15]

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The Role of the Balint-Group Leader: A Critical Re-appraisal*

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My re-appraisal consists solely in relation to general practitioner Balint-group leaders, as I still believe that the primary model of the Balint-group leader is of a psychoanalyst who understands the general practice setting. Our problem as general practitioner Balint-group leaders is that we, broadly speaking, are not psychoanalysts and are too deeply identified in the general practice setting, in which we do our daily work. Although we are not psychoanalysts, we must have absorbed, perhaps by a process of psychological osmosis, something of the analyst's understanding of unconscious processes. Without a training analysis and the supervision of cases in that discipline, it is difficult to validate the general practitioner leader's qualifications to be a Balint-group leader. I certainly could not validate my own credentials. I have been encouraged by Enid and my dear late friend and colleague Mary Hare, to accept that I have some understanding of unconscious processes as revealed in group-work, although I often remain sceptical myself.

The Society is honouring me in asking me to give this talk, and I have been touched by some personal apologies from members who cannot be here tonight. It is perhaps these mundane events that make me reflect on an interesting parallel. Many of you are apparently approaching this evening with the unrealistic and idealised expectations that the Old Guard (of which I am not in historical terms a member, though they often seem to forget it) approached Michael and Enid in that first seminal seminar.

We somehow expected the Balints to tell us the answers to those questions we raised about our work, even though we knew they were not general practitioners. In your sober moments you know perfectly well that given your long experience of working in Balint-groups with many leaders that I am not in a position to tell you anything you do not know already, and that my best hope is to shine a light on our work from a slightly different angle so that you will be able to say 'Of course I know that!' And of course you do.

It is in the preparation of this talk that I have perceived in one of the great Balint exhortations, 'Have the courage of your own stupidity', a deeper level of truth. I am courageous, sitting here in front of you, not because I know more than you, understand better than you, or lead a group more competently than you, but because I understand the word stupidity more deeply. I know I am stupid, but the Balints have allowed me to come to terms with it — I understand more about myself as a doctor (and as a person come to that), and have learned to live with it better. In Enid's words it concerns the naturalness of man himself, particularly the aspects which seem most irrational and unacceptable.

You are now, I hope, fully prepared for that sense of anticlimax which is bound to descend on you as the evening advances. Jack Norell posed the question to the Leaders' Workshop 'What is the essential role of the group-leader?' My reply would be 'the encouragement of a 'safe' atmosphere for the doctors to explore their own personalities interacting with their patients, so that they may become more flexible and develop new skills in dealing with patients as people in distress.' That's a tall order, and it obviously needs putting into Anglo-Saxon. Perhaps, in simpler terms one might see the leader's role as freeing the imagination of the members of the group, with the hope of reducing any rigidity in them, while at the same time protecting them from personal over-exposure. The leader must not be too authoritarian, but always responsible for what goes on in the group. He may be wise to eschew psychological *obita dicta*, but on the other hand a short burst of 'teaching' may be entirely appropriate. This does not mean that he has to expound any theory, but boldly say what has to be said if he feels the group is going down the wrong path; calling every patient 'manipulative' for instance.

The introduction of such jargon, especially if perjorative, can easily become a canker. The problem is that, especially with a new group, there is a great pressure on the leader to 'succeed', whatever that might mean. Principally it may mean that the group should not fall apart or leave. This tends to promote too much activity on the leader's part, 'trying too hard' in fact, and we all know what that does for our tennis shots! If one looks on the continued life and growth of a group in the same way as one might approach a patient seeking self-understanding and personal growth, it becomes obvious that the leader must aim at an active passivity, tuning his third ear to all that goes on in the group, whether it be the kind of case presented, the reaction of the members to the case material, the presenting doctor, and each other. For instance, is there a resonance between the patient's problems presented and the doctor's own? Do certain members always behave in a particular way, and what does that mean?

A problem which may persist for the leader is the temptation to treat the presented patient, rather than lead the group. This is a bunker which seems difficult to get out of. I have observed it often in the Leaders' Workshop, and even by experienced analyst Balint-group leaders commenting on demonstration groups at International Congresses. The problem is that the leader must make a diagnosis of the presented patient quickly and privately, and then use this in terms of the group-work only. That doesn't mean the leader will understand the case perfectly, and may often miss aspects which group members discern, but that is how it should be. However, it does allow the leader to formulate what he would like the group to learn from the presentation of the case.

*Paper read to the Society on 26 November 1985.

But apart from listening to all that goes on, the leader must also listen to what is not said. Such negative findings can be as, or more important, as what is actually said.

With regard to the interaction of the group, there must be a constant watch on any vicious tendencies which may arise, and need to be countered, and the difficult line between constructive confrontation and open aggression must be drawn and held.

Even group interpretations may occasionally be useful, though their use should probably be sparing if avoidance of a therapeutic group is to be achieved. Other questions are thrown up: What should govern the nature and frequency of the leader's remarks; by what criteria may a leader judge his/her effectiveness at the end of a meeting (or in previous meetings)? But these expose the problem, such judgements can only be retrospective and applied to a particular group session or series of sessions. Making plans in a vacuum is a meaningless exercise.

But this is all old hat, and rather than listening to me developing this in detail, I should like to try a participatory exercise, to see if it is a useful analytical exercise (using analysis in the vernacular sense). I have asked the members of the Leaders' Workshop to bring a case, and I am now going to invite them to come into the centre in two interlocking circles: the inner one representing group members, and the outer one, leaders. I am going to hand them each a litle folded card, inside which is written an 'instruction', if they will bear with me using that word. The presenting doctor will be prsenting a genuine case, but all the other members of the group will be behaving in a manner distorted by my instructions. Each of the leaders will have received instructions which request him/her to concentrate on one particular dimension of the leadership role. I shall attempt to act as master of ceremonies, and we can arrest the process to discuss anything that arises, or wait until some time has elapsed in the group-work and discuss the various points which have arisen. So, let's try it!

The members of Leaders' Workshop present were invited to sit in the inner ring of a fishbowl arrangement. They were then handed small cards, alternately to a doctor who would be a groupee (presenting group-member), and a leader, so that in effect the group was made up of nine groupees and eight (part-time) leaders with the author as master of ceremonies.

What was written on the cards appears in the Appendix. The first case discussion (at a time when nobody in the inner circle knew what was written on the cards other than the one held in the doctor's hand (and all totally unknown to the outer circle), proceeded remarkably similar to a real Balint-group discussion. The author cut it short after half an hour, and invited each doctor to read what had been on the card.

A further set of cards was then handed round the inner circle, the previous groupees becoming leaders and *vice versa.* This time the discussion was stilted and unreal, the reason for this being disputed. Was it that the groupees did not believe the case to be an actual one, or was it that everyone knew what sort of role instructions were printed on the cards. The author contended that the exercise demonstrated that one couldn't lead a group by numbers.

In fact, in the first case the master of ceremonies did not speak. In the second case he made one attempt at a group interpretation (that being his role listed on the card). There was an extremely lively discussion, in which all points of view were advanced, but there was only general agreement that it did attempt to tease out various facets of groupee behavior and leadership activity. It was thought that this aspect might usefully be explored in greater detail at another meeting.

It was thought that the 'game' would have been improved if there had been only two people playing leader roles, as it was clear that the groupees could not focus on any specific leadership because of the fragmentation of the leader role into nine separate individuals.

Appendix

GROUPEE CARDS

1) You are a groupee (not a leader).

If you have a case — Yes, you have! Claim priority. If you haven't thought of a case before tonight, pick the nearest 'pregnant nun' and present it as if you are a crazy doctor (in a controlled sort of way).

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2) You are a groupee (not a leader).

Please present a case if you want (allowing for the usual bargaining).

During the discussion of the case comment on any traditional aspects (medically speaking) that you can identify, to the exclusion of the emotional.

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3) You are a groupee (not a leader).

If you have a case, please present it (allowing for the usual bargaining).

If you are not selected, please support the presenting doctor in any way you like during the discussion of the case.

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4) You are a groupee (not a leader).

If you want to produce a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, please be somewhat aggressive towards the presenting doctor during the discussion.

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5) You are a groupee (not a leader).

If you have a case, present it (allowing for the usual bargaining).

Whether or not you present, please challenge the leader's 'hidden agenda' during discussion.

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6) You are a groupee (not a leader).

Even if you have a case, please do not offer it, and do not join in the discussion of the case.

What a dreadful task I have set you! Bear with me if possible! And remember how you felt for later.

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7) You are a groupee (not a leader).

If you wish to present a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, please contrive to have a conversation with the person next to you, regardless of the group work.

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8) You are a groupee (not a leader).

If you want to present a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, try and get the leader to tell the group the 'answer' to the presenting doctor's problem during the discussion.

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9) You are a groupee (not a leader).

Even if you have a case, please do NOT present it.

During the discussion please play the role of a 'superior' doctor who knows exactly what to do about the case presented, and tell the group what!

For the second case card No. 1 read:

1) You are a groupee (not a leader).

If you have a case — Yes, you have! Claim priority. If you have not thought of a case before tonight pick the most goddam awful case you are dealing with at present, and present it in distress.

LEADER CARDS

1) You are a leader (not a presenter).

During the discussion please concentrate on how you think the case should have been treated, and neglect the group process.

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2) You are a leader (not a presenter).

Please concentrate on what you would like the group to learn/understand from what you perceive to be the overall diagnosis of the case.

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3) You are a leader (not a presenter).

Please concentrate of what you see as the personal elements displayed by the presenter of the case, in terms of the choice of case.

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4) You are a leader (not a presenter).

Please concentrate on any evidence of over-identification displayed by the presenter in the course of the presentation.

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5) You are a leader (not a presenter).

During the discussion watch for any attack on the presenter and deal with it appropriately.

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6) You are a leader (not a presenter).

During the discussion of the case watch for sub-groups appearing, and deal with them appropriately.

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7) You are a leader (not a presenter).

During the discussion of the case watch out for any 'superior doctor' and deal with him/her appropriately.

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8) You are a leader (not a presenter).

Please concentrate on the possibility of making a group interpretation during the discussion of the case.

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9) You are a leader (not a presenter).

During the case discussion, please act as a rogue co-leader, either disagreeing with the leader, or leading the group off at a tangent.

Who Needs Balint . . .?*

Marie Campkin
General Practitioner, London

Some time ago, during a session in a vocational training scheme in which the group had been asked to talk about books which had interested or influenced them, a trainee described with great satisfaction a book in which, he said, the author had 'demolished' Freud in the course of a nine-page chapter. More recently, at a national conference of course-organisers, a participant was heard to remark 'Oh yes, we know all about Balint — but of course we have gone way beyond all that.'

Perhaps the trainee was merely demonstrating a forgiveable immaturity, together with a desire to be provocative, and the course-organiser a more culpable, if not uncommon, degree of ignorance and presumption. But the significant factor linking these two otherwise unrelated incidents is the implication that the name of Balint, like that of Freud, has come to represent a philosophy which may be casually invoked, and as casually dismissed, without necessarily having first been studied, still less understood.

In his book *What Freud Really Said*,[1] David Stafford Clark wrote, 'It is possible for people to gain the impression that they know what Freud really said without ever having read a word that he himself wrote.' Likewise it now appears that doctors can pontificate on Balint without knowing who he was, let alone what he said or did. Only recently, in a medical newspaper, Michael Balint was described by that well-known medical communicator David Delvin as 'a London family doctor'!

It is timely, therefore, for those who do appreciate the value of his work to ask themselves how this situation has come about, and to answer for themselves the question 'Who needs Balint?' if his legacy is not to be relegated to a half-forgotten backwater of general practice, and practised by a dwindling band of ageing devotees.

There has always been a disparity between the considerable influence which Balint's work has had in the world of general practice and the relatively small number of doctors who have actually undertaken the form of training he devised — again, the parallel with Freud seems unavoidable. There emerged from the early training and research seminars of the 1950's and 1960's a number of 'graduates' who were to become highly influential figures in the newly-developing institutions of general practice — the College, University departments and vocational training at the start of its long gestation.

They brought into these establishments the important new concepts about the doctor/patient relationship and the nature and potential of the general practice consultation, so that these ideas began to permeate all levels of general practice education, reaching out to students, trainees and established practitioners.

Meanwhile, the publication of work emanating from Balint research-groups on such aspects of practice as night calls,[2] family ill health,[3] school refusal,[4] asthma,[5] sexual problems,[6,7] repeat prescriptions[8] and the use of time in general practice,[9] was making its contribution to the emergence of general practice as an autonomous academic discipline and a desirable career. Surely the stage should have been set for the widespread dissemination of Balint's teaching and a burgeoning of training groups?

But, as often happens, rather than this impetus being sustained, the concepts which had seemed so revolutionary in their initial impact gradually became accepted as part of the background furnishings of general practice thought, while the many other pre-occupations of the time — academic research, the delineation of a curriculum along with the evolution of the College examination, and the inescapable bureaucracy of an expanding discipline — took precedence over the promotion of a philosophy of general practice which did not readily accommodate itself to definition, measurement or evaluation by checklist, 'bingo card' or examination.

Nonetheless, Balint and his colleagues were persevering with their pioneering work, offering seminar training to small numbers of interested doctors and keeping careful records of their progress, while some of those who had completed their 'apprenticeship' were graduating to research-groups to apply their experience to the study of specific projects and questions. Perhaps it was necessary for the movement as a whole to pass through a series of evolutionary stages somewhat similar to those experienced collectively by a training group or individually by a group member in the course of his own development — first, the tentative exploration of 'pregnant nuns' and other impossible cases; then increasing fervour in response to early successes leading to a missionary zeal with somewhat unreal expectations; then a quieter period of disappointment, re-appraisal and consolidation, eventually moving towards a more realistic understanding of the method's potential for the individual and for the profession.

But after this considerable period of introspection and strict conformity with the ground rules laid down by Michael Balint, a dilemma was becoming apparent. 'Who needs Balint?' is either a rhetorical and derogatory question, or it is a serious enquiry inviting that the need should be identified and supplied. Should Balint's work be preserved in its original purity by an embattled minority, or should there be an active crusade to spread his influence throughout the greater world of general practice?

Many who trained in traditional groups feel uncomfortable about the way in which the original

*The Michael Balint Prize Essay, 1986.

criteria for training have been diluted in order to offer experience of the work to a wider audience in the trainee groups and at the 'Oxford weekends'. And equally, those general practitioners who try to lead these groups feel very aware of their inadequacies in stepping into the shoes of the psychoanalysts whose understanding of the unconscious processes at work in the doctor/patient relationship in the reported cases and within the training group itself was regarded by Balint as an essential pre-requisite for leadership.

But perhaps we should be encouraged by looking at some of the questions which Michael Balint raised in the book, *A Study of Doctors,*[10] in which he tried with his colleagues to review the results of the early seminars from 1950-1964, to assess how well the participants appeared to have achieved his training objectives, and to look to the prospects for the future. Referring to the method of selecting doctors for training, he asked 'Would it not have been better if we had revised our uncompromising aims, reduced them to more practical levels, and developed less exacting methods that would have made this highly important field accessible to a larger proportion of general practitioners?' How strikingly apt this question seems today!

At that time his conclusion was in favour of retaining the selection procedure, but he recognised that general practice might be changing; that participants in the seminars were coming from a younger age-group and in future might be more aware of what they were undertaking than were the current applicants; that medical opinion generally was becoming more favourable towards the concept of whole-person medicine; and that general practice might undergo a revival resulting in its becoming a career of choice for the most promising young doctors rather than being largely a matter of 'negative selection'.

He anticipated that such changes might necessitate a 'shift of emphasis' in his teaching methods. 'In preceding years I was more concerned with making the doctors aware of their own resources — such as sympathy, sensitivity, understanding and so on — than offering something external to them and at the same time helping them to cope with the conflicts, fears and problems that this offer might provoke.' He had found there were only a small number of 'gifted' doctors who had been able to achieve the 'considerable though limited change of personality' which would enable them to continue their development independently of the seminars, having learned to use to the full the resources within themselves.

There were a much larger number who could also achieve valuable diagnostic and therapeutic skills from the training to become 'confident and sensible craftsmen', rather than 'artists' like the first group, but their needs were different: 'not so much becoming aware of what has already been there in the doctor, but accepting something new that he has not yet possessed, and assimilating it to the extent that he can use it with ease, free from being impeded by his new acquisition.' Balint also recognised that at that time at least half of all doctors would find this sort of training method completely unacceptable, and some would attempt it but be unable to profit from it.

In these questions and predictions it seems to me that Michael Balint left a remarkably prophetic blueprint for the adaptation of his methods to the circumstances of today, and that the compromises which are already being made in trying to make his work available to vocational trainees would have had his blessing. Many of these are indeed promising young doctors with a primary vocation to general practice. Most are motivated towards a whole-person view of medicine, and may have already been influenced by Balint's ideas in their undergraduate training. Moreover they share in the more sophisticated appreciation of basic human psychology which is part of the common experience of their generation, and as a result, the proportion of them who could accept and benefit from seminar training must be much higher than when *A Study of Doctors* was written.

The vocational training scheme with its emphasis on small-group learning is ideally structured to include regular sessions for case discussions in the Balint style, and there is a particular need to offer this counterbalance to the highly behavioural view of the consultation, and performance-orientated attitude to practice, which are currently fashionable in training circles, where the video camera and the checklist reign supreme. There are several obvious ways in which a trainee-group cannot meet the criteria for traditional Balint training; the timescale is short, usually only a year; the group is seldom optimum size and often members are joining and leaving in 'carousel' fashion throughout the year; as trainees they do not carry full responsibility for their patients; and perhaps most crucially, the group members are not selected, nor indeed are they even volunteers, but conscripts, some of whom could be ill-suited, and some disinclined, for the work involved.

On the other hand, they already constitute a cohesive and functioning group, and if we ask who needs what Balint has to offer, it surely includes these doctors as they begin to face the uncertainties and incomprehensibilities of life in general practice. Perhaps, too, the circumstances of the trainee-group do favour Balint's projected 'shift of emphasis' in combining the recognition and fostering of the trainees' own resources, both individual and collective, of human understanding, with the introduction of new concepts and skills in handling and relating to patients.

No one would pretend that a year in a group of this kind is an adequate substitute for the experience afforded by two years or more in a stable group of established principals under a fully-trained Balint leader; still less can the 'brief encounters' of the Oxford weekends supply more than a tantalising sample of the real thing. Yet an impartial onlooker might find surprisingly little difference in the quality of some of the case presentations and discussions in these different settings — it is the intensity and continuity which are inevitably lacking.

Regrettably it is only a minority of vocational training schemes which include this kind of group, and only a few dozen doctors who can come to Oxford, but it is clear that even these limited forms of experience at once fill a need and create a further demand — for more 'real' groups and more leaders. Those who attend these groups should not be regarded

as 'poor relations', nor the groups themselves as 'cheap substitutes'; they provide an experience of intrinsic value to their participants, and a means with greater potential than that of the 'mutual selection interview' for identifying those doctors who will benefit from, and have their desire to undertake, the full seminar training which must continue to be the mainstay of the Balint movement and the source of its leaders and supporters, researchers and innovators for the future.

For the essential fact about the Balint movement is that it is, indeed, a movement, and must continue to go forwards and develop — on the basis of what has gone before, but in the light of what is happening today and what tomorrow may hold. It is true that the initial lessons which Balint taught have made their way into the currency of general practice — the idea of actually listening to what the patient is saying, and then listening not only with the ears but with the feelings and the imagination; the concept of the doctor/patient relationship as reflecting and illuminating the patient's other relationships and way of behaving; the role of the doctor as drug, and the use of the consultation for therapy as well as diagnosis — this is what permits people to suppose that they 'know all about Balint and have gone beyond that'.

But the methods he devised are scarcely beginning to realise their potential — they have not yet reached all those who could use them, nor have they been applied to all the questions which still need answers. Our patients still need Balint.

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International Balint Memorial Congress:

Budapest: 29-31 May 1986

Over 300 doctors from 16 countries attended the International Balint Memorial Congress which was organized under the patronage of the International Balint Federation in Budapest, Hungary, on 29-31 May 1986, to commemorate Michael Balint's 90th birthday.

After warmly welcoming the delegates who came from Canada, the United States of America, Israel, the United Kingdom and several European countries, Dr Endre Schnell and Dr Marianne Szatmari introduced Professor Imre Hutas, Secretary of State for Health, and Patron of the Congress, who officially opened the Congress.

The very full programme started with several commemorative lectures, the first by Mrs Enid Balint, Michael Balint's close collaborator for many years (see page 8, followed by speakers from Belgium, Hungary, and Switzerland, as well as two others from Britain, Jack Norell (page 11) and Philip Hopkins (page 14).

Three main sessions followed, on the unorganised state of illness; the psychosomatic approach to the patient; and the Balint method as a tool for professional growth and self-education. All the main papers were accompanied by simultaneous translation into English, French, German and Hungarian.

It was fascinating to hear speakers from so many different countries expressing and discussing the same problems that we experience with our patients in Britain. They all described in different ways how Balint's influence had affected their work with their patients.

Balint seminars were also arranged in each of the four official languages. The English speaking groups were comprised not only of the British delegates, but also by those from Czechoslovakia, Finland, Israel, Italy, Romania, Sweden, and even some from America and Canada, who felt more at ease in English than in the other European languages!

The group I led contained members from Holland, Canada, Italy, Sweden, Yugoslavia and Britain. At first there was the usual tension while we waited to see who would be the first doctor to offer a case-history for discussion.

The first to be produced by an Italian psychiatrist was predictably a complex and very difficult problem. Again in keeping with my experience in many groups, this at first led to the other group members beconing considerably reluctant to speak.

However, after he had been telling us how his patient had become very dependent on him, so that somehow she managed to find him where ever he was, and frequently telephoned him at all hours of the day and night. At that precise moment, the telephone in our room rang loudly. 'There she is! . . .' commented a Swedish doctor — our happy laughter at once united us.

There was no further difficulty for us, everyone talked continuously, until we realised that I had not brought the group's discussion to an end when I should have done, and we had been talking together for over two hours, instead of the one-and-a-half hours allowed on the programme!

During the very successful large group demonstration led by Jack Norell in the conference hall, all the lights fused. The discussion continued, at first in the dark, and then for a while by candle-light. An experience enjoyed by every one present!

The way all the discussions flowed so beautifully, clearly demonstrated how all the problems we see in our patients in British general practice are shared by our colleagues wherever they practise.

On the third day, in spite of the rain which made the British contingent feel quite at home, most of the delegates witnessed the unveiling by the Minister of Health, of a marble plaque set in the wall of the house at 12, Meszaros Street, Budapest, stating that Dr Michael Balint had lived and practised there. He had also held the first ever Balint seminars there for the local general practitioners in the early 1920s.

It was a simple ceremony, but for most of us it was the highlight of the Congress.

As so often happens at conferences of this sort, it was during coffee and tea breaks, at meal-times and in the evenings there was the opportunity to meet old friends and to make new ones, as well as for the free exchange of our ideas and experiences. There was complete agreement about the benefit we all had gained from this excellent congress.

Finally, at the congress dinner, many speakers expressed their gratitude to the organizers of the congress, and to the Hungarian government for arranging the commemorative plaque for Michael Balint.

In reply, Dr Enre Schnell commented that, 'Although Michael Balint was born in Hungary, his fatherland was the world.'

P.H.

Photographic Display at the Congress

Unveiling the plaque at 12 Meszaros Street, Budapest.

From the Annual General Meeting held on 10th June, 1986

An Address given by Dr John Ball
Ex-Chairman of the General Medical Services Committee

'Approaching Infinity'

The fulcrum of clinical medicine is the consultation. This is an infinitely variable incident and may well be described as a jigsaw puzzle in three dimensions, but very significantly the individual components of the puzzle are constantly undergoing change — hence the infinity. But there is yet one further dimension perhaps well illustrated by the following story.

A doctor in a remote practice had his clinical affairs reasonably well organised with the significant exception of one patient. This was a lady who lived close by, one Mrs Evans. She would never conform and was never considerate. She was a constant thorn in his side because, despite her apparent vigour, she continually pressed her demands on the doctor in the most unreasonable circumstances.

After a busy day, having finished his surgery and completed his evening meal, he might be sitting by the fire at home relaxing when there would be an irritating tap-tap-tap on the window followed by the voice of Mrs Evans saying, 'doctor! doctor! doctor! do you have something for the colic?'. He knew she would persist and that he had no option but to attend to her needs. But, within a few days, perhaps when he was entertaining some treasured friends at the end of a demanding day, there would again, at the most inappropriate moment, be a tap-tap-tap on the window and Mrs Evans would say, 'doctor! doctor! doctor! do you have something for the cough?'.

Despite his best efforts, she persisted and persisted until finally when yet another tap-tap-tap came on the window the doctor was seized with a crushing pain in the chest which heralded his demise. What surprised many, and was commented on by some, was that despite the nature of his going, his face registered a beautific smile — and those who knew him well recognised that this was due to his final sense of release from the demands of Mrs Evans. What the doctor was not to know, was that within a few days Mrs Evans failed to pay attention when crossing the road and met a similarly swift demise.

It was several weeks later, while the doctor lay in this coffin, revelling in the absolute tranquility and studying the intricate workmanship that had gone into the production of his casket, that he was rudely disturbed by an awfully familiar tap-tap-tap followed by the voice of Mrs Evans saying 'doctor! doctor! do you have anything for the worms?'. It is on this basis that I submit that time is yet a further and important element in the process of the consultation!

Personalities are important features of our craft and can be weighed up in many ways. One useful insight is a study of the owners' bookshelves. For the book itself the title is often all important because of the immediate image it conjures up. I have never read *'Lucky Jim'* but have always been attracted to the title as it seems to portray an unusual degree of good fortune. I count myself as one who is unusually lucky and even the darkest clouds have proved to have their silver linings. However, our presence here on this occasion demonstrates my obvious good fortune, for I count myself lucky indeed to have the privilege of addressing you this evening.

If I were to write my autobiography, which I hasten to add I am not, a suitable title could well be 'Lucky John'. My good luck is for example borne out by my sharing the acquaintance of your distinguished President. He stands extremely high in my regard and passes two of my crucial tests. The first is, 'would you accept a brain transplant from this man?', and (given that our hat sizes are compatible) I most certainly would! The second is to ask if I would invite him to join a select survival party designed for very testing circumstances, again because of his outstanding qualities, I would. From time to time I enjoy the luxury of shared reflections with Jack when towards the end of the evening he always seems to give his accord to my considered views in his deep pile velvet voice. The satisfaction of such an important endorsement inevitably lingers well into the following day during the course of which I begin to suspect, and subsequently to realise, that it was Jack who had planted the successful proposition much earlier in the evening. such is his skill and persuasiveness.

One treasured item on my bookshelf is entitled *'A Fortunate Man'*, a volume that I bought in the late sixties and which has been a constant companion ever since both to me and also, I am pleased to say, to our trainees. *'A Fortunate Man'* traces the story of a doctor in a remote practice and examines the personal relationships between the doctor and his patients in a most meaningful way. It really constitutes a direct invitation to pursue the philosophies of your Society but I confess to not having taken up this important invitation. When I first read the book there were perhaps two reasons, firstly, running a small practice in difficult times was very much an issue of survival and left little room for possible embelishments. The second reason was that such activities then seemed to be far more appropriate to those who lived and practised south of Potters Bar where the reflective approach was likely to be more suited than to those who lived in houses furnished by Harrods and whose surgery waiting rooms were likely to be inhabited by the Harrods' customers. More recently I may claim, with tongue in cheek, that it the international aspects of your Society which I have found more forbidding especially as my life and career has been prepossessed by events and affairs at home.

Internationalism can be looked on either as a dream or as a nightmare. In the dream world the police force is English, the kitchens are staffed by French cooks, the garages by German mechanics, while the

Italians are the lovers, and the organisers are Swiss. However in the nightmare world the police are Germans, the cooks are English, the mechanics are French, the lovers are Swiss and the organisers are Italians!

Rather more seriously, one must ask where the Society's values stand in the world of medicine today. We see the ascent of technology and are hot in the pursuit of quality. But how will we protect and develop the personal transaction that takes place in the surgery. Present techniques offer the slick and easy tabulation of key events which can readily be converted into performance profiles which allow instant judgments without unacceptable and difficult personal decisions. 'Bloggs is a splendid chap but he showed rather badly in the index'.

Unless we are very careful this approach will lead to what, if I may borrow a phrase from your President, is readily described as 'Robotic Medicine'. The prospects for hospital practice, I find, can be equally chilling because their circumstances lean so heavily and unavoidably on the application of technological medicine coupled with the more recent balance sheet approach to clinical practice. I mention their circumstances as an expression of sympathy and not as an implied criticism but it is a situation which heavily underscores the importance and value of personal communication in medicine more than ever before. Current circumstances raise the questions 'is personal care becoming an 'endangered species'?, 'do we need an action group to preserve the consultation'?

While I do not aspire to provide the answers to these questions I must undoubtedly underline the importance and role of the Balint Society with its role of safeguarding and developing the delicate transaction between doctor and patient. The Society whose contribution in medicine today and tomorrow is of every increasing importance. I know I speak for the many who will rely on your successful influence Mr President, when I wish you and the members of your Society the very best fortunes in the future. Thank you.

Secretary's Report

This has been a most successful year, primarily because of an increase of new young members, partly due to the reduction in the criteria which now require group membership of only one year; also we successfully canvassed among ex-members of the Tavistock groups.

Last September we held our residential Balint weekend at Pembroke College, Oxford and entertained 104 visitors, in 9 groups. Mrs Enid Balint ran the demonstration group and Dr. Jack Norell chaired the plenary session. As a direct consequence, 3 provincial Balint-groups have commenced work.

The first meeting of the sixteenth session was held at the Royal College of General Practitioners in October. Dr. David Zigmond spoke on Dialogue Dialectic and Didactism, three differing methods of communicating with patients.

In November, Dr. Marc Sundle formed a group and presented a case of a woman with a headache, and then after discussion he showed a video-recording of her in consultation. Further discussion followed about the internal and external reality of the doctor.

In February, Dr. Michael Courtenay spoke on the role of the Balint-group Leader and formed two successive groups for case-discussion, in which he separated out various aspects of the role of the leader, using cards as a guide. Once the roles were known, the game became a farce. You cannot learn leadership by numbers.

In March, Mrs Clare Rayner talked abour her agony column 'What your patients tell me' and found much common ground. She thought her success was due to her honesty of purpose.

In April, Dr. Deidre Paulley spoke about a closed Trainee-group in which she had been involved in Ipswich, for eight years. It increased awareness but we had no direct evidence of how the groups worked.

An extraordinary general meeting was held in November, 1985, and two motions were carried:

1. With regard criteria for membership, the required time spent in a Balint-group is now one year.
2. Honorary Officers of the Society will be entitled to hold office for three years.

It was also agreed that in future, the Society's Accounts shall be independently audited by professional accountants in March, each year. For this purpose, Mr Arnold Woolf, of Bennett Nash and Woolf, Chartered Accountants, was invited and kindly agreed to act as Honorary Accountant to the Society.

The Balint-group Leaders' Workshop continues to run smoothly, and is now under the Chairmanship of Dr. Oliver Samuel.

This year, another residential Balint Weekend at Pembroke College, Oxford, has been arranged for September 19th-21st.

PETER GRAHAM

Book Reviews

First Steps in Psychotherapy: Teaching Psychotherapy to Medical Students and General Practitioners, Ed. H. H. Wolff, W. Knauss, W. Brautigam. (Pp. 164. Paperback. £16.95. ISBN 0-387-15042-0) New York, Springer-Verlag. 1985.

This book, although published in German in 1983, was not available in English until 1985. Whatever the reasons for this unfortunate delay, all must be forgiven, as it was well worth waiting for — and the editors thoroughly deserve all the praise and congratulations I can help to heap upon them.

Divided into four parts, it is very readable (even the contributions translated from the original German) and provides in the first part, by Heinz Wolff, a most excellent and explicit account of the theoretical concepts involved in the place of psychotherapy and psychodynamic understanding in Medicine.

The second and third parts deal with the teaching of psychotherapy to medical students, and of psychotherapy in general practice respectively.

Since 1958, medical students at University College Hospital have had the opportunity to treat a patient with weekly psychoanalytically orientated psychotherapy, under supervision, for a year or more, and on a voluntary basis. A similar course was started in 1977 at the Psychosomatic Clinic of Heidelberg University, and an account of this joint educational venture forms the basis of the second part.

Over the past few years I have met a number of mature and established doctors who recalled with pleasure and gratitude the influence that their experience in these groups had upon them. Ball and Wolff first reported their early experiment in the teaching of psychotherapy to medical students in 1969,[1] and Michael Balint and his colleagues has also described his work with student-groups at University College Hospital.[2]

The editing and skilful co-ordination of the eleven sections, written by eight authors, which form the second part, has resulted in a very clear account of many aspects of the teaching of psychological understanding and basic psychotherapeutic skills to medical students.

This all goes a long way to show how that gap in the future doctor's training can be filled. As Balint pointed out, there is a need to correct the fallacy in thinking that an experienced doctor acquires enough 'common sense psychology' to enable him to deal with his patients' psychological problems. He needs to acquire the skill of listening to his patients — 'The use of empirical methods acquired from everyday life are as limited in professional psychotherapy as are the carving knife and screw-driver in surgery.'[3]

Anyone involved in the training of medical students can only benefit from reading this section alone, and indeed perhaps it should be compulsory reading for all Deans of Medical Schools!

Several aspects of psychotherapy in general practice are superbly described in the nine sections of the third part. These will be of particular interest to readers of this Journal as they include not only detailed accounts of the present state of psychotherapy, and psychotherapy and general practice, but also an excellent resumé of the essentials of the history, concepts and aims of Michael Balint's work, as well as many other related topics.

An interesting mention is made of the method of paying general practitioners in the Federal Republic of Germany. Claim forms are submitted every three months for each patient seen, specifying the number of consultations and items of service rendered. This included three different types of 'psychotherapeutic talks', but as might be expected, members of Balint-groups quickly reach the maximum number of claims for which they can expect to be paid!

The fourth part consists of Irene Bloomfield's account of her personal experience as an associate member of one of the groups Balint led at University College Hospital during the last three years of his life. The result is a vividly drawn impression of his style and method of leading a group which bears his name.

There is a full bibliography at the end of the book, together with a useful index, although that most important topic which is mentioned often throughout the book, time, is not included in it!

Nor, by some strange oversight, is there any indication anywhere in the book or on its cover, apart from the three named as medical students, as to what appointments the authors hold.

These are but small criticisms of what is a most easily readable and interesting book, which brilliantly outlines the essentials of Michael Balint's work, and again demonstrates the need for doctors to deal with their patients' feelings as well as to apply the technological advances of scientific medicine.

PHILIP HOPKINS

Psychosomatic Disorders in General Practice: Theory and Experience, by B. Luban-Plozza and W. Poldinger. Second English Edition; 1985. Editiones Roche, Balse, Switzerland.

The authors of this comprehensive publication, who are psychoanalysts in Switzerland, are to be congratulated on producing a work which will prove of great interest as well as of practical use to British general practitioners. It contains a wealth of information about psychosomatic aspects of medicine, is easy to read, and adopts a common sense approach together with challenging ideas. Particularly commendable are the sections dealing with the problem of integrating psychotherapeutic principles into general practice, and "Relationship therapy".

According to the authors, the psychosomatic approach is meant to complement the achievements of anatomy, biochemistry and pathophysiology, both diagnostically and therapeutically. They recognise that psychogenic factors represent only one aspect of pathology and that therefore the comprehensive

approach requires these factors to be taken in conjunction with the more conventional aspects of medicine.

The authors are well aware of the 'delicate problem' generated by the very term, psychosomatic: namely the implication of dualism. They quote Siebeck as saying that while a distinction should be drawn between psychic and somatic factors, they should never be fused nor separated. Minkowski is also quoted: 'The essence of psychosomatic medicine lies not so much in the mere bringing together of psychic and somatic factors as in attempting to take a human being as he is, a living combination of mind and body.'

Among the many psychomatic disorders listed are bronchial asthma, hypertension, stomach ulcer, colitis, eczema and pulmonary tuberculosis; but it is worth recalling that interest in the possible psychological basis of certain diseases tends to wane as soon as effective remedies become available. This has certainly been the case with tuberculosis, asthma and duodenal ulcer.

It is surprising to note that although there is a section on over-eating, there is little reference to excessive alcohol intake and none at all to smoking, both of which certainly qualify as self-inflicted dangers to health.

Understandably, there is a tendency to specialist interpretation of common events. For example it is well known that neurotic symptoms often recede when somatic illness develops, but this is explained here in terms of Mitscherlich's 'two-phase repression': namely, that 'when such *psychic* response to overcoming the conflict situation is inadequate, there is a shift during a second phase to dynamic *somatic* mechanisms.' Many practitioners might feel a little sceptical about this; and also about the heads-I-win-tails-you-lose suggestion, 'Even when they present with their symptoms at the doctor's, they live under the delusion of having no emotional problems.'

The authors seem optimistic about the usefulness of tranquillisers as a means of preparing patients for proper therapy. Interestingly, the counter-argument is hinted at in the book itself when, in discussing the anxiety of parents about their children not eating enough, the authors remind us that such children 'tend to regard their parents' persuasion as merely a means of achieving their own peace of mind . . .' How true! And how reminiscent of the experience of the patient who remarked: 'I feel that when the doctor writes me a prescription for Valium, it is to put *him* out of *my* misery.'* (See Footnote)

A section on the dentist/patient relationship draws attention to, among other things, the lowered esteem which accompanies loss of teeth. Modern dentistry is described as possessing 'too specialist-minded, technically orientated training'. One could be forgiven for assuming that this is precisely what is required for dental patients; but — as elsewhere in this splendid book — we are being given food for thought.

Perhaps it is appropriate that the last word about this excellent and thought-provoking work should be by Michael Balint, who wrote the foreword: 'Here, then, new ways of thinking and of acting are offered (to the doctor), not by devaluating his present knowledge and skills, but by using them as a basis upon which to extend his therapeutic resources.'

J. S. NORELL

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(*Bottling it up, page 35; Curran & Golombok; 1985; Faber & Faber, London.)

The Balint Society Prize Essay, 1987

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the theme 'The courage of your stupidity . . .'

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 clinical 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.
The prizewinner will be announced at the 17th Annual General Meeting in 1987.

Entries must be received by 1st April, 1987, and sent to:

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

Please tell all your colleagues.

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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