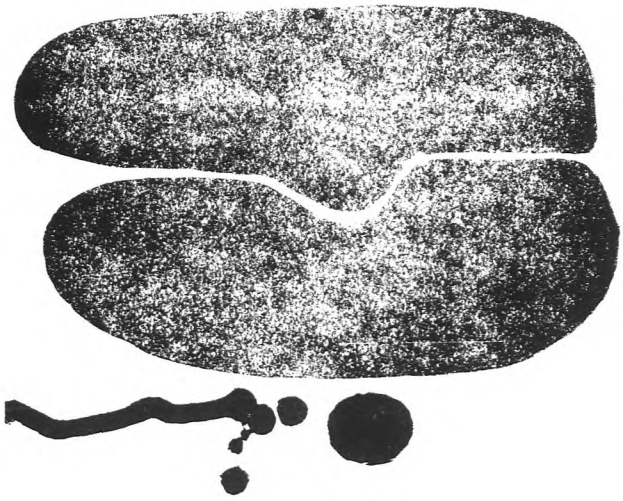
Journal
of the
Balint Society

1993



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JOURNAL OF THE BALINT SOCIETY

Vol. 21, 1993

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Editor: Philip Hopkins
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Photograph by Dr Philip Hopkins

Dr. Arnold Elder, Dr. Sally Hull, Mrs Enid Balint, Dr. Paul Julian and Dr. Michael Courtenay at the launch party of The Doctor, the Patient and the Group: Balint Revisited.

The Balint Society:

The Balint Society was founded in 1969, to promote learning, and to continue the research in the understanding of the doctor/patient relationship in general practice, which Michael and Enid Balint started in what have since become known as Balint-groups.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group, and to anyone involved in health-care, established or students and trainees, who are welcome as associate members.

The Society holds regular meetings for discussions about relevant topics, as well as for lectures and demonstration Balint-groups in London and residential Balint Weekends at Ripon in May, and Oxford in September each year (see page 44).

The Annual General Meeting is held in June each year.

The formation of new Balint-groups is under constant review, and the Balint-group Leaders' Workshop continues to meet throughout the year, and is also an excellent forum for Course Organizers for discussion of their work.

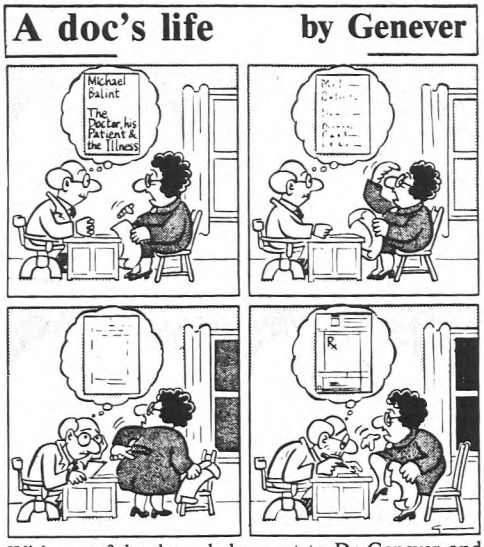
The Society is affiliated to the International Balint Federation, which co-ordinates similar activities in other countries, and organizes a bi-annual International Balint Conference.

There is an annual Prize Essay of £250.00p (page 31), and the Journal is circulated each year to all members.

Editorial

What happened to Balint?

This question has repeatedly been asked over the past few years. Whereas doctors' interest in the Balints' work has been increasing in many other countries, leading to the formation of Balint Societies in many of them including, most recently one in the United States of America. Not many general practitioners in Britain, however, appear to have found it all that attractive, even though our Society was founded in 1969.



With grateful acknowledgement to Dr Genever and Editor of DOCTOR

In discussion with colleagues and friends from various parts of the UK, many have referred to the difficulty of finding time to attend regular Balint-group sessions every week, as well as their reluctance to become too involved in their patients' emotional problems. Even those trained in Balint-work have found it difficult to attend the monthly meetings of the Balint Society. Dr Genever's perceptive cartoon published in DOCTOR on 8 October 1981, sadly says it all!

The unavoidable delay in producing this issue of the *Journal* has allowed up-to-date reference to the fact that now, just twelve years later, three out of four of the general practitioners who responded to DOCTOR'S recent survey on the profession's morale, stated they would leave National Health Service practice if they could.

It now seems that some will have the opportunity to do just that. The National Health Service Management Executive has announced their proposal that general practitioners will be able to retire at age 50-55. We should soon know how many will do this. It would also be interesting to know whether this proposal has been in response to demand, or because it follows the government's usual desire to run the National Health Service on the cheap, which may well be possible if nurses were employed to perform an increasing number of the procedures previously accepted as part of the general practitioner's job, so that fewer doctors would be required.

We may well find that a new application for Balint-groups will be to help the nurses who will almost certainly be wanting further training to enable them to cope with their increasing responsibilities. Although we deplore the trend towards this fragmentation of health care, we might find it useful to engage in damage-limitation by offering Balint-groups for other health professionals so that they can also benefit from the insight gained thereby.

For example, to recognise that regular ante-natal examinations are not merely a matter of checking the blood pressure, measuring the increase in girth or listening to the foetal heart, but that they also offer the opportunity for discussing the attitudes and expectations of the expectant mother, as well as her anxieties and fears.

For some time, we have been discussing possible ways of adapting Balint-work to the social, political and economic climate of the 1990s, and this could be a useful way of doing this.

P.H.

The Legacy of Michael Balint to General Practice

Jean and Stephen Pasmore

The Tenth Michael Balint Memorial Lecture, given on 16th March 1993

Jean and I are naturally very honoured to have been asked to give this 10th Memorial Lecture and would like to thank all those who have provided us with information about the past, particularly Philip Hopkins, who has done so much to record the Society's activities.

In this lecture which we have entitled 'The Legacy of Michael Balint in General Practice', I shall touch mainly on the past, while Jean will say something about the future by describing the work and aims of the Institute of Psychosexual Medicine. This Institute was an off-shoot of one of Michael's special seminars for the study of sexual problems, and was founded mainly by Dr. Tom Main, a close friend of Michael, and the Medical Director of the Cassel Hospital on Ham Common in Richmond.

Introduction

As you will all recall, a familiar cry from Michael at the start of any seminar was 'Who has got a case?'. Well, I have one. I came across an amusing cutting in my files the other day of a letter from a doctor writing to the *Lancet* in the early 1950's. It read:

'Annie has been coming to the surgery for years with a new complaint every time. In my early days I used to hunt for the causes, but for some years I have tended, I fear, to treat her rather light-heartedly.

She came in on Friday evening with a story of burning water and a bottle to prove it. To support my reassurance I tested for albumen over a bunsen burner. There was a roar and a burst of flame, and I dropped the lot, shocked and singed. 'My God, Annie, you've really got something wrong this time.' 'Oh, doctor, I'm terribly sorry, I've given you the wrong bottle. That must be my new shampoo.' 'I have today,' added the doctor, 'ordered some of these new tablets for urine testing. I am told they are simpler and cleaner, but it's their safety that really attracts me!'

This letter is typical of the atmosphere that prevailed in general practice forty years ago when the practitioner confronted a neurotic patient. Practitioners did not consider it safe or prudent or good manners to ask patients what they felt about the symptoms of which they complained, for we had been taught only to diagnose and cure symptoms of organic disease by knowledge derived from books, pathological tests, X-rays and electrocardiograms. We had not been taught to use our own minds as a medical instrument, rather than as a thinking machine.

The significant effect of the mind on the body has been re-affirmed many times down the ages. A noteworthy advance nearer our time was made by Sigmund Freud in 1896, when he discovered how to analyse the unconscious mind by the method of free association. Since then, mental disorder has been taken more seriously by the medical profession. By 1903 asylums for the insane were being called 'mental hospitals', and indeed I have some connection with that as my father was appointed the medical superintendent of the first new asylum to be called a mental hospital that was built outside Croydon, and later became known as Warlingham Park Hospital.

By 1929 organisations like the Child Guidance Council had been set up, and psychiatrists were beginning to mention the psychosomatic approach to medicine in their lectures to medical students. But the leaders of the medical profession looked upon general practice as an inferior branch of medicine, and never seemed to realise that there was a vast difference between hospital practice and general practice, and that doctors could become eminent in either field.

Biography

Michael Balint was the first doctor to undertake research into the psychological aspects of general practice and to devise a method of training general practitioners in the art of recognising and dealing with this other side of medicine. Many of you will be familiar with the story of his career.

Michael was born in Budapest in 1896, where his father was a general practitioner. He was a brilliant student with a love of the classics, and it may well be that this was the source of his Socratic method of teaching. He also had a special interest in chemistry, physics and mathematics. However, he decided to take up a medical career rather than follow his original idea of becoming an electrical engineer. He graduated MD in Budapest after spending two years in war service, before being wounded and then demobilised.

In 1921 Michael married his first wife, Alice, and on account of the anti-semitism of the Horthy regime in Hungary, moved to Berlin, where he worked as a research chemist and biologist, and gained a PhD. degree in biochemistry. At the same time, he and his wife became interested in psychoanalysis. Three years later Michael returned to Budapest, continued his analysis under Professor Zandor Ferenczi, a pupil of Freud, was appointed training analyst to the Budapest Institute of Psychoanalysis in 1926, and became its director on the retirement of Ferenczi in 1933. By this time he had given talks to general practitioners on psychological problems in medical practice[1] and had acquired an international reputation in the field of psychoanalysis. Then, as a result of the increasing racial intolerance in Hungary, with the police supervising some of his seminars, he emigrated with his wife to England in 1939. Sadly his wife died soon after, while his son, John, later became a professor of medicine in Albany in the USA.

Michael settled in Manchester where he obtained the necessary British medical qualifications, practised as a psychiatrist, was appointed medical director of a child guidance clinic in 1942, and an honorary consultant to the Royal Northern Hospital the following year. In 1948 he was invited to join the staff of the Tavistock Clinic, where he remained until his retirement in 1961. He then joined the staff of the Department of Psychological Medicine at University College Hospital, where he remained till his death on 31 December 1970 at the age of seventy-four. But before that, in 1968 he was elected President of the British Psychoanalytical Society.

Michael also acquired an international reputation through his seminars for general practitioners, with the result that Balint-type seminars were set up in many countries, including France, Holland, Belgium, Germany, Italy, Switzerland, Norway, Sweden, Finland, Australia, New Zealand, and the United States of America.

Balint Seminars — Origin and Development

Michael's great contribution to general medical practice began as a result of his contact with his future wife, Enid, who in 1947 was working for the Family Welfare Association. Enid sought the help of the Tavistock Clinic to devise a programme for training her social workers to solve the problems of their clients with marital difficulties. The following year Enid formed a seminar of these workers, known as the Family Discussion Bureau, and later secured the services of Michael from the Clinic to train them. Enid and Michael between them developed the 'case-discussion seminar' or 'training-cum-research seminar' as it was sometimes called, where the emphasis was laid on the client/worker relationship, as well as the psychopathology of the client. This proved to be so successful that Michael proposed to the Tavistock Clinic that he should try this method with groups of general practitioners. His proposal was accepted and his first seminar with them began soon after this.

Only thirty-six general practitioners responded to the advertisement about the proposed seminars, and only fifteen of them decided to become regular attenders. By 1952 there emerged a group of fourteen doctors who worked well together and became known as the 'Old Guard'. Michael organised them into a research-group and their work formed the basis of his outstanding book, 'The Doctor, his Patient and the Illness', which was published in 1957.[2] I must say I was pleased to find a case of mine quoted in it under Dr. K., though I was not a member of the 'Old Guard'.

If you would like to hear another case history at this stage, I will tell you why Jean and I joined the seminars in the autumn of 1954. We were in general practice in Kensington, had a family of three and had reached our forties, and were beginning to ask ourselves what life was all about, and why we could not understand the reason for so many of our patients' complaints. Jean noticed an advertisement in 1955, and went to the first one that autumn by herself, as I said I was too busy to attend any more postgraduate courses. When she returned she said I would have to join her the following week as it was 'what we had both been looking for'. So I went and, like her, was spell-bound by Michael's exceptional approach to postgraduate study. Such was the start of our pilgrims' progress, and I should like to record what happened to us in those experimental years, experimental both for Michael and Enid as well as for the group of practitioners with whom we worked.

Jean and I attended our first seminars in a room at the Tavistock Centre, which was then sited at 2 Beaumont St., W.1. We felt at ease with the other doctors, as we all shared the common interests of general practitioners. I was surprised to find that several had travelled such long distances to attend. I was surprised, too, to find Michael did not lecture us, but invited us all to take part in a general discussion. There was then a break for tea followed by a short lecture from another member of the staff, but I remember little of what was said on those occasions.

It took us about a year in the seminar to realise how ill-equipped we were to deal with many of our patients' problems, and how we failed to carry out a full examination of their feelings in mental stress, in contrast with our examination of their physical parts in suspected organic disease. When we presented a case in the seminar of a patient with some vague illness associated with anxiety or depression, we would find we had little to say, and would feel stupid when our colleagues asked for straightforward information, but when we adjourned for tea

downstairs and received some sympathy from them for our poor performance, we soon recovered our composure. After a time we gained more confidence in ourselves, and found we could talk to our patients more easily and more meaningfully. There were fewer painful silences ending with the writing out of a prescription to boost our egos. Better communication led to our making a better diagnosis, which later became known as the 'Overall Diagnosis' which gave more detail than vague terms like anxiety or depression.

About three years after Jean and I started, a meeting of all the Balint-groups was arranged at a hotel in Bloomsbury, and I was surprised to find that one could tell how long a doctor had been in a group by what he said in the discussion. It was evident that little progress could be expected from limited attendance at the seminars. Indeed Michael emphasised the fact that the acquisition of psychotherapeutic skill could only occur after a limited, though considerable change had occurred in the doctor's personality. Later on I found the proof that my personality had changed when I was inspired to write a paper on *The Patient's Use of the Doctor* for the first International Conference of the Balint Society in 1972.[3] If I had been asked to write a paper on the same subject when I started the seminars eighteen years previously, the emphasis would have been on the doctor and not on the patient.

We all made steady progress in the seminars and found outselves working harder and keeping fuller records of our psychotherapeutic interviews. We attended meetings of Balint-groups here and abroad; one of the first I recall was the Boerhaave Conference on Training Methods in Medical Psychology at Leiden University in Holland in 1960. We were stimulated to write papers and in 1958 I was thrilled to get an article in *The Lancet* on *Psychiatry in General Practice*.[4] And in 1961 I remember reading a paper at a symposium on Emotional Disorders in General Practice held at Torquay, and ending by saying that I had at last learned the ghastly fact that the only person I had ever reassured, when telling a patient not to worry as I could find no evidence of organic disease, was myself.

The Origin and Development of the Institute of Psychosexual Medicine: Dr. Jean Pasmore

In the 1940's the only advice generally available to the public on contraception was from Family Planning Assocation (FPA) Clinics, administered by lay workers and funded by fees charged to the patients who attended them. In 1951 the limited resources of the FPA resulted in the committees who ran the clinics having to ask their doctors to see more patients in a session than they could treat properly. As a result, a small group of doctors, including myself and some others from as far afield as Liverpool and Exeter, met at Dr. Joan Malleson's house in Paddington to discuss the problem. We felt we could not fit any more patients into our sessions, as so many of them sought advice for their sexual problems while being given instruction about contraception. We were determined to see our patients as a whole and give them the help they needed. Our talks quickly turned to discussion of our inadequacy to deal with their sexual problems, as the subject had not been mentioned in our medical schools. Although Dr. Malleson, Dr. Helena Wright, also of Paddington, and Dr. Mary Macaulay of Liverpool, had written some books and papers on the subject, they did not go deep enough.

In 1955 some of us, including Dr. Sylvia Dawkins and myself, started to attend Michael's seminars at the Tavistock Clinic. Two years later we persuaded the FPA to invite Michael to start a special seminar to discuss sexual problems. When the seminar started, one of the members, who had been reading Jung, suggested that Enid be asked to join us as the 'Wise Woman'. Fortunately, Enid agreed and brought much wisdom to the group's discussions. A little later the original women members of the seminar were joined by some male colleagues.

In the course of these special seminars, we discovered that the moment of the vaginal examination gave an unique opportunity to explore patients' feelings and fantasies about their genitals and their sexuality. Michael asked to attend one of our clinics to experience at first hand what was involved, and I remember him coming to one of my evening sessions at the FPA clinic in a poor quarter of North Kensington. He was able to talk briefly alone with one of my patients who had raised a sexual problem. I was pleasantly surprised when he asked me for a follow-up of the patient when we met again at the next seminar. The FPA later agreed to start some special sessions for marital problems at their clinics, and when I was appointed to one of the first, Michael was so pleased that he gave me a sixpenny-piece, which transitional object I still cherish.

Some of the results of these seminars were published in *Virgin Wives*, by Leonard Friedman,[5] a member of the staff of the Tavistock Clinic. Subsequent papers about the work of these seminars were published in medical journals and read at various congresses here and abroad.

Later, Tom Main became interested in these seminars and, after attending several, became co-leader, led the group when Michael was away and took over his work completely when he retired in 1961. Tom, under the aegis of the FPA, then started new seminars at his house in Putney and at the Cassel Hospital with several male colleagues joining his groups. On one occasion, when he suddenly decided to go to South Africa, he told Dr. Prudence Tunnadine, one of his outstanding members, to lead the group in his absence, just as Michael

had previously told some of us to go out into the provinces and lead groups. Prue is now the chief Scientific Director of the Institute of Psychosexual Medicine.

Tom continued to promote his seminars and build up an organisation not only for training doctors, but for training leaders as well; and when it became evident that the National Health Service were going to take over the FPA's work, decided that an independent organisation would serve the public better. In April 1974 Tom called a meeting at his house in Putney, of leading FPA doctors to discuss his proposal. The doctors welcomed his ideas and arranged another meeting at the Royal Society of Medicine in June to consult with their other colleagues in the FPA. Seventy-two doctors attended this meeting and as a result of their approval of Tom's proposals, the Institute of Psychosexual Medicine was founded, though their first annual general meeting did not take place till March 1976. It was naturally agreed to set up a steering committee, and I well remember chairing that committee which met regularly at our house in Edwardes Square, Kensington, for some two years. Dr. Margaret Blair played a leading part as secretary, and other well known leaders were present such as Drs. Sylvia Dawkins, Katherine Draper, Fay Hutchison, and Prue Tunnadine, together with Mrs Nancy Raphael, a stalwart supporter of the FPA movement.

The scheme developed by the Institute for putting the study of sexual problems on a firmer basis involved the setting up of two stages of training for those who wished to become full members of the Institute:

1. *Basic Training* for increasing the skills of doctors who encountered sexual problems in their practices of family planning clinics.

2. *Advanced Training* for those wanting to specialise in the subject. Full membership could only be achieved after the doctor had attended the appropriate seminars for 4-5 years and had been approved by the Accreditation Panel, while further training was obligatory for those who wished to become leaders, necessitating their attendance at on-going workshops to discuss their roles as leaders.

The Institute of Psychosexual Medicine, therefore, had its origins in those early meetings at Joan Malleson's house in Paddington, which led to Michael coming to the rescue of the hard-pressed FPA doctors by responding to their plea for a special seminar to discuss sexual problems. Clearly the Institute is one of Michael's legacies to medical practice. Another of his legacies has been the independent setting up of a network of seminars for nurses who are confronted with the psychosexual problems of their patients, such as occurs in the Cassel Hospital. This has developed from the initiative of Mrs Doreen Clifford, the late Matron of the hospital, who worked with Tom.

The Institute is now flourishing with seminars held in several parts of the British Isles. Scientific meetings and international meetings are held regularly, an excellent newsletter is circulated twice a year, and much research is undertaken which is shown by the number of articles and books that have been published.

I am sure Michael would approve of my suggestions to you all, that you should not despise your professional doubts and uncertainties, because it is in that unpromising compost that the seeds of progress can develop.

A Research Seminar: 1966-1971

In 1966 Michael and Enid started a research-group of eight doctors, including myself, mainly to find out how to conduct a meaningful ten-minute psychotherapeutic interview, as so few doctors could spare the time for a longer one lasting thirty to fifty minutes. Moreover short interviews might prove to be more effective than long ones.

At the end of 1967, Michael expressed his concern that the seminar was not making much progress and stimulated some of us to write a report on the situation, for he was just as interested in hearing our views as expounding his own. On this occasion I reported that I thought the emphasis in the seminar had been on what the doctor had tried to get from the patient, rather than on what the patient had tried to get from the doctor. I also reported, as a result of watching a popular police story on television, called *Dixon of Dock Green*, that we had enjoyed acquiring the skills of a detective-inspector by asking the reporting doctors endless questions about their patients so that we could create a remarkably good identikit picture of them. We were beginning to realise that this new picture was only a shadow of the patient we presented, and that we would have to alter direction if we wanted to reach their hearts.

At the same time the word 'collusion' was often being used — collusion between doctor and patient, where a comfortable relationship was set up between the two without any attempt to help the patient with her basic problem. It was again evident that more attention would have to be paid to finding out what patients were trying to get from their doctors.

It took the seminar another two years before they began to see the light, which began to shine when they were invited by Professor Millar and Dr. Richardson to give a demonstration of the techniques in Aberdeen in October 1969. I well remember a case which Michael Courtenay reported at our first seminar there. His patient was an attractive married woman of thirty-two, who had been on his list for fourteen years. She complained of a recurrence of a pain in her neck and Michael C. enabled her to express her real feelings when he said 'Who is the pain in your neck?'

The next day we were all spellbound by

a case Jack Norell presented about an unattractive married woman with a decided pong, who was complaining of a spotty face. Jack seemed unaware of the remarkable rapport he had built up with his patient after his initial distaste had turned to sympathy, and how much ground he had covered in ten minutes without indulging in any collusion or detective-inspector work. As a result, his patient was able to reveal some of her deep-seated worries.

It became evident that this was the sort of interview Michael hoped we would all be able to achieve, when we could judge what observations, remarks and behaviour patterns we should take up so that our patients could see for themselves what the real problem was behind their complaints. Indeed, at the third and last demonstration seminar, Michael summed up our efforts by saying, 'What we are trying to do . . . is proper general practice. Proper, that is not to be restricted to the patient's offers, but understand them in their true sense and react to the true meaning of what the patient's complaint was.'

Jack's case at Aberdeen showed us how a meaningful interview with a patient could be achieved in ten minutes with little talk, provided the doctor became sensitive to his patient's feelings. His case reminded me of a remarkable session I once had with an elderly insane female patient in about 1937, long before I had practised psychotherapy. A psychiatrist asked me to attend this patient for a few days at her daughter's home before he could admit her to a mental home, and told me to give her Nembutal at night for her bad insomnia. When I saw the patient I was horrified at her tired, worn out, haggard appearance. I asked her what was the matter and she said she had an alligator in her stomach. By some remarkable intuition due to the compassion she aroused in me, I immediately said, 'Well, let's try and disperse it. I'll pummel the head if you will hold on to its tail. We dispersed the alligator between us in about two minutes, and when I called the next morning was surprised to find she had slept like a top and looked a different person.

Four years after the Aberdeen meeting our research work in the seminar was summarised in a book, edited by Enid Balint and Jack Norell with the engaging title of *Six Minutes for the Patient*.[6] It was translated into many languages, including German, where the title was altered to '*Funf Minuten pro Patient*'. I always thought this was because the German did not like to use the phrase *Sechs (sex) Minuten pro Patient*, but I am told the Germans were more used to the phrase Five Minutes for the Patient.

By this time I had learned enough to achieve an occasional success in a short interview. I was returning with Jean from a tour in Venice when we boarded a plane at the Rome airport for the final flight home. Miss B., a member of the tour, who was sitting on my right, started to breathe heavily and take sips of water from a flask in her handbag after a long delay in the expected take-off. To pass the time and relieve my companion's anxieties I decided to give her a six-minute interview: 'You are feeling a bit nervous?' I said and Miss B. agreed. 'What are you afraid of?' She did not know. 'Perhaps it's in your unconscious?' I ventured and was amused at her reply of 'Where's that?' Three of my six minutes had gone. 'If you ask questions, you will only get answers' flashed across my mind, followed by 'Examine her feelings, you blockhead'. 'What do you feel might happen?' I said hopefully. 'I feel the plane might disintegrate.' 'Do you recall any incidents in your childhood connected with flying or heights?' I asked, daring another leading question. 'Yes, when I was ten and doing the flying angel and falling.' 'The flying angel?' I queried. 'Yes, in the gymnasium at school. You pull yourself up on a pair of rings hanging from the ceiling, put your feet through them, and form a triangle. I was doing this and fell. I thought the rings had given way.' 'And you got no sympathy at all?' I hazarded. 'No,' she replied emphatically, 'I am fascinated by what you have said. I believe that's it. I'm feeling much better already and can breathe again.'

I looked at my watch and found my six minutes had just expired.

The Balint Society

The members who took part in the demonstration seminars in Aberdeen found their work so inspiring that a closer bond than usual was felt between them, so that when they returned to London, they readily agreed with a suggestion from Philip Hopkins to form a Medical Society of Balint-groups on the same lines as the one just formed by the French. The Society was founded a month later in November 1969 with Philip, a member of the 'Old Guard', elected as the first President. A little over a year later, it was agreed to alter the name to The Balint Society.

Few outstanding men in London have had medical societies founded in their honour, apart from William Harvey, John Hunter and Sir William Osler. Hunter and Balint had much in common. They both had brilliant minds and an insatiable curiosity to pursue their many interests, and both had the capacity to draw together a group of followers to share their research projects and further their ideas.[7] The only difference between the two was that the Balint Society was formed during the latter's lifetime.

The Logo of the Society

When the Council of the Society decided to publish an annual journal with a suitable Logo for the cover, they accepted my suggestion that I should ask my artist brother, Victor, to design

one. When I next met him we had a fascinating discussion on his approach to modern art and Michael's modern approach to a psychological interview with a patient. We were both surprised to find that there was little difference between the two.

I told my brother that Michael had urged us to 'identify closely with the patient's feelings, withdraw and look at what our involvement had been, communicate our reaction with the patient in the patient's terms, and then go on repeating the process'. My brother replied that he no longer painted in the traditional classic manner with an object in view. He would now select his canvas or paper, draw or paint a dot or a line or a shape on it, or perhaps use a spray, with no preconceived ideas of what he was going to do next. He would then withdraw and look at his involvement with what he had done and then make another suitable mark.

The common ground between Michael and my brother's approach was clear. My brother was moving from his past objective approach to a more subjective one, comparable to a musical composition though using colours and shapes rather than gradations of sound, while Michael had moved from the objective approach of examining physical parts to the subjective approach of examining his patient's feelings and the relationship between himself and the patient.

The Logo of the Society is concerned with relationships, and can only be appreciated if the viewer examines their own reaction to seeing it. Its main features are two interlocking masses, above, suggesting a firm relationship, with some small dynamic shapes below of a different texture. A new harmony appears when the opposing features are seen as a whole, similar to that which occurs in a good doctor/patient relationship.[8]

The Mind in Literature

Another of Michael's legacies was to give some of us a better understanding of the writings of authors down the ages, touching on the subject of the mind.

In the 5th century BC Hippocrates wrote:

> 'Both physicians and sophists aver that medicine cannot be understood if one does not know what man is.'

Alexander Pope took up this theme in the 18th century in his famous *Essay on Man* with his lines:

> 'Know then thyself, presume not God to scan,
> The proper study of mankind is man.'[9]

In the 6th century BC Heraclitus wrote:

> 'Abundance of knowledge does not teach men to be wise.'

In the 16th century Shakespeare touched on the heart of the matter when he wrote the sleep-walking scene in Macbeth, where a gentlewoman asks the doctor to observe Lady Macbeth walking and talking in her sleep, and gets the reply:

> 'This disease is beyond my practice,
> More needs she the divine than the physician.'

And when Macbeth later asks,

> 'How does your patient, doctor?'

The doctor replies,

> 'Not so sick, my lord,
> As she is troubled with thick-coming fancies,
> That keep her from her rest.'

Macbeth answers,

> 'Cure her of that:
> Canst thou not minister to a mind diseas'd,
> Pluck from the memory a rooted sorrow,
> Raze out the written troubles of the brain,
> And with some sweet oblivious antidote
> Cleanse the stuff'd bosom of that perilous stuff
> Which weighs upon the heart?'
> . . .
> 'If thou couldst . . . find her disease,
> And purge it to a sound and pristine health,
> I would applaud thee to the very echo.'[10]

In the 17th century the French theologian and mathematician Blaise Pascal, wrote,

> 'The heart has its reasons, which reason knows not of.'[11]

In the 19th century that great playwright, Anton Tchekhov, who qualified as a doctor and set up his practice in Moscow, once said that he always wanted to reveal to medical students the 'subjective pathology of suffering', and added 'If I were a lecturer I would try to draw my audience as deeply as possible into a study of the subjective feelings of the patient, and I think this would really be of use to the students'. And indeed the merit of Tchekhov's plays lies in his ability to express the inner feelings of his characters by the remarks they make in their asides.

In the 20th century Wilfred Trotter, the famous surgeon at University College Hospital, was an early admirer of Freud through Dr. Ernest Jones, who had been a fellow student and whose sister he later married. Trotter opened the 1932/3 session at the hospital, at which Jean and I were present, with a talk on 'Art and Science in Medicine'.[9] He told us that the good doctor should cultivate the power of attention, and the ability to give his whole mind to the patient without the interposition of anything of himself. He added that it was an active process and not either mere resigned listening or even politely waiting until you could interrupt. Disease often told its secrets in a casual parenthesis. It was only our contact with Michael some twenty-two years

later that enabled us to understand what Trotter had been trying to tell us as students.

T. S. Eliot had much to say on the same theme in his *Four Quartets*. In Burnt Norton he wrote:

> 'Human kind cannot bear very much reality.'

And in East Coker he added:

> '. . . There is it seems to us
> At best, only a limited value
> In the knowledge derived from experience.
> The knowledge imposes a pattern, and falsifies.
> The only wisdom we can hope to acquire
> Is the wisdom of humility: humility is endless.'[10]

And finally, there was a lot of truth in Peter Cook's observation when he was discussing with Dudley Moore on television his relationship with his wife, and said,

> 'We have a very good understanding of each other. She doesn't understand me and I don't understand her.'

Personal Reminiscences

We all know that Michael gave us more insight into the patterns of life than we had before, and that he enriched all our lives and through us, many of our patients' lives, but I should like to end this lecture by giving you a glimpse of the other side of Michael as I saw him.

I remember being asked to read a paper at a meeting of the medical section of the British Psychological Society at Chandos Street in December 1958. My paper was on the subject of *The Integrating Function of the General Practitioner*, and I sent a copy to Michael for his approval, not realising that there was only a very limited time for me to read it. Michael wrote me the following charming letter,

> 'Dear Dr. Pasmore,
>
> Enclosed I am sending three copies of your paper. I tried to shorten it but I became so sympathetic with the author that I could not proceed with the operation. In any case I was afraid that you would dislike my propositions and feel hurt by what I was doing. So I must leave this unpleasant task to you or to any of your family who cares to call your wrath on his or her head.
>
> I must emphasise, however, that the typescript in its present form contains about 300 words per page, which means that the text you can read must be reduced to four pages, that is, half of the present text must be cut. This is a highly unpleasant fact, but a fact that is imperative. May I send you my sympathy.
>
> Sincerely yours,
> Michael Balint.'

Michael Balint was always a father figure for me, so I dutifully carried out his suggestions, but some people, I believe, found his challenging attitudes a little too forceful. This was apparent when one of our very competent seminar secretaries made a Freudian slip, for I noticed the other day when I was re-reading a transcript of one of our Aberdeen seminars the following sentence, 'Dr. N. seemed a bit ashamed of presenting Mrs D. and so was defensive and teasing. The group responded with levity until called to hell by Dr. Balint.'

I should also like to recall an excerpt from a tribute I paid to Michael at a meeting of the Balint Society soon after his death:

'On Monday 21st December 1970, I found I had some time to spare in the afternoon and decided to visit Michael at University College Hospital, where he was recovering from a heart attack. What should I take him as a little present? I looked in at Peter Jones in Sloane Square hoping for inspiration and found it in a little ruby candle-holder made of Swedish glass — very strong, like a round pebble and small enough to fit into a waistcoat pocket. Michael always lit a cigarette during the Tuesday seminars and invariably looked vaguely round for somewhere to put his ash. 'If he could produce a magnifying glass from his pocket, why could he not also produce an ash-tray?' I thought as I purchased the small glass holder.

A little later I was treading the familiar path through the front doors of the hospital and shown Michael's room on the third floor. I opened the door and was delighted to see Michael in good form sitting in his dressing gown by his bed, talking to Mr. Mary Hare who was sitting on the bed and to Dr. Cyril Gill who had just arrived. We exchanged greetings and a few pleasantries with him — 'There are three of us here, what about taking a seminar?'

Then, a nurse arrived with a bunch of flowers from someone. I said, 'My present is much smaller and produced my packet carefully wrapped up in Christmas paper. 'You will never guess what it is.' Michael started to open the packet eagerly, like a child, and we all enjoyed the fun. First he removed the wrapping paper, then the tissue paper, and then held the object upside down in the palm of his left hand. It was a little surprising to observe how limited his vision was, though we all really knew it. Michael turned the object over and as his right thumb found the hole in the glass, he exclaimed , 'It's an ash-tray.' Uncanny, I thought, how Michael was always right. Anybody else would have said it was a candle-holder.

Cyril and I continued our chat and then bade our farewells as Michael was beginning to look tired, though he insisted, with that unfailing courtesy of his, in getting up and walking down the passage to see us out of the ward. We shook hands with him again, never realising that this would be the last time we should see him alive.'[14]

Conclusion

Mr President, Ladies and Gentlemen,
It was Shelley who wrote,

'Music, when soft voices die,
Vibrates in the memory.'[15]

And now Michael's soft voice can no longer be heard, I think we can truthfully say that his music vibrates in all our memories, not only for what he was himself, but for what he did to improve the standards of general practice both here and abroad, and enrich the lives of the doctors with whom he worked.

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Rival Concepts of Health: Science and Medicine*

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Science has increased the curative powers of medicine — while revealing that most cures of medicine have little to do with science.

It seems to have been during the early and middle nineteenth century that the practice of medicine in Britain evolved into its present disease-based system. Each disease was (ideally) to be based upon the identification of an underlying pathological lesion. A lesion was a physical abnormality identified by the science of eliciting physical *signs*. The five senses were used to observe the patient for signs of disease (the senses being amplified by tools such as the stethoscope, tendon hammer, magnifying lens etc). The ultimate arbiter of disease was a post-mortem examination where physical abnormalities of the internal organs could be observed directly. Instead of *subjective* symptoms reported by the patient, there was a concentration upon *objective* signs observed by the doctor.

Thus, the first application of 'science' to medicine was to correlate the patient's reported illness with the signs of disease — the science of *morbid anatomy*. Medical education also began a process which has been dubbed the 'science takeover' of the curriculum, which has led to the present two or three years of *pre-clinical* science at medical school (anatomy, physiology, biochemistry, behavioural sciences), which precedes the *apprenticeship* in hospitals. However, once the link was made between science and medicine, it began to evolve from describing the disease to evaluating the treatment.

People began to realise that the question of whether or not a given medical treatment was effective was not a simple matter. Throughout most of history there had been the general idea that when a patient was ill and a doctor gave a treatment, the patient got better — then the credit should go to the doctor. Every time the patient recovered, this counted as a 'cure'.

Natural history of disease

However, as diagnosis became better validated by the application of anatomical science, an awareness developed of the natural history of disease. Careful delineation of the newly established diagnostic categories enabled the great physicians and surgeons to describe the course of illness and disease over time. The *natural history* is the normal course of an untreated illness, left to its own devices. For example, pneumonia would tend to get worse over several days until it reached a *crisis*, after which the patient either died or recovered.

So people realised that when a patient recovered from an illness it might be due to a doctor's treatment, or it might equally be the natural and evolving course of an illness. Many illnesses such as the common cold led to a natural remission — they were self-limiting. The body has power to cure itself. Science therefore had to be employed in order to distinguish what was the natural behaviour of disease and what was the result of medical intervention.

The more scientifically-minded doctors began to realise that they did not, after all, have a great deal to offer in the way of treatments for most illnesses. They came to believe that treatment should be minimal, supportive — *expectant*. The doctor's major role should be to listen to the patient's story, examine, diagnose, explain and give a prognosis — then remain available until the patient either recovered or died. This was the era called *therapeutic nihilism* when the important thing was not for the doctors to engage in *heroic* (and damaging) treatments; but to *do no harm*, as Hippocrates put it — to offer understanding and reassurance, keep the patient comfortable, pain-free and well nourished, and to wait for the natural course of the illness to play itself out.

The rise of modern therapy

The next step was the discovery of obviously effective medical or surgical interventions. This was something new. There was, for the first time, agreement among all competent people that these interventions really made a difference for the better. In other words the prognosis was radically or consistently improved. The natural history is altered. So that a condition with a predictably bad prognosis has that prognosis improved by the doctor's intervention.

The first really effective treatments came within surgery. General anaesthesia revolutionised the possibilities of surgery, and a number of previously fatal conditions could be cured either by cutting out the abnormal anatomy (eg. resecting a cancer or inflamed appendix), or by restoring the anatomy to normal (eg. stitching-up a perforated bowel or fixing a damaged limb).

Within nineteenth century medicine there were only a few drugs whose effectiveness we would recognise today — only some analgesics such as morphine, and sedatives such as paraldehyde or bromide. The therapeutic revolution began in the twentieth century and involved replacing a variety of hormone and vitamin deficiencies by using concentrated extracts. Then came antibiotics and a host of other pharmaceutical agents. Some of these drugs were clearly effective and able to improve a predictably bad prognosis; there was no doubt of the effectiveness of penicillin when it was first

* Paper read to the Society on 27 October 1992.

introduced, patients were brought back from the brink of certain death.

However, not all diseases have a predictable prognosis. Illnesses such as asthma, eczema, hay fever, rheumatoid arthritis, osteoarthritis, breast cancer and multiple sclerosis all have a very variable course over time. In these unpredictable illnesses it is difficult to know whether or not the treatment is making a difference. If the patient gets better after treatment there is always the possibility that they would have got better anyway. There is an enormous range of *individual* variation. Therefore, to evaluate a medical intervention in these unpredictable illnesses requires the scientific study of *groups* of patients.

The placebo effect — a shattering insight

The placebo effect is the *non-specific* effect of medical treatment. The specific effect is the actual treatment prescribed — a drug, an operation, a specialised form of psychotherapy. The placebo effect includes all the surrounding aspects of the treatment: the colour and taste of the tablet, the 'tender loving care' surrounding an operation, the bedside manner of the doctor etc.

The placebo effect is a *real* effect. A patient may get pain relief from a sugar pill because they believe it will do them good, not because sugar is an analgesic. But the pain relief is real. Isolating the placebo effect of the sugar pill is done by dissecting the overall benefit of treatment into the specific (in this case chemical) effect of sugar as against the non-specific effect of the consultation.

While people have discussed the placebo effect for many decades, it is only within the last thirty or so years that doctors have really begun to think about its implications for what they are doing. The effect has been shattering. In most situations, in the general run of human illness — the placebo effect seems to be the *single most important factor in therapy.* The benefit of doctors seems to be less to do with their treatments and more to do with the doctor/patient relationship.

The paradox of science

The influence of science on medicine has thus been paradoxical. While the application of scientific thinking to the study of disease and the development of therapy has resulted in a massive increase in the power of medicine to cure illness; at the same time the application of scientific scepticism has resulted in less credit being given to doctors for these cures. A combination of natural remissions and the placebo effect accounts for *most* of the benefit of medicine. Medicine is indeed specifically effective, but only in a small minority of cases.

There are some specifically effective treatments which have a predictable effect (morphine for pain, for example) and some treatments which can improve the prognosis of a disease with a predictable natural history, such as the life-saving effect of steroids in Addison's Disease. But there are also other potentially useful treatments which have a less predictable effect, or are being tried on diseases with an unpredictable natural history so that it is hard to know whether they are useful or not. Are these potential treatments better than a placebo? How do we decide whether these potentially useful treatments are specifically effective or not, or how effective they are compared with the alternatives? The answer is a therapeutic trial.

The therapeutic trial

The therapeutic trial comes in various forms. The double-blind, randomized, controlled trial is an experimental evaluation of treatment. It is able to isolate *specific* effectiveness by cancelling-out the general effects of natural remission, non-specific placebo responses and the idiosyncracies of individual patients. The randomised trial thus gives a statistical measure of the specific effectiveness of the intervention under test. Other types of therapeutic study are somewhat less reliable (cohort studies, case-control studies and the case series), but add to the statistical data available on disease and its outcome. All these study types, it will be noted, involve groups of patients.

With the therapeutic trial, medicine at last has a tool whereby its knowledge base can be explained in a rigorous and objective manner to build a consensus of good practice derived from science, rather than from anecdote, assertion and enforcement. We have entered the era of 'post-critical' medicine and there is no going back: things will never be the same again.

The usefulness of trials

However, the question arises as to why, if therapeutic trials are such a powerful technique for providing objective data about the effectiveness of treatments, medicine still retains such a large place for *judgement* — for individual experience, opinion and 'unvalidated' treatment. Why, for example, do doctors simply not feed clinical information into a computer programme and then implement whatever the machine tells them is statistically speaking, the best plan for management? Is the resistance to computer diagnosis and treatment merely nostalgia, inertia and irrationality? How do the results of clinical trials fit into the overall aim of medicine which is to practise in the most *effective* manner.

We must remember that the group trial is only employed in conditions of individual unpredictability. Obviously effective treatments — which work predictably for everybody with a given diagnosis — do not need a controlled trial to establish their usefulness (although they may need a trial to establish their side-effects). When streptomycin was introduced for tuberculosis there was no doubt that it was more effective than anything which had gone before: even more

obviously this applies to a surgeon replacing an amputated finger. These examples of obviously effective therapy derive primarily from observation with the minimum of theory.

From such examples of primary observation a whole range of theoretical questions may be derived by a process of logical reasoning. Effective treatments give rise to explanatory theories, and theories lead to the development of new treatments. So that new drugs can be developed which have a similar action to the first 'obviously' effective one (for example the newer members of the penicillin family), then these must be tested against the original drug to see if there are any advantages in terms of effectiveness or in side-effects. This is another role for the therapeutic trial.

Limitations of the group trial

Trials give us a statistical probability of effective treatment on a *group* of patients. But in order to construct groups it is necessary to choose common, shared criteria which define the groups — tight diagnostic criteria. And not every patient is suitable for inclusion in the groups — only those who satisfy the criteria. Also the control group must *match* the treated group as closely as possible in every aspect except for the treatment.

So there is a price to pay for the objectivity and quantification achieved by therapeutic trials. Gain in objectivity is only achieved at the price of simplification and at the cost of completeness — by what is shared by groups of patients, not by what is distinctive to individuals.

In other words, the whole philosophy of the therapeutic trial is to "partial-out" and to exclude individual differences, to concentrate on group similarities. Indeed, such partialling-out should — ideally — apply to *every aspect* of the therapeutic encounter except for the specific intervention under trial.

All this process has unintended results: the patient is depersonalised, the doctor is deskilled, and the treatment is rationalised. The group trial tends toward management of patients becoming merely the routine application of simple procedures — which could just as easily be done by an appropriately trained technician, or even a computer! A world where effective medicine is so simple and so straightforward that the professional standards of the doctor and the idiosyncracies of the patient are rendered unimportant compared with the statistical probabilities established by objective evaluation — medicine becomes a science.

Medicine is not a science

But science is not, and never has been, the whole of medical practice. Medicine is a *practice* and the gold standard of medicine is best practice; not best science.

From the patient's viewpoint, the deficiencies of group trials are obvious. When the patient tells the doctor that 'story of sickness', they find that the doctor does not listen to the story. Instead, the unique story is put through a sieve, and only those symptoms testable by group trial are allowed through the mesh to be considered as a part of the diagnosis. Not the individual but the group is of interest — only that which has been subjected to statistical evaluation.

Or, the story and symptoms of illness may seem to be ignored completely, and all attention directed towards *signs* of disease. In effect, the doctor may listen, *but does not take notice;* attention is diverted to the objective world of signs, not to the subjective world of symptoms. The patient's individual experience is of no more than curiosity value because it does not help make a diagnosis, nor decide on treatment, and does not assist in predicting the prognosis. By definition: what is individual and unique cannot be used to make general prediction.

But medicine is not *only* a science and so it cannot subject itself entirely to the methods of science. Medicine uses science, but is not itself a science. The best medicine is medicine done by the best doctor. There is no medicine better than this. Theory is secondary to practice and must not dictate practice.

Opposing tendencies

We can see that the trend towards objective, group evaluation — vital though it is — begins to open up space for the emergence of opposing tendencies. Space for trends which aim to occupy the space left by the narrowing of medical practice. Alternative therapies — completely different systems of diagnosis and treatment — are one extreme form of opposing tendency: but there are tendencies within conventional medicine which also aim to restore the individual skills of the doctor on the one hand, and the individual story of the patient on the other. Because when it comes to the crunch, 'healers' and their clients are alike in being unwilling to have their greatest (and oldest) allies removed from the clinical armoury — I am talking of natural remissions and the placebo effect.

After all, the magnitude of the placebo effect is not a fixed quantity; it depends on attitude (depends on 'faith', you might say). The unique, natural charisma of a therapist plays a part, and, as we saw in earlier sections, so does the nature of storytelling and the system of diagnosis. The point to emphasise is that enough is known of the nature of placebo factors for doctors *deliberately* to maximise them. This is as valid a part of *effective* medicine as the application of group results. It has, indeed, been the way of good medicine since antiquity. After all, what matters is effectiveness; not science.

And what does the objective trial have to say about the brilliant doctor who gets better results than anyone else, yet cannot explain how?

It is not unreasonable to assume that some medical skills are just too subtle to be measured, codified, and subjected to comparison by trial. Such skills may be transmissable by a prolonged and intensive apprenticeship (which is why this method of education is essential and irreplaceable); but sometimes special abilities must simply die with their possessor. I have always been astonished by the results of that pioneer of modern anaesthetics, John Snow, who had just one anaesthetic-related death (and that one probably not his fault) during a busy lifetime of innovation, practice and experiment using primitive techniques! Are we to deny the value of genius because it cannot be reproduced?

How to use group trials in practice

Given the major influence of spontaneous recovery and the power of suggestion in effective medicine, we must conclude that even the ideal trial cannot be better than a rough guide to the management of an individual patient. There is always room for clinical judgement in fitting the group result to the individual person.

A fully comprehensive system of medicine which offers rational explanations to a patient must inevitably extend beyond the strictest scientific facts. Otherwise medicine is reduced to a series of isolated observations with nothing to link them. Medicine should not be pure theory; but theories (and 'stories') are vital to effective and innovative medicine. The nature of explanation and analogy is itself a powerful therapeutic tool — allowing the patient a sense of understanding, control and mastery. If the doctor does not provide a *useful* theory of why the patient is sick (and why the treatment ought to work) then the patient will simply invent a theory for themselves. A theory which might not be so helpful for managing their illness.

Disconnected observations are not what is wanted, but they are all that science can offer. Science gives the information, but does not tell us why — science does not tell a 'story'. The observations might tell us that sixty per cent of patients with ulcer pain will be improved by tablet X compared with forty per cent improved with a placebo. But if the patient is told a helpful theory or story, for example that the tablet is a powerful and expensive new drug invented by those clever Germans which cuts off excess acid secretion and allows the stomach to grow back and heal itself, the results are likely to be *better* than sixty per cent. It makes a difference to tell a 'story'.

Indeed, as Richard Asher pointed out, there may even be a trade-off between effectiveness as a doctor and the ability to think critically and scientifically. "If you can believe fervently in your treatment, even though controlled studies show it is quite useless, then your results are much better, your patients are much better, and your income is much better too." Asher's paradox should not be ignored, but accepted as part of real life; and medical education and practice must take it into account and use it to maximum effect. Remembering that the gold standard of medicine is best practice.

Trials are necessary, but not sufficient

Even though we have seen that they are not the *whole* story, the relevant results of careful clinical trials are an essential background to a clinical consultation. All doctors should be aware of this statistical information. It makes up a part of the 'core curriculum' which should be hammered home during medical training. Group studies are a genuine contribution to the progress of medicine.

But although necessary, factual knowledge of group trials is not sufficient for good practice. The facts *must* be taken into consideration, but on their own they do not tell the doctor what to do. That decision is a matter of *judgement,* and how to inculcate the power of good judgement is a very different question from how to inculcate factual knowledge.

We insist that a student doctor attend clinical practice as an apprentice, rather than merely completing a correspondence course, because we recognise that clinical practice is not susceptible to abridgement and abstract formulation. Something very important is lost when practice is written down, and what is lost is that which makes the difference between consulting an experienced physician and looking up a diagnosis in a textbook of medicine. Our recognition that experience is valuable depends upon our recognition that factors exist which cannot be got from a book. Practice is primary — theory comes second and derives from it.

It is the element of judgement which establishes the place of group trials in individual medicine — and the place of science in medicine. There is no scientific formula for determining exactly how statistical knowledge derived from group studies should be applied to individual patients. Such judgement — although central to clinical practice — falls outside the scope of the therapeutic trial, because judgement is exactly that aspect which is partialled-out by the process of setting up a therapeutic trial.

Implications for medical education

The fact that science is only a part of medicine must be made absolutely clear during medical education. Doctors ought to realise that knowing the results of a group trial is only part of the answer, the other part is knowing how to interpret this result for the individual patient. How to fit the statistics of science into the ongoing story which is the patient's life. Science must *inform* judgement — it is not a substitute for judgement.

However, typically the sheer prestige of 'scientific' medicine will impose itself on medical students by default. Doctors often tend to see a choice between slavish and uniform application of group results to individuals on the one

hand (which may result in embracing a mish-mash of alternative therapies).

But the choice is not between science and chaos, between pure observation and pure theory. Medicine is a practice, and there are valid modes of non-scientific reasoning, of educated judgement, which are inculcated by the apprenticeship element and the process of professionalisation.

Conclusions

If we ignore the limitations of group studies, then medicine will become less effective. Doctors would cease to regard patients as individuals and instead see them only as representatives of a group. They would reject the natural remission and the placebo effect as unworthy of their attention.

But the evidence is that when this happens there are plenty of alternative therapists who are only too pleased to step into the gap left by the excessive narrowing of conventional medicine. Although alternative medicines — such as homoeopathy, acupuncture and herbalism — entirely lack the predictable modifications of disease natural history that we see in conventional medicine — their practice does tend to use individual factors more convincingly, and it is from this enhanced placebo effect that they gain their, often startling, effectiveness.

However, the warning is clear. Unless conventional medicine can find a place for individuals — for individual doctors, as well as for individual patients — and unless conventional medicine can establish conditions of practice which allow for a proper use of the placebo effect — then patients, and their doctors, will begin to look elsewhere.

Some Random Thoughts about Balint-group Pitfalls, Pratfalls and Pot-holes*

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Where I am from, Pittsburgh, Pennsylvania, the wide swings in winter weather, combined with a great deal of truck traffic and an overly thrifty highway department, combine to create in our roads VERY LARGE holes we call pot-holes. These are large enough and deep enough to cause one to a) lose a hubcap, b) blow a tire, c) bend an axle, d) end or delay one's trip. Some are so large they are dubbed 'tank traps'. When asked to comment on some of the pitfalls available to Balint-group training in the context of family practice residency, the image of these pot-holes kept emerging. I have been in almost all of them, witness my car!

Type A: System-issues that can sink a Balint-group:

1. Balint-groups are powerful tools for learning all kinds of 'lessons' about the doctor/patient relationship in the context of ongoing patient care. According to Michael Balint, the process, if conducted effectively, can result, over time, in a significant change in the physician's personality — at least in his/her approach to patients and a tolerance for difficult problems. However, it is a pitfall, I believe, to attempt to form a Balint-group in the midst of a residency (training programme) in which no one, or only the behavioural scientist, is interested and enthusiastic about the goals of patient care that Balint-groups promote. In other words, unless there is a mandate from the director and the faculty to have Balin-group training as an integral part of the residency, I think Balint-groups will find a way not to succeed:

   The group will be relegated to a scheduled time that is impossible or noxious to attend, such as evening or when no residents are free. It will be scheduled in a built-in conflict.

   It will be led and attended only by behavioural science faculty, instead of co-led by family practice faculty, and no faculty member will present a case.

   There will be no accountability for attendance and no policy to encourage attendance at Balint-groups; like at other conferences in the programme.
2. One must recruit equivalents to trainees in general practice, who are exposed to Balint-groups, understand what they are, and 'buy' Balint-groups as an important part of their training when choosing their residency.
3. Other parts of the residency programme (medicine, obstetrics, paediatrics, etc.) should be strong or residents may backlash against a strong weekly 'behavioural' processing of cases. If the precepting is not good, they will be seeking to augment it in Balint-group sessions. This point rests on the notion that problems in residency get projected into Balint-group discussions, in the affect presented, or the cases chosen. This is true in the group discussion itself, usually woven into the case, but especially in the 'idle' talk at the beginning. A strong programme in which residents can become secure in their medical knowledge creates an important balance for regular Balint-training and prevents pressures to pre-empt it with another type of case-discussion or support-group.
4. Balint-groups might be best evaluated by the residents and faculty without questioning the given nature of them in the residency. Feedback can be used to alert faculty Balint-group leaders to shifts in the process that are counterproductive. However, faculty leaders must also talk to each other after each session or after a series of sessions. At least some form of supervision should be available, because we too, as leaders, also project our own unfinished issues into the cases and into the group's process. We need to be aware of that to continue to be facilitators of the group.
5. Lack of trust in the programme, the faculty, director, residents, staff, leads to an atmosphere of low self-disclosure and posturing that is poison to Balint-group functioning. Conversely, Balint-groups that function well can keep an atmosphere of self-disclosure, genuineness, collaboration and trust alive in a programme.
6. Cancelling the group interrupts the continuity that is meant to run parallel to the continuity residents have with their patients. Be careful not to cancel or do so only under very unusual circumstances.
7. Residents must have some minimum opportunity for continuity with their patients. They must have office hours and follow their own patients. If this is not true in a given programme one is more likely to get cases like the dead patient or misbehaving attending (consultant) who spoke harshly to the resident on call, during Balint-sessions.

*Talk given at the American Balint Society Workshop in San Diego, 24 April 1993.

Type B: Pitfalls Within the Group

1. Leaders who push the group process, push THE POINT and talk too much, represent a common pitfall (or pratfall). It is tempting to do, because it is exciting to have access to the participants' thought processes concerning crucial patient-care issues. However, when the group is doing well, meaning when they are talking and thinking and diverging, even if the leader does not like the content of what any of them is saying — leave it alone. Let them arrive at their own diverse conclusions. You may want to solicit different opinions and perceptions if someone is getting very dogmatic. However, it is best to busy yourself observing the process in the group so you are ready to know what is going on when the process bogs down.
2. When a group starts up or adds new members at the beginning of the residency year, residents (preferably) might well remind each other of the rules or conditions of the group to help get them started.
3. Case-presenters who talk too long holding off other members' involvement. Find a gentle way to get others into the discussion to escape this pitfall (or pot-hole).
4. Either group-members or leaders giving someone the third degree (asking them lots of questions) too long, or giving advice on how to handle the case is another common pitfall (maybe even a tank trap). There is an urge to 'fix' or 'do' that can overtake the discussion before there has been time to learn about the patient or to think. There is a fine line between the natural tendency to find out more about the case and trying to remote-control it. Reflecting on one's own reactions, or hearing and reflecting what the physician presenting the case is saying, or thinking about the patient, are all preferable to 'solving the case'.
5. A dilemma and potential pitfall lies in how to use observations of parallel processing dynamics. Sometimes reflecting it too soon, or even at all, interrupts the group's process and makes everyone self-conscious, in a non-functional way. Likewise, forcing someone to self-reveal is deadly to the Balint-group process and the trust it is based upon.
6. Over-directing the process, making the group dependent, rather than commenting or sharing observations in a constructive way, at an appropriate time is a common leader pitfall.
7. Finally, it is important to know, as best one can, when it is time to leave a particular case and go on. Perhaps now would be a good time.

Residential Balint-Group Leaders Intensive Workshop

13th to 16th October, 1993

The American Balint Society is holding a residential intensive workshop for Balint-group leaders, at Wild Dunes, an island resort near Charleston, South Carolina, from 13th - 16th October, 1993.

Participants will be able to analyse and discuss their own and each other's leadership skills as demonstrated by videotapes and audiotapes, as well as in live groups.

For further information and application forms, please call the co-ordinating secretary, Margaret Porcher in the Department of Family Medicine, Medical University of South Carolina, Charleston, SC, United States of America: 803 792 2410, or John Salinsky: 081 904 0911.

Back to the Future*

Address by Jon Sklar
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The Balint-group started with the idea that psychoanalysts do make a contribution to the work done in such a group and to the skills which may become a part of it. To quote Mrs Balint and her group's new book, 'We can even say that partnership between members of the two disciplines has been the essence of our method of work'.[1]

What is such cooperation between the two groups today? Mrs Balint still continues. There are other colleagues at the Tavistock who are now running only a single group from the several in its heyday in the seventies and the eighties, and there is a group in Cambridge, Antonia Shooter is working in Birmingham, all four groups work with a psychoanalyst, so few!

So much of the work around the presentation of the Balint-group is about an area in which something is not said, is left out, is not understood, unable to be said, or is too dangerous to say etc. . . — and if it can be conceptualised in a group, and spoken about, the patient has a better chance of finding the words for it themselves.

When I look back from the present to my past, I began to be interested in this work in a twofold way in the late 1970's and early 80's. I was in analysis with Mrs Balint whilst training to be a psychoanalyst and concurrently working in the Adult Department of the Tavistock Clinic as a Senior Registrar and observing Balint-groups in that place. Neither experience managed to put me off in my interest in this sphere — especially as a model for enabling staff other than general practitioners to think and work creatively. I will return to it as a model of working with staff later.

As I grew up in these worlds I began to perceive a split between the Balint Society which was of itself and also connected to the Royal College of General Practitioners, somewhat disconnected from the group working at the Tavistock Clinic. They both did work but to my observation, separately. One can ask, if the observation is correct, why? But I do not think it is in my brief to answer and I really do now know other than it is to do with personalities and human relationships.

A split which is pathological means that all the individuals' resources are unavailable for healthy direction of living. I do not think that all our resources are being used collectively in the best of possible ways. For instance, I do not know what will happen shortly when the two consultants at the Tavistock interested in our work retire. It may be a matter of out of sight out of mind at the Tavistock. Representation from the Balint Society, The Royal College of General Practitioners, and other colleagues may help for such a training resource to continue. Already such a thought, to my mind, addresses the split and at the same time is moving in a creative direction.

Or one can argue it another way. Why is such a paucity of newly trained psychoanalysts becoming interested in our work? Again, I expect that it is to do with politics and human foibles. But I am interested in the small ripples of a new development in my Society which is quite concerned that so few medically trained candidates are coming forward to train in psychoanalysis and, concurrent with that an idea, that the Balint methodology may be quite useful in broadening the possibilities of having created dialogue with other groups (such as medics, scientists, and artists) in relation to the British Psychoanalytic Society. Balint's methodology is being revisited in some people's minds and again there is a possibility that in my Society the future may have quite a strong return to the past in relation to Balint's work. This may attract more psychoanalysts to be interested in our joint ventures.

And then to look at the same structure from the frame of the general practitioner. I am delighted that general practitioners up and down the country are interested in our work. I am less keen when colleagues describe their work as Balint-type or think that they are doing Balint-groups when general practitioner colleagues are meeting to support each other, but not doing the work that we do. When colleagues say 'Balint-type' it is invariably in the same embarrassed way in which they feel that something is not good enough for themselves and in relation to the other — in other words the doctor does not feel as if he is standing on solid enough ground in this area. This is a particularly difficult area because it is unlikely that we want to put potential colleagues off and, of course, we want to nurture them, and yet at the same time I think that we are capable of lying to ourselves if there is an acceptance of differentiation, as if general practitioners who have not been in a Balint-group run either by a psychoanalyst or a leader who has been in a group with a psychoanalyst can do real work using our methodology. Of course, as you all known, the little boy who tells the emperor that he isn't wearing any clothes, is not exactly enjoyed.

I certainly think that it is valuable to discriminate those colleagues in the Balint Society who are attempting to do some work which has an affinity or even a smell of a Balint-group, but actually is likely to be quite different. The structure of membership is that associates

* Read at the Annual General Meeting of the Society on 10th June 1993.

only become members if they have been with an experienced group-leader. Any associate member then, who takes it on himself to run his own group, needs to know that it could not be called a Balint-group or even a Balint-type group but it would be a group of their own and different from the Balint Society groups.

At this point in my address, I fear I may be treading on egg shells and yet I do not apologise, as I feel that this might have to be the place where one finds oneself standing, which needs to be addressed. I will summon the artist George Grosz to my aid. He said many years ago 'the more practical the world becomes, the more permanent will be the concealed romantic-irrational world of the useless.' This does not mean madness, but rather the result of eternal laws. Man is becoming more peculiar or, to state it more clearly, some people get deeper satisfaction from the image than from the thing itself. This is typical of the times in which we live. We are all so beautifully enlightened, and have left imagination to the geopoliticians and the technocrats.

Both as general practitioners and as psychoanalysts, we observe how the other in the dialogue with us perceives/misperceives and has us misperceiving what the truth might be. This is particularly the case in how general practitioners perceive what the Government and particularly, Virginia Bottomley is doing to patient-care in the National Health Service. All around, colleagues point out evidence for destruction of good working practices only to have some bland blanket recitation of the good things that are coming out of the present National Health Service programme. Why are the new trusts so called? The name invites us to trust and because words have an antithesial meaning — mistrust.

But let me give you a somewhat interesting example of problems of misperception and the trouble it might get one into. George Brown, as British Foreign Secretary was visiting Latin America. He arrived at a diplomatic reception with everybody resplendent in evening dress, medals and all. Generals, their wives and mistresses filled the Hall. Swaying across the room to an apparition in purple, he asked whether the lovely lady would care to dance. 'No', she replied. 'For three reasons: firstly, I don't dance with drunks, secondly, they are playing the Peruvian National Anthem and you should be standing to attention, and thirdly, I am the Cardinal Archbishop of Lima'.

In a similar vein I came across a story in a new Journal which is sent to me *gratis,* called *Management* which is (supposed to be) a Journal about managers in the National Health Service. A group of fund-holding general practitioners somewhere in England were handing out questionnaires in the hope of discovering how they are 'perceived' by their patients. The writer of the story wondered whether the answers would be as truthful as ones offered of a particular general practitioner who, when visiting a patient at home, had to pass a deaf old lady sitting in a chair. As he went by, she stared at him with a puzzled frown. 'Who is this' the old lady asked. 'It's the doctor' said the daughter. 'Who?' 'The doctor, mother.' 'Who?' 'The doctor' said the daughter. 'The what?' 'You know mother, the man who killed father?'

Such a story, really, is the beginning of an exploration in a Balint-group. One knows in one's bones that such an important statement contained within the joke, if you will allow me to unravel the humour, is actually about a perceived relationship within a family about a widow and her doctor and the shadow it presumably casts over the relationship between the whole of that family and the doctor. How any of that real gut feeling emotionality will get into a questionnaire on perception of general practitioners by their patients? One will never know, or rather one does. It will not get into the questionnaire, and the questionnaire will be assimilated and something clever will be written about it in the area of management and computerisation of standards, but it will not be about the work that we know about.

Let me now turn my attention to one of the great success stories in the last two years. The enormous rise of counsellors in general practice. In one direction one can be exceedingly pleased that the patient's mind and thoughts and feelings are being taken seriously by the Health Service. It is very good that so many people are coming forward and beginning a training in order to help other people. But there is a catch.

In my district, I think it is true to say that they are the only group of Health Service workers who do not have to appear before an appointments Board, their CV does instead and it is examined by a Panel of Staff who have very little expertise to know what they are looking for. Patients are offered a very small number of sessions. For bereavement work, I am sure it is of great value, but it is unclear how general practitioners and counsellors assess how well a patient is; either to have the counselling or definitely not to have it. Some peculiar bit of medical legal folklore seems to have invaded this arena such that counsellors are so careful about confidentiality that general practitioners are sometimes not told when the treatment is ended or anything about the findings, not specifically but not even in a sketch. Furthermore, if that patient needs to be referred for more in-depth psychotherapy, no findings are sent to the consultant psychotherapist. Again, using the reason it will be against the interest of the confidential nature of the work that the counsellor and the patient have done. This begins to sound like an Alice in Wonderland script in that pomposity and arrogance can invade in what ought to be a good territory for doing some creative work in the field of human relationships.

But, I have another further caution in this area because while I think that the good

counsellors will get further training in order to learn more in order to be more creative in their work, I fear for the emotional guts of general practice being removed from the general practitioner himself. I am sure everybody in this room knows the immense value of looking after the generational family, that you are there, knowing a great deal about the emotional content of grandparents, children, and grandchildren, following lines of emotional life throughout the family. If, however, general practitioners for whatever reason are influenced, coerced, delighted to give up this particular knowledge into the hands of a counsellor who may not pass it on, who may not record it, who may leave the practice after two or three years, and be replaced by another, then a whole piece of emotional life in the family is missing from the general practitioner. This may well suit many of our colleagues who are not dining with us this evening, but I think we need to have a cautionary view towards its actual potential negativity in the doctor/patient relationship and if one thinks further, one can quite quickly work out ways for counsellors and their general practitioners employers to find some *modus vivendi* in which things which are confidential can also be connected to the psychosomatic understanding of the general practitioner in his work. If the rules of the counselling engagement is private and separate and secret then the patient in the practice will be perhaps left with the image of therapy instead of therapy itself. And what is left for the general practioner in the New Age of Trust Hospital? The general practitioner has an invitation to be a technocrat who computes. He is shown a bit of body, makes a diagnosis which leads to treatment but 'without the time consuming relationship between the doctor and the patient'. You can all see so many more patients according to the Department of Health if you become a general practitioner mechanism.

It is essential that the general practitioner and his counsellor find some way of working together so that important communications are communicated. Doctors have no problems with this in terms of the communication between doctors and specialists as it is privileged medical communication and it may be this could be worked out further in the relationship between counsellors and their general practitioners. I suppose I am pointing out that something which seems a shortcut and an efficiency saving actually is no such thing unless one works hard at it and, to return to Grosz's sentence, 'that some people get deeper satisfaction from the image than from the thing itself'.

Let me now turn attention to a small piece of research. I have applied the Balint methodology in examining staff attitudes and counter-transference feelings to the nursing staff in a District General Hospital. Eight sessions in which the staff's clinical difficulties about patients, staff and the institution were examined in the usual way, as in general practitioner groups. The nurses came from intensive care, accidents and emergency, oncology and geriatrics. The working hypothesis was that such staff are invariably overburdened at particular times with huge job pressures, management changes, incomprehensible institutional pressures, as well as close emotional ties to particular patients who die. The effect of all this 'lies under the skin' as it were, with no hospital space for the nurses to discharge into. Nurses return home to kick the spouse or the cat and often catch a strange illness for forty-eight hours, called flu, spelled flew. The nurse disappears, sort of recovers and returns usually with no questions asked. We investigated before and after the group and compared it with another match group of staff who were given a paper on stress management to read. Using a burn-out inventory and a cope inventory to examine stress the following findings were established:

The nurses with the brief Balint methodology had:

1. significantly greater internal sense of accomplishment in their work
2. a decrease in their immediate venting of things, indicating a capacity to hold on and think about clinical maters,
3. the capacity for sudden disengagement was significantly reduced, meaning that the nurse could stay in touch with very painful matters without emotionally or physically rushing away,
4. they did not need to seek social support for emotioal reasons significantly. Thus they could keep working matters at work and not take them home for discharge.
5. the nurses did not need to seek more support such as obtaining 'advice' as they could do emotional tasks and their clinical work better within themselves.
6. the nurses were able to pass on these skills to colleagues working in their units.

The control group's emotional exhaustion only increased. This in itself is an interesting finding as it scientifically gives credence to the idea that one had previously, that giving papers on stress management to people who are in stress, actually makes matters worse or, as Freud once put it, it's like handing out menus to the starving!

The rate of staff absence was not seen to shift, but data was thus far only taken for the duration of the eight weeks and has not as yet been followed up.

Thus we have some interesting measures offering a move towards a validation of the Balint methodology by examining staff counter-transference. I hope that now that this Balint study is one to be able to focus more on such measures of staff coping capacity using the Balint methodology and have hopes to have data that shows economic value of such work, including staff malaise, burn-out and absence from work. These are matters which being expensive, cost the National Health Service dear every year. For some, statistical methodology such as I have described, counts highly in their

capacity to value something and may well help the struggle to gain more acceptance for the work that we support in the Balint Society. The working out of such matters using a questionnaire however does not reach down to the level of the story — of how it is told and how it is heard. That is the real importance of our work.

So in finishing my address to you I thank you for inviting me. I have advocated a return to the tried and tested fomula of the general practitioner-group, utilising counter-transference examination to expand the emotional range of skills that the general practitioner can offer. Such work is valid, valuable, and can be proven as methodologically sound. It does need the care of both general practitioner and psychoanalysts who, together, can still forge valuable ideas together for the future and for our patients. Perhaps some new energy can be directed to give attention to more research and training, especially with general practitioners far away from known centres, by closer links between the Balint Society, the Tavistock Clinic, and other Psychotherapy Centres who know about our work.

Reference:

1. Balint, E, Courtenay, M, et al. *The Doctor, the Patient and the Group: Balint Re-visited.* London, Routledge, 1993.,

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Residential Balint Weekend at Lincoln College, Oxford

16th-18th September 1994

General practitioners, whether trainees or established principals, and experienced teachers of general practice and course organisers are invited to sample the experience of attending a Balint-group for a weekend.

There will be an initial demonstration group, consisting of volunteers, on Friday evening: followed by an open discussion of the group's work. Most of the rest of the weekend will consist of work in small Balint-groups, each having two experienced group-leaders.

All who attend are requested to come with suitable case-histories to present for discussion, and all group-members will be expected to be committed to stay for the full course of four group-meetings on the Saturday and Sunday.

Accommodation will be available for husbands/wives wishing to spend a weekend in Oxford. They are invited to share the meals, including the Conference Dinner on Saturday evening. All will be welcome to join in the walking tour of Oxford which will be arranged.

Section 63 approved, but trainees should check with their Regional Adviser to ensure that they will be fully re-imbursed through Section 63.

Further details and programme/booking forms from: Dr. David Watt, Tollgate Health Centre, 220 Tollgage Road, EC 4JS.

Still Angry After All These Years*

John Salinsky,
General Practitioner, Wembley

Twenty years ago, when I joined my first Balint-group, I was troubled by the way certain patients could make me terribly angry. Sometimes I managed to control it, more or less, and my feelings would be betrayed only by unconscious body language (including a tendency to quiver all over in the manner ascribed by James Thurber to Lionel Barrymore[1]). More often, my rage would erupt into the consultation; I would find myself shouting, hectoring, abusing, insulting, even swearing. Some patients would happily join in and shout back; others would get up and leave, muttering threats under their breath.

Either way, I would feel bad shortly afterwards and frequently rushed after an offended patient to apologise. Perhaps this rapid switch from anger to remorse saved me from regular appearances before the Complaints Committee. All the same, it was unsettling and not, I thought, a professional way to behave. To my colleagues in the Balint-group I brought a succession of patients who made me angry and it certainly helped to be able to talk about them. Sometimes I seemed to get some clues about why I found particular patients so maddeningly provoking. Over the years I got better at observing my feelings without acting on them. On the whole. But the awful thing is, it still happens. Quite recently, in fact, there was an unpleasant little incident in which a patient got under my guard with a well targeted arrow. Shall I tell you about it? I would really rather not, because it is so embarrassing. Oh, very well, if you insist.

Celia is a 75-year-old lady who first had the word 'hysterical' recorded in her notes in 1961. She has diabetes (non-insulin dependent, moderately controlled, not dangerous) and she lives with her apparently long suffering but possibly, deep down, deeply disturbed husband, Claude. Every so often, Celia is seized by a terrifying illness in which she feels sick and giddy, she heaves and sweats and groans, and she believes she is dying. When this happens, I have to rush round and minister to her. On the latest of these occasions, she greeted me with her usual wail, 'I'm very ill, doctor, am I going to die? Please help me . . . my husband says he's leaving me, he can't take any more . . .'

I examined her conscientiously. Then I asked whether anything had upset her. She told me it was her birthday and she had friends coming to tea. But now she was very ill and Claude was leaving ('I didn't say I was leaving', shouted Claude from the next room, 'I said I was going OUT!'). Celia grasped my hand and held it to her damp bosom. 'Please, doctor, stay with me, don't let me die . . .' This pathetic, impulsive reaching for human contact produced in me a feeling of revulsion. I hated Celia for wanting me to stay with her, perhaps having the power to make me stay with her. I pulled my hand away abruptly and began lecturing her about how she was not ill, it was just her nerves again, like the last time. She must be more grown up, stop behaving like a child. Although I was shouting by this time, she seemed not to hear me and quavered that she needed to go into hospital. I threatened her with the psychiatric ward . . . I will not go on, the whole thing is too degrading, but you get the picture. Needless to say, I escaped soon afterwards, but I did not feel good. I felt unclean and unprofessional.

How could I have sufficiently lost control to let this happen, after all my years of experience and Balint-training? What must they think of me? Perhaps they would complain. The papers were full of stories of complaints against doctors. And now patients were entitled to complain about rudeness as well as medical malpractice.

I imagined myself appearing before some terrible National Health Sevice tribunal in which the prosecutor was saying, 'And believe it or not, m'lud, the accused was actually President of the Balint Society.' 'Of what Society?' enquires his Lordship, raising his quill and peering at me over his *pince nez.* Counsel for the Prosecution (all right, I know it is not really like this at Service Committee hearings, but this is my fantasy, OK?) Counsel for the Prosecution explains that this is a medical society dedicated to fostering understanding of the doctor/patient relationship. 'I see,' says his Lordship, and a discreet ripple of laughter runs round the crowded court. Before the bench can come up with some caustic witticism I hasten to absolve the Society from all responsibility. I say that I was only made President because I was the most needy member of the Society, the one with most to gain from the slightest increase in understanding. I beseech the court to imagine what I might have been like without the help of the Balint Society . . . Well, I think it is time to dismiss the courtroom fantasy, of which I am sure you will agree we have had more than enough. You will find it more bracing to learn that after the episode with Celia, I decided to undertake a serious examination (an audit, if you will) of patient encounters which made me feel angry. I would try, for at least one morning, not to lose control and to monitor the factors that threatened to ignite my aggression.

On the day of the Anger Audit, my surgery was overbooked (not unusual) and too many patients had been allotted five minutes instead of the more desirable ten. Never mind.

*Address given at the 8th International Balint Congress on 19 July 1993, in Zagreb, Croatia.

I was going to stay calm and just give everybody as long as they needed, if it took all day. Everything went well until Maureen and Wayne came in. Maureen is a young, single mother and Wayne is a four-year-old whose feet are never still and whose hands are ceaselessly engaged in unravelling, dismantling or otherwise destroying anything they get hold of. A quick look at Maureen's notes reminded me that on her last visit she had said, 'Why is it that every time I come here I get told I'm depressed?' So the desomatising approach was ruled out. Maureen had pains in her back and legs. She had a sore throat and an ear ache. She had been tired and unwell for months. And what were these hot feelings in her anus?

We did some examining. Her throat and ears were normal. Her chest was clear. From the corner of my eye I could see that Wayne was attacking the baby scales with a roll of parchment which he had managed to extract from its cardboard cylinder. What could it be? Some forgotten diploma awarded to me in happier times by a Royal College? I asked him nicely to put it down. He threw it across the room and slipping neatly behind my back, began a serious assault on the telephone. Restraining him firmly with one hand, I asked Maureen in a calm and reasonable voice whether Wayne might possibly sit and wait outside? I was finding it difficult to concentrate on completing the examination.

She replied that if Wayne went outside he would only cause chaos in the waiting room. I decided that this was the preferred alternative. Wayne thereupon left us. I did what I thought was a reasonable job examining Maureen's back. I explained about intervertebral discs and facet joints, the need for rest ('with Wayne? you must be joking') the judicious use of analgesics, the protection of the back during bending and lifting, the body's natural propensity to heal itself and the possible benefits of physiotherapy. I wrote her a prescription. It had taken a long time and I was now running quite late, but never mind, it had been worth it. Maureen trusted me. One day, we might even talk about her feelings — but only if she wanted to.

However, instead of departing gratefully, Maureen said, 'What about this burning pain in my back passage?' I clenched my teeth firmly. Could we perhaps address that another day? 'Why not now?' demanded the grateful patient, 'I booked a double appointment!' I wanted to say, 'I don't have double appointments. Can't you see I've got people booked in every five minutes?' But I did not. Still sweetly reasonable, I pointed out that we had spent quite a long time on her back and really gone into it thoroughly. I'd like to examine the bottom problem equally thoroughly but there really was not time today. How about Wednesday? 'OK,' she assented grudgingly. I sat back and gave a little sigh of relief. Maureen said, 'Right. The next appointment is Wayne's. Wayne! Where are you? Come back in here when I tell you!' So we finally gave Wayne the attention he had been seeking. All this time, I had been barely containing my anger and wondering what it was about. It seemed to have been lit by a number of different sparks: the prohibition about mentioning 'depression', Wayne's restlessness, Maureen's heavy agenda of physical symptoms and finally the 'double appointment'. Strangely enough, her victory over Wayne's appointment amused me and defused my irritation. I couldn't find a satisfactory explanation of Wayne's 'noisy tummy' and she left, still disgruntled, but I felt quite contented.

The next patient was a previously unknown woman from somewhere in West Africa, who was pregnant and had symptoms suggestive of hayfever. Her husband kept interrupting and when I asked him if he was registered with the practice, he produced a medical card with a different name on it. He said it really belonged to his father. I could feel myself losing control. 'Are you sure your appointment was to see me?' I asked. I had an idea that it might be possible to send him off to see a partner or a trainee. 'No, no,' he said, 'my appointment is with you. You are my doctor. If you are not my doctor, then I have no doctor and must go away into the street . . .' 'No, you needn't go away into the street,' I told him, 'but why didn't you make a separate appointment for yourself?' No answer. I looked at his foot. It was normal. His wife wanted some antibiotic tablets for her cold and some heavy steroid ointment for her skin. I explained that both of these were (a) unnecessary and (b) potentially hazardous. They grinned at each other. The wife pointed at me and said something to him in their own language. 'What does she say?' I asked him (irritably). They grinned again. 'She says you are ''teefer''. Well, that is what it sounded like. I was not sure what it meant, but I had a rough idea. I would have to try harder not to be so teefer.

The last patient to make me cross that morning was Henry. Henry is a single middle-aged man with a sex problem which I had invited him back to talk about. I was quite prepared to discuss his feelings about being unable to achieve an erection and to hear more about his relationship with his mother. Unfortunately, Henry had come with a different agenda. He wanted a letter to take to the Social Services to help him get a free telephone. He claimed that his chronic back pain could at any moment make him seize up and be unable to reach his neighbours in order to summon urgent medical help. Back pain had never featured much in our dialogue before, although it was true that he had been off work for four years with it. At first, I said that there was no chance of his getting a free phone and I refused to write the letter. As he tried to persuade me, I could feel myself getting angry and beginning to quiver like Lionel Barrymore. This time I managed to save myself from getting really venomous with the unfortunate (all right, the manipulative) Henry. Then, I said to myself, this is ridiculous. He is a nice man and I wish him

well. He wants a letter, he shall have a letter. I wrote him one of my best and he went off with it happily. Much later on, I wondered about telephones and impotence. No doubt he felt disempowered without one. Perhaps he thought women would start phoning him with arousing proposals. At least he would feel more connected. Who knows? The main thing is that I kept my temper.

The audit was over and it was time to draw conclusions. What made me angry and how could I control it? Or, to put it in Balint terms, how could I use my awareness of anger more effectively without letting it spill over onto the patient? Often the problem seemed to be about losing control of the consultation and having my time 'wasted' or being used to do things which I felt were inappropriate, professionally degrading or even slightly dishonest. In this situation, it helps to tell myself not to be pompous (teefer?) and to try to see the funny side. Does it really matter if I see someone without an appointment or write a few generously overstated letters? Of course not. I can afford to let the patients win a few victories over the system. Naturally, it helps if I can see things from the patient's point of view, put myself in his shoes or as the master of Empathy, Carl Rogers puts it, 'enter fully into his private world . . .'[2] The idea of fully entering Celia's private world fills me with panic — maybe I'm feeling her panic? Finally, it has been a great help to be able to share these cases with you guys. You listened very patiently and some of your comments were quite perceptive. Why don't we start a Balint-group?

FOLLOW UP: I saw Celia again a week later, in the surgery. She and Claude apologised for having been such a nuisance, and they brought me a piece of her birthday cake. This time, I allowed my hand to be held for a few seconds. Celia said they did not know what they would do without me. Claude said, 'Have you got a minute? I'd like to show you something.' He produced a piece of paper bearing some verses which he said he had kept in his pocket as an inspiration since 1963.[3] The first verse was:

'Pray don't find fault with the man who limps
Or stumbles along the road,
Unless you have the shoes he wears
Or struggle beneath his load.'

References:

1. Thurber, James. 1933, My Life and Hard Times. reprinted in *The Thurber Carnival.* Penguin Books, London, 1945 (and many times since).
2. Rogers, Carl. 1961. *On Becoming a Person.* Constable and Co., London.
3. Anonymous, 1963. Verses in The Daily Mirror.

From My Bookshelf

THE DOCTOR, THE PATIENT AND THE GROUP: BALINT REVISITED. Enid Balint, Michael Courtenay, Andrew Elder, Sally Hull and Paul Julian. Routledge, London and New York, 1993. 176 pp. Hdbk. £11.95p. ISBN 0 415 08053 3, Hbk. £35.00. ISBN 0 415 08052 5. 0

As Michael Balint described in his introductory chapter of *The Doctor, his Patient and the Illness,* 'The discussion quickly revealed that . . . by far the most frequently used drug in general practice was the doctor himself (p.1). We therefore determined to obtain reliable data about the pharmacology of the drug 'doctor' by studying the doctor/patient relationship (p.4). Accepting, albeit conditionally for the moment that according to some, Balint is history, it is appropriate that now, to use a well known phrase, is the time of return to the future, in this case, of Balint-work.

Enid Balint and her co-authors are to be heartily congratulated for doing just that, by providing this very welcome fresh look at Balint-ideas and ways of thinking in the context of general practice in the 1990s. In the preface, Enid emphasises that the authors hope that their book will illustrate the essential nature of Balint-work, the aim of which is '. . . to add to the pleasure, satisfaction and competence of doctors in their ordinary work' (p. *xi*). Case studies and texts of their group discussions are used to show how Balint-groups can help general practitioners to observe and reflect on the way they work in their professional relationships. This is very much in keeping with Balint's original aim, which was to '. . . help doctors to become more sensitive to what is going on, consciously or unconsciously, the patient's mind when doctor and patient are together'.[1] (p.302).

The book is divided into three parts, with a final, fourth part called *The Booklet.* It was in order to allow the reader to see a large sample of the data on one case, so that s/he might come to a fuller understanding and judgement of the way in which the group had worked. It contains nearly all the data collected by the group about one patient and her 11-year-old son, who were presented first at the group's meeting No. 9, on 24.1.85, and were last discussed at meeting No. 69, on 11.12.86. The data consists of transcripts of the case discussions; weekly written reports; and the transcripts of the case discussions of these reports. It all makes riveting reading, and leaves your reviewer wishing that the Balints' earlier practice of recording 'predictions' at the end of each case-report presented, had been followed for this case-history, or at least at the final discussion — with a final follow-up report before the book was published this year! We are told that this Booklet is one of eight made up in this way, so perhaps we might hope to see them all published together in the future?

In the first part, the scene is set, with a description of the five forces which can lead to a change in the doctor's routine approach to his patients. The first force, *novelty,* comes into play when a new patient consults him, bringing relief from chronic problems — and something of a challenge. The second force, *surprise* occurs in the context of a long relationship, and so on. Each is discussed and illustrated by case histories, making this beautifully constructed and written 'new look' at the Balints' work just what we need to help us apply it to present day general practice in Britain. I can only hope that this dip into it is enough to encourage readers of this Journal to add it to their practice library.

Reference:

1. Balint, M. *The Doctor, his Patient and the Illness.* London, Pitman Medical Publishing Co. 1957.

THE LAST APPOINTMENT: PSYCHOTHERAPY IN GENERAL PRACTICE. John Salinsky. The Book Guild, Sussex; pp. 172; £12.95p, Hdbk. ISBN 0 86332 854 7.

John Salinsky describes in this fascinatingly frank and honest account of how, on realizing that human misery is not as standardised as bronchitis or high blood pressure and, faced with the inadequacies of the National Health Service psychiatric services, he started to invite a few of his carefully selected and more distressed patients to book the last appointment of the evening surgery, when he would be free to spend up to an hour (previously called the 'long interview') with them for psychotherapeutic counselling.

Readers who have followed this practice after attending a Balint-group as John Salinsky did, will know of course, the feelings he discusses about the self-doubts (and indeed, the doubts which professional psychotherapists might express about the advisability of general practitioners doing this), and the fear which can arise, that somehow this intervention might make a patient worse. However, as he explains, his technique is patient-centred, and it not based on Freudian interpretations. Melanie Klein and Carl Rogers seem to inform his assertion that a caring parent/child relationship between doctor and patient proves more effective than intellectual persuasion.

In addition, however, he underwent a lengthy personal analysis which he describes in a way that de-mystifies the process for the general reader. It also allows him the authority to write interestingly about this process, and to enlighten his readers about the intricacies of transference and countertransference in a very understandable way.

We are reminded that Michael Balint came to see the 'long interview' as a 'foreign body' in general practice, and thought it was no longer appropriate even for a 'psychotherapeutically-minded' general practitioner. A view which Dr. Salinsky supports; he states: 'There

is a lot to be said for this refocusing of the general practitioner's attention to his ordinary consultations; much help can be given to a large number of patients if we can observe and notice our patients' emotions and the effects they have on their own feelings as they talk about their symptoms. It does not require a great deal of extra time in the surgery, and a Balint-group is the ideal place for learning to improve one's insights and skills'.

Nevertheless he writes that he still sees one psychotherapy patient weekly, and I am happy to read his last sentence, 'I can only hope that with all the health checks to perform and the statistics to collect, I will still feel able, at the end of the day, to settle down and give my full attention to the patient with the Last Appointment' (p. 168).

This book is a 'must' for every practice library, not only for the doctors, but also as a valuable background study for all ancillary health workers.

DOCTORS AND THEIR FEELINGS: A PHARMACOLOGY OF MEDICAL CARING. Benjamin Maoz, Stanley Rabinowitz, Michael Herz, and Hava Elkan Katz. Praeger, London, Connecticut, Westport, 1992. pp. 150. ISBN 0 275 93990 1. Hdbk. £37.95p.

If more evidence is needed to confirm the Balints' worldwide impact of their influence, here it is. In this well constructed book from Israel, four authors from different professional fields and points of contact with family practice, who all teach in the Department of Family Medicine in the Tel Aviv University — a family physician, a psychologist, a psychiatrist and a family therapist — focus on the problems which arise in the doctor/patient relationship. They help the reader to understand the psychodynamics involved, by looking at the effects on the doctor's feelings: Also to emphasise the important part played by the family doctor not only in making a diagnosis, but also in helping him to accept the discomfort of not always being sure of a specific diagnosis, but nevertheless guiding his patients through the maze of somatic, psychological, psychosomatic, psychosocial, psychosexual, and all the other possible disorders and illnesses which he encounters in his daily work. Modern scientific advances help in the diagnosis and treatment of only a small percentage of the ills we see, but all those other patients also need our help. This book will provide its readers with greater understanding of this need, but its essential message is that the best method of developing the skills required to meet it, are best developed by attending a Balint-group.

BEFORE I WAS I: PSYCHOANALYSIS AND THE IMAGINATION. Enid Balint. Edited by Julie Mitchell, Michael Parsons. Guildford Press, London; New York; 1993; pp. 248; ISBN 0 89862 258 1.

We are told on the back cover of this book by Enid Balint, aptly described by her American publishers as the 'mother of the Balint-group', that the question at its heart, is how do we become truly alive? In his introduction to its contents which he and Juliet Mitchell edited, Michael Parsons says, 'not many have contributed so fruitfully to such different areas of psychoanalytic activity'. The proof of this is in the reading of Enid's elegantly argued and clinically rich set of essays on the nature of analytic listening.

The book is divided into three parts showing her at work (I) with individual patients in analysis, (II) with general practitioners in Balint-groups, and (III) in groups with marital therapists. An extra part — Afterthoughts — consisting of an Interview with Enid Balint by Juliet Mitchell, is about her work with general practitioners in Balint-groups, and also about whether her whole interest not just in medicine, but in family doctors, had anything to do with the origins of psychoanalysis?

To say more about this remarkably fascinating and interesting book here, would be superfluous as it must be compulsive reading for all who have been in a Balint-group, as well as for those who are concerned, or work with the problems and struggles in the field of human relationships.

THE SOCIAL HISTORY OF THE UNCONSCIOUS: VOL. 2. CIVILISATION: UTOPIA AND TRAGEDY. George Frankl. (2nd Edition. 238 pp. in Pb. £8.95p. ISBN 1 871871 174). London, Open Gate Press. 1992.

The concluding comment in my review of the first volume of Frankl's *Social History of the Unconscious (Journal,* **20,** 22), that it must be regarded as the first part of a monumental work, is proved to be right by this second volume. He maintains that the assumption that since psychoanalysis is concerned with individual therapy, Freud neglected and disregarded cultural and social factors, was mistaken. He takes us into the history of Western civilization, demonstrating in a masterly way, the significance of the concept of democracy, of monotheism and upon rational enquiry. On one hand, these have produced a rich variety of ideas concerning the meaning and purpose of life, of man's submission to divine authority as well as his freedom to exercise his intellectual potentials, and on the other, oppression and impoverishment of large sections of the population, warfare and bloodshed on an unparalleled scale.

He suggests that if the West is to fulfil its responsibilities, it must overcome its deep-seated and mostly unconscious conflicts which have made a mockery of its moral and rational aspirations. These conflicts have to be understood before they can be resolved, and this book goes a long way towards this end.

PHILIP HOPKINS

From the 24th Annual General Meeting held on 10th June, 1993

Presidential Address given by Dr John Salinsky

This has been a year of achievements and disappointments. I will start with the achievements in the hope that they will give us courage to deal with the disappointments.

First of all, I would like to congratulate all the authors of the new Balint book, *'The Doctor, the Patient and the Group.'* They are Enid Balint, Michael Courtenay, Andrew Elder, Sally Hull and Paul Julian. Their book was based on the work of a group which met under Enid's leadership between 1984 and 1987. I believe that it was originally going to be called 'Surprise and Change in the Consultation', and I think those are still its main themes. the book frequently draws our attention to the way patients can surprise us by revealing aspects of themselves can bring about changes in both doctor and patient. The book also has the ability to surprise and change the reader. I enjoyed it very much and expect to keep returning to it. We can welcome it as a very worthy addition to the series of books produced by British Balint doctors since the publication of Michael Balint's original classic.

The second achievement of the year is a more modest one, but it holds promise for the future. I mentioned, last year, that we were hoping to start a new research group to continue the tradition. Interested members of the Society were invited to get together at last year's Oxford Balint weekend for preliminary discussions. This group survived the weekend without losing its enthusiasm for the idea, and there have been a number of subsequent meetings devoted to deciding on a theme and a time to meet which would suit everybody. The latter at first seemed impossible. With all the extra demands on our time imposed in the last few years it seems that even the most dedicated Balint doctors in the country were unable to find a time to meet weekly or even fortnightly. So, as an alternative strategy, the group is going to have three intensive all-day meetings a year plus the Oxford weekend. This will provide the equivalent of sixteen weekly sessions in a year. The group is still only at the embryo stage: but an egg is a good symbol of rebirth and renewal. If we incubate it with care it should hatch in time produce a sturdy chicken.

I would also like to welcome the arrival of another new group which has recently been hatched (or do I mean laid?) in the Manchester area. Like the Liverpool group, this one began as a spin off from the Ripon weekends, where a number of people within reach of Manchester got together and decided they needed to have a group more than once a year. We wish them a long life and every success.

Now, are you ready for the disappointments? Here we go. In spite of all our efforts, I am afraid the evidence is that family doctors in this country are not at present very interested in Balint. Society numbers are static. For most of our members, working in a group is only a fond but distant memory. More seriously still, we have no young members. Attendances at evening meetings have declined greatly. Sometimes less than ten members have turned out to hear a guest speaker, which is very embarrassing. For this reason, Council has considered replacing some of these meetings with day conferences: we will come to this subject later in the agenda. One of our most important aims has always been to promote the formation of new Balint-groups for established general practitoners. But there are still very few of them. I can think of only five in the whole county, including the new Machester group. Even the Tavistock Clinic which used to run five or six groups, is now finding it hard to recruit members for one. With trainee-groups, the picture is a little brighter. We know of a dozen or so vocational training schemes which have proper Balint-groups led by Balint-trained doctors. There are probablly a score of others with something approaching a Balint-group. Most of the rest have some sort of group-work built in because this is more or less obligatory. But it is anybody's guess what goes on there. Paul Sackin did a survey of trainee-groups in 1980 and concluded that Balint did not exist North of Watford. Perhaps it is time to send our vice-president out on the road again to see whether this is still true. Whatever the training course organisers are doing in their groups there is no evidence that they are coming to us for help. We have tried to attract them to Oxford and Ripon weekends but without success. Nevertheless, I believe, as I am sure you do, that their trainees are suffering from this Balint deprivation.

My suggestion for the future is that we look at the way the American Balint Society attracts teachers of Family Medicine to its annual workshop. This is held at the same venue as the Family Medicine Teachers' Conference on the day before the main conference starts. This means that anyone attending the conference who also wants to know about Balint-groups can go to the workshop simply by arriving at the conference a day early. I think that we should talk to the Association of Course Organisers and see if they will allow us to hold a Balint-workshop tacked on to the front of their annual conference in Ripon.

So my doleful litany of disappointments ends with a hopeful suggestion for the future. Perhaps we should bear in mind that Balint-

activity in Holland flourished brilliantly in the seventies, disappeared almost totally in the eighties and is now rapidly reviving. Hopefully the same sort of revival could happen here: if we hang on. Meanwhile, we must keep the flame alight so that if and when people start to get interested again, there will be a few of us around to show them how it is done.

I would like to thank you all for having me as your president for the last three years. I have enjoyed it very much in spite of all the doom and gloom I have been spreading this evening. I would also like to thank all the members of Council who have given me wonderful and unfailing support. Finally I want to welcome Peter Graham as my successor. As you know he was a very hard working and effective secretary of the Society for many years. His loyalty and devotion to our Society are unsurpassed and I am sure he will give us the leadership we are going to need in the difficult years ahead.

Secretary's Report, 1993

The year again began at Lincoln College, Oxford with 45 attending, including 5 medical students. There were five groups, one of which was the inaugural meeting of a new research group to continue in London.

The first of the senimar meetings at the Royal College of General Practitioners was very successful with a stimulating speaker in Dr Bruce Charlton, at the time an anatomy lecturer at the University of Glasgow, but now a lecturer in the General Practice department of Newcastle Medical School. He spoke about the threats to health from a market-place philosophy and from the dichotomy between popular alternative therapies and a medical establishment often obsessed with technological care.

The second meeting on November 24th was very poorly attended which made it difficult to discuss matters with the speaker, Dr Graham Curtis-Jenkins, who spoke about his Counselling in Primary Care Trust, whilst he is increasing psychological care in a general practice setting, all members were very antithetical to his very cut-and-dried ideas about it.

On 2nd February 1993, Aidan Bucknall, Clinical Psychologist in Tower Hamlets, spoke about the psychology service in this inner city area which has a large community based element working separately from the hospital service, based in general practices but not controlled by the general practitioners.

Drs. Jean and Stephen Pasmore gave the tenth Balint Memorial Lecture on March 16th to a large group, including Enid Balint.

The final lecture was on April 20th, given by Dr Anne Clover, one of the four consultants at the Royal Homeopathic Hospital. It was a useful, clear presentation about the work done there and at the other NHS homeopathic hospital where she works, in Tunbridge Wells. Though we may disagree with their medicine-orientated treatment, which tends to subsume psychological problems, it does appear to have a part to play for some people.

The Ripon weekend, attended by only nine participants, was worthwhile, with very positive feedback. Two senior Russian doctors from the Institute for Advanced Medical Studies in St Petersburg attended. The small number was due to the foundation of a new group to start in September in Manchester. The Balint-group Leaders Workshop continues to meet at the Royal College of General Practitioners, organised by Dr Peter Graham.

With an interesting and varied programme for next year, I hope that more people will attend Society functions which start with the Oxford Weekend, from 17th-19th September, 1993.

DAVID WATT

Incoming President's Address

Given by Dr. Peter Graham

It gives me very great pleasure to be standing here today knowing that the Council have confidence in me to lead them back to the future and to follow in the footsteps of some real giants in our Society. Some of you may well question my qualifications for this role — apart from sheer time-serving — because I have not published any new papers. But I feel justified in having served as Stage Manager or facilitator who set the scene, booked the venue and advertised the correct date, turned on the lights, switched on the tape recorder and enabled others to lead groups on the centre stage while I sat back and admired their performance from a distance. I must also pay tribute to my wife, my invisible co-Leader, and also Heather Suckling and present these two bouquets.

Before I go any further, I must pay tribute to the work of John Salinsky, our retiring president; a man of few but pithy words who has a remarkable talent for getting things done. Where would the Society be without the guided tour of Oxford, the stable financial base since he took over from Aaron Lask as treasurer. He is the prolific author of a remarkable series of papers. He inspired us at Oxford and Ripon and now has inaugurated a new research group. He is well-known as treasurer of the Federation International and has recently been promoted to Secretaire-Generale of the United Nations de Balint, a reward he richly deserves. We have indeed been fortunate to have a man of his calibre at the helm for the past two years and we wish him every success in the future.

Also I would like to thank the whole council for the hard, noble work they continue to do, particularly David Watt, who has kept the ship running so smoothly these last few years; Philip Hopkins, our Editor, for an excellent journal; and Heather Suckling for holding the financial reins.

Recently I was invited to attend the Michael Balint weekend of the Object-Relations Program, a 2-year course in Psychotherapy run under the auspices of the Washington School of Psychiatry by Dr. David Scharff and his wife Jill. Dr. Harold Stewart was the keynote speaker, and we were entertained with the usual lavish American hospitality.

In the final summing up, David Scharff revealed that he had been analysed by Dr. Leonard Freidman in New York. Suddenly the jigsaw fell into place. He was the author of Virgin Wives, one of the first books that Michael Balint had inspired with the Family Planning Association, that had inspired me to go on with the work, and many others I am sure. I was literally astonished at the memories he brought to life of Michael Balint at the Tavistock and I recognized the man I once knew. At that moment I realized the universality of truth that was contained in the message that Michael Balint wrote in his books that has spread to become truly universal.

What struck me most about the fifty students, was how enthusiastic they were for the work. They all agreed that the understanding of the relationship had helped them and also Balint's books. I must say I was reassured by the number of them who wanted my personal opinion of their case.

By the way, their idea of brief psychotherapy was thirty sessions of fifty minutes each.

Their big worry was that I might meet the Hilary Clintons and tell them about 6 Minutes for the Patient, and then they would be reduced to fifty-two weekly sessions of six minutes each and that would really hit them in the pocket.

Perhaps my most abiding memory will be of Harold Stewart kissing fifty graduands in turn, on receipt of their diplomas.

I know that the real legacy of Michael Balint is the many books and papers in the Journal of the Society and others, that are a rich source of wisdom that never fails to inspire me whenever I read them. But they are a skeleton that demands explication like the five books of Moses in an Oral Tradition that we dare not lose. But besides the writing, there is, in addition, a wonderful cosmology of myth, legend, folklore and personal experiences that are shared by the members of this Society. They are the Crown Jewels that are in danger of dissipation if this Society should fail.

I am particularly referring to those live demonstration-groups, and here you must forgive an old lag's nostalgia and sentimentality. There have been some star performances that will stand out forever in my memory like gigantic theatrical performances of Shakespeare or opera. I will always remember the Montreux Congress where Professor Wernher Stucke from Hamburg and Jean Guyotat from Lyons led their groups — one after the other — in entirely opposite ways; Arthur Trenkel and his group from Berne at the Imperial College, ticking like a Swiss watch; Enid at the Royal College of General Practitioners three years ago; Michael Courtenay at the Karolinska in Stockholm, leading a cosmopolitan group equal to any other performance we have ever seen; Cyril Gill, when I was privileged to call myself his co-leader at Oxford — 1984. If one wanted to measure their value it would be like Crown Jewels to me, but, like Halley's comet, it's gone in a flash. If only I could lead a group like that of Michael Balint — that has been my dream wish.

'Fame is the spur
that the clear spirit doth raise
that last infirmity of noble mind'

It is my worst nightmare that with the creeping privatisation of the National Health Service, that this Society will be lost or forgotten amongst all the new initiatives that are being planned. We are on the brink of disaster just waiting to tip us into oblivion, unless we are determined to survive. I would like to start a debate throughout our membership on the various options that are open to us, and initiatives to change and to set up a Working Party to make recommendations to the next Annual General Meeting on where the Balint Society should be heading in the 21st century because, if we do nothing, we will stagnate and disappear without trace.

There is nothing that would give me greater pleasure than to see a crash program of Balint-groups set up at every Academic Centre in every district throughout the United Kingdom to look at the core problems of doctors and patients in this new era of Health Economics. We never knew we had it so good, as Harold MacMillan said.

Now that the recession is over, I hope that we can continue to fertilize the green shoots of research and the new Balint-groups to work in the future as we have been inspired in the past by those lively giants we have seen and heard.

The Balint Society Prize Essay, 1994

The Council of the Balint Society will award a prize of £250.00 for the best essay on *Pain in the doctor/patient relationship.*

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.

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

The prizewinners will be announced at the 25th Annual General Meeting in 1994.

Entries must be received by **1st April, 1994,** and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 4JS.

Balint Weekend at Oxford

18th-20th September 1992

As experienced by five medical students.

I heard about the Oxford weekend meeting of the Balint Society through a friend from the British Holistic Medicine Association which has kept us sane as medical students, promoting a view of health-care involving the whole person, including recommending relaxation and exercise, alongside tablets and hospital treatment, as well as working with counsellors, masseurs and other complementary therapists to achieve this.

Therefore, although I knew very little about Balint (his book was one of the works which my hectic social and musical life precluded me from reading at College!) the idea of investigating and trying to improve the doctor/patient relationship sounded like a marvellous 'holistic' idea — perhaps as refreshing to a medical student now as it must have done originally. I had just done my general practice attachment in rural Cumbria and loved the feeling of being part of a community, of hopefully 'being there' to care for people and of knowing the context into which people fitted. This also gave me an interest in meeting other general practitioners, and seeing if they bore out the differences between general practice and hospital medicine which I sensed in Cumbria.

I knew it was going to be a good weekend when I piled out of the traffic-jam dogged coach from London and melted into the venerable stone and flower-sprinkled silence of Lincoln College. I felt warmly welcomed even though I was late, and the atmosphere was one of celebration and pleasure in meeting again. I looked forward to the first session with interest.

It surprised me intensely, evoking obviously strong feelings in people about the difficulties inherent in treating friends and colleagues. It was difficult at this stage to see whether the aim was to come up with ideas about the particular doctor/patient relationship in question, or to comment generally on problems of patients becoming friends and vice-versa.

The most powerful feeling for me was of the complications brought into interactions with people simply by the title 'doctor'. It felt as if the reverence with which doctors are sometimes treated, because of people's need to believe in miracle workers, could get in the way of responding to people as human beings and not as patients. I could imagine that the secrets confided in doctors as well as the intimate activities they are allowed to carry out would encourage this need to stand apart slightly from patients. I could also understand a need for a professional persona with which to protect yourself from too much responsibility for other people's problems. I was left feeling that, for myself, I would like to develop as a person able to stand alongside others in difficulty, and offer a service, much as a mechanic or plumber does; as someone with more knowledge of human biology than most which I would use to help when I could. I felt as if it could be detrimental concentrating on the difficulties inherent in doctor/patient relationships to the degree that a natural human response, which I seem to see more in nurses in hospital, disappears.

I enjoyed chatting to different people on the Friday evening and at breakfast on Saturday, pleased to be so accepted and included, and happy to be with positive human doctors who seemed to share a concern for really caring for the whole person as well as possible. The rest of the weekend, spent in our small groups, seemed to confirm by the patients who were found to be problematical were the ones left behind when the prescriptions and the referrals had been written. We discusssed one interaction in which an old lady labelled as schizophrenic was being maintained very successfully in her own home through an unusual combination of friendship, Chopin and conventional doctoring. There seemed to be agreement, though, amongst the practising doctors that 'special patients' brought their own concerns, such as whether they obtained better treatment because of the friendship developed.

The politics of general practice, such as not offending partners or doing them down to be in favour yourself, came up in one presentation. It seemed as if a lot of experience would be needed to avoid being forced into some of the roles different patients want the doctor to assume. Another theme was one of being 'rejected' by a well-known patient who changes onto another list after years of successful relationship. We, the students, were all for confronting the new doctor (a known colleague) and asking how the patient was, or even ringing up the patient and asking for an explanation of her decision. However, as was pointed out, the patient has the right to terminate a professional relationship at will, which puts you in the position of having to respond professionally and not 'humanly' as before. One of my worries is that we go into caring professions to fulfil a need in ourselves but, as someone wisely said to me, that need is in everyone and as long as it is not the sole reason for looking after people then it is what provides part of the satisfaction of the job.

At the end of all the sessions, and particularly on Saturday evening, I felt emotionally drained and needed time by myself to think through some of the numerous ideas and feelings that had been buzzing around. I felt certainly as if taking time to present patients

about whom there were queries was an enormously valuable process for doctors. It also felt as if standing back and allowing other perceptions of the situation to be expressed would in some cases untimately help the patient because it opened up new ideas for the interaction.

As a student I felt as if I learned in a general sense about the way that doctors perceive themselves, and their patients, and the pitfalls that await the doctor and patient alike, which could lead to an unproductive relationship. I felt a need for balancing the human and the doctor, for giving out and yet protecting enough to give again the next day, and for loving the job sufficiently to make it possible to tolerate the bureaucracy and the demands made!

I came away inspired certainly, quite astounded at the psychological strength needed to explore and develop relationships with patients, and relieved that some people out there do think about it! Thank you for having me.

Liz Anderson
Final year student,
Royal London Hospital Medical School.

I planned the weekend as an introduction to my elective period in geriatric medicine at the Radcliffe Infirmary, Oxford. A medical student from Germany, I hoped to meet some students from Oxford and to join eventually their ongoing Balint-group. Unfortunately, only students from Cambridge and London attended. But my expectations were more than met, nonetheless.

Apart form the overwhelming experience of getting from the noisy airport and through busy London directly into the silence and peace of Lincoln College, I enjoyed the openness of the general practitioners in my group, and how they were dedicated to their profession.

I was already familiar with Balint-groups, but still appreciated the plenary session to warm up for the small groups. It took me a while to feel free and comfortable in my group, but then a feeling of trust and respect came up. There was another foreigner, she was a general practitioner from Iceland, but I did not have the impression that language difficulties were any obstacle to the group process.

When I finally decided to present a case, I was surprised how strong my feelings were involved. She was a 20-year-old drug addict, who I met on a general practitioner attachment. She particularly appealed to me because she had a child taken away from her because of her addiction. While I had difficulties understanding why she was addicted, I could easily comprehend her feelings about the child. She continued not telling us the truth about what she had taken, knowing that we would do a urine test each time. I found this very stupid. She was not capable of arranging anything with her social counsellor or us to control her disease or get her child back. After the group I could accept her without the condition of being 'clean' and take her false statements as an attempt to be a 'good' patient, which she may well have liked to be, and considered it to be rather stupid of us to test her urine. I still find it difficult to understand why she takes drugs and am still helpless about it, but this is no more so unbearable as it was before.

I found it remarkable how few medical students took part, in spite of the fact that it took place so near a famous Medical School. That is also true when it comes to house officers or hospital doctors in general. In Germany these weekends are introductory and promotional rather than a substitute for a regular group. We also have some non-medics in these groups, and there are also groups specially for nurses or social workers etc. You find also 'History' groups for students only. There were also a lot of psychoanalysts in the German meetings, which I did not miss at Oxford, as they often were unable to talk about their own feelings and analyed others instead. The British are known in Germany as being rather cool and to have difficulties in expressing their feelings. My findings do not support this prejudice.

I definitely liked the weekend very much and I strongly recommend it to any other student, even if he or she is dedicated to anaesthesia.

Michael Andreae
Clinical Medical Student, F.R. Germany.

I am a final year medical student at St. Thomas Hospital and have done a BSc in psychology which contained an introductory course in psychotherapy. I would like to become a general practitioner. I have no experience of Balint-group work, my only background to the weekend was to read *The Doctor, his Patient, and the Illness.*

The group-work, the serious part of the weekend, started on Friday evening with an introductory Balint-group. This and each of subsequent groups consisted of eight participants, including two leaders. The introductory group was a 'scratch' group, made up by volunteers. This was the first odd, interesting thing about the weekend. At first, nobody wanted to join in the introductory group and there were several silent minutes until someone volunteered. I was hesitant about volunteering, thinking perhaps I might not have much to offer as a medical student, but everyone was very encouraging, which continued through the weekend.

The first, introductory group was done as a 'fishbowl'. That is, the small group was observed by the large group, who were invited to comment at the end of the session. The first group discussed a case involving a patient who was also a doctor and colleague, and friend of the presenting general practitioner, which provoked a lot of strong feelings in everybody

about the nature of the doctor/patient relationship and of the doctor's role.

All the group-work from then on was done in five groups, who met in two sessions on Saturday morning and one in the evening, and a final one on Sunday morning, followed by group feedback at a plenary session.

The second odd, interesting thing was that at no point did anyone explain what was supposed to happen within a group, other than that one person should present a case, selected basically on the basis of being difficult, 'niggling' the doctor, or 'getting under his skin'. After the case is presented, everyone comments on it, but it was never quite clear to me what people were supposed to say. Some gave a sort of gut-emotional reaction to the situation, some gave a psychological interpretation or suggestion, about the doctor, the patient or their relationships, others made more general comments, others offered advice and so on.

My group consisted of five general practitioners who had done some Balint-work before, one who was new to groups, myself, one leader who was a retired general practitioner and one leader who was a psychoanalytically trained psychotherapist.

The patients consisted of a 68-year-old woman who spent most of her time at the surgery or in a variety of out-patient clinics, with a variety of gynaecological complaints which she documented with obsessional precision in a number of notebooks. The doctor wanted to know how to spend less time on this woman and her notebooks. The psychological general practitioners wondered what was going on in the woman's life and in her backgroud to make her spend time obsessed by her physical health. The sympathetic GPs and myself felt sorry for this lonely old woman and thought she ought to be allowed to fill her life with her diseases. The psychoanalyst pointed out the gynaecological nature of the diseases and also how she was controlling the GP, and everyone else with her books.

The next case was a woman who called out her doctor for a sore throat at 6 a.m., then complained to the Family Health Service Authority when she felt so dissatisfied with the doctor, despite his coming out. We were generally supportive of the doctor, sympathetic about being complained about, not loved by his patients, and so on. We wondered what was going on with the patient, why she seemed so angry, why she had called out her doctor, what she was dissatisfied about? The psychoanalyst pointed out the sexual side of sore throats. The practical general practitioner (the first presenter) said do not get involved during the complaint. The sympathetic members of the group said go and talk to the patient.

The third case was a middle aged Irish woman who presented complaining of high blood pressure, which in fact was 150/90. She was a hot-tempered woman who had taken a job very successfully in her middle age, when her husband had lost his job, and the family home, and was now left at home to bring up the children and do the housework. She despised her husband who was 'not a man', had bad breath which put her off sex, and frustrated her by his lack of drive.

The practical doctor asked about anti-hypertensives; the psychoanalyst pointed out the smelly hole represented a female orifice which she was rejecting in her self, the sympathetic doctors worried about the husband and the children. The psychological ones suggested she was emasculating the doctor like her husband.

The fourth case was a Barbadian woman with metastatic breast disease. The general practitioner had 'allowed' her to go to Barbados before the breast lump was biopsied and felt guilty about this, which she admitted freely. She wanted to counsel the woman about how to organise her future and also help control the pain which, however, did not fit any conventional pain pattern.

We sympathised with the doctor's guilt feelings. One doctor pointed out in fact the disease was probably already metastatic since there was a lump; another said one could not know that. The retired doctor talked about Barbadian culture, how pain was different there and also how going home was important. The general practitioner felt unsupported by the hospital, as no diagnosis on the secondary involvement had been made, therefore she could not advise the patient and we acknowledged this without giving much help.

The fifth case was of a small and quiet couple; the husband was the patient of more interest, a tall and good looking primary school teacher; the wife, who had one child and was not very interested in sex. He had been a single adopted child whose adopted parents had died. He was very sexually active and wanted his wife to enjoy him having sex with her; also to have oral and anal sex, which she objected to, to the extent that he had anally raped her. They had been to a psychosexual counsellor who had lost his temper and called the husband an oversexed pig. The local psychiatrist had declared him normal. The general practitioner sympathised with the husband who was bewildered that everyone was angry with him, though previously he had been on the side of the wife and angry with the husband himself.

Although this was a complicated case involving two people, we felt optimistic because the husband seemed to be gaining insight into the fact that his wife's needs might be different from his own. Their doctor was worried that he might not be able to cope with too much realisation. We were also worried about the wife. The psychoanalyst made much of the woman's hysterectomy and the way the husband had brought a drawing of the vagina without a cervix and his own penis unable to 'reach the end', and suggested this represented losing touch with the

womb and hence his real and adopted mothers. The psychological doctors pointed out the husband's immaturity and his unawareness of his wife's needs. However it did seem that this was changing.

The sixth case was presented by the general practitioner new to Balint-work. She was an aggressive woman who had called him out to her husband with 'flu', had bullied him into coming by threatening to slam the phone down, then had been rude and ungrateful when he arrived. Subsequently she had seen him again two months later with a vaginal complaint and had been more grateful.

We were interested in the woman's relationship with her husband; she was apparently generally aggressive and domineering, a bully. The general practitioner had said she would always upset general practitioners, but he stood up to her and perhaps that was why she was more polite next time. Much was made of the vagina. I wondered about, but did not mention colour; the reporting doctor was Asian.

I presented the seventh case, an anorexic student nurse whom I had seen during my psychiatry term. I had been very confused about my role as student, not sure what side I should be on and how involved I should be. I had had a very domineering and organic consultant who insisted that she be fed up before any therapy be done. The others sympathised about the confusion between roles especially as a student. The practical general practitioner said this was a continuing problem, especially with one's own age group, but was 'told off' for being too general. The psychoanalyst suggested that the rigid anorexic was the same as the rigid consultant, that I was afraid of her psychosis. There was a lot of discussion about friendliness, how involved one should get and whether it is helpful or not, reflecting the introductory case to some extent. The suggestions were very interesting and I did feel it might alter my behaviour another time.

Anyhow, despite these personal things, I found the group experience very interesting and helpful. I would definitely like to come again and develop both my group-work and psychotherapy skills.

The plenary session was largely involved in describing Balint-groups, dynamics, size. The lack of 'young' general practitioners and other interest in the rest of the profession. It was suggested that we do not take ourselves seriously enough, are apologetic about Balint-work in fact, and this is why it has not 'caught on'.

Between the sessions there was ample opportunity to mix and chat with everybody, which was a very enjoyable part of the weekend. Other high points of the social side included simply staying in Lincoln College, which was lovely; the food was excellent and thoughtfully vegetarian; and an interesting tour of Oxford, led by John Salinsky, including climbing St. Mary's tower.

In summary, I found the weekend enjoyable and interesting both on the play and work side. I found the group-work interesting but never quite right for various reasons, which I am not fully sure of, but have tried to identify. I would certainly like to develop my group and psychotherapy skills more.

Suggestions, practical ones are asked about vegetarians beforehand. Lincoln coped admirably. Why not ask about car-sharing, considering so many people were coming from London? We might as well be ecologically sound.

As far as the work goes, I would definitely have liked to have had slightly more of an idea of what was expected, as in a way I am still not sure. Perhaps only experience teaches that. I was very struck by how much each person said their own thing over and over, and in a sense the patient was a projection of individual general practitioner's problems and attitudes. If nothing else, Michael Courtenay's article on Balint for the plain speaking doctor would have been a good introduction.

DAVID BOSSANO
Final year medical student,
St. Thomas' Hospital Medical School.

When most medical students think about becoming a general practitioner, the idea is in the same distant, almost intangible realm as 'When I get married . . ' or 'When I have children . . '; something that you do when you grow up. Perhaps because the majority of our training is within a hospital setting, or concept of 'doctor' is determined, to a large extent, by the consultants who teach us, and our perception of medical practice can easily become limited to the immediate environment in which we work.

It was, therefore, a desire to learn more about the largely unknown world of general practice and the doctor/patient relationship in this context which prompted me to reply to the conference advertisement on the medical school notice-board.

The conference in Oxford was attended by both doctors and students, and I am sure that even those who did not come from the harsh, spartan world of the student appreciated the beautiful setting and the catering of Lincoln College. Those already working in general practice may not, however, have realised how unusual it is for a fourth year student to meet so many general practitioners and to hear about their work.

It is equally unusual within the course of training to give detailed consideration to the psychological aspects of our dealings with patients. As a medical student, I was aware that my relationship with a patient is different from that which a qualified doctor would have, but I also came to realise increasingly over the weekend that it is nevertheless a relationship subject to the same processes affecting the doctor/patient relationship. I am grateful to the

group of which I was a member, for encouraging me, despite my misgivings, to contribute a case for discussion, an experience which I found very useful.

Aa is often the case at such events, I left the conference inspired and fully resolved to reassess my attitude to myself, my patients and their illnesses. However, as is equally often the case, those resolutions have been more difficult to follow through back in the context of the ward. It is hard to avoid slipping back into a pattern of diagnosis where psychological considerations only become important when no 'proper' diagnosis is possible, and to avoid using the word 'neurotic' with its negative connotations to relegate such patients to a lower-priority category.

To achieve such a change in attitude takes time, and it was stressed over the weekend that the Balint method cannot really be practised authentically outside an on-going group. I am, however, grateful for the opportunity afforded me by my experience at the conference to start to think about the implications and the potential of my interactions with patients, both during my training, and in the future.

Heather Buchan
University of Aberdeen
Medical School

Making plans for my impending elective as well as moving house had been quite enough to occupy my mind, and I suddenly found myself in Lincoln College, Oxford, on Friday, 18th September, realising that I had given very little thought to why I was there and to what I was expecting out of the weekend.

This sounds rather careless and irresponsible which, indeed, it was. However, at least it meant that I did not have time to become intimidated at the prospect of being one of only five medical students among a large number of general practitioners, many of whom knew each other, or of spending lots of time in small groups, the thought of which is usually much worse than the event.

I am glad that I did not make time to worry as it would have been time wasted. After a most welcome dinner, taken at trestle tables, sitting beneath ancient portraits of learned gentlemen, eight people formed an inner circle and gave a demonstration Balint-group, while the rest of us sat in an outer circle and restrained ourselves from giving our opinion until the discussion was opened up.

This first evening was useful for several reasons. It provided a model for the small groups which would subsequently be formed. This was particularly helpful for those of us, both doctors and students, who had never taken part in a Balint-group before. It also meant that we all had some contact with each other initially, which would not have happened had we formed groups straight away, and I feel that that would have limited the social value of the weekend, which is important! Thirdly, a fascinating case was presented and some interesting ideas were exchanged, at times quite heatedly, and I am sure that we all learned something.

On Saturday, we had three 90-minute sessions in our small groups and on Sunday, a final session. Those on Saturday were spread over the day which I think was a good thing. I do not think I could have coped properly with any more sessions, as the cases presented provided quite enough material to think about over coffee or during our free afternoon.

As each case was presented, I felt mixed emotions at the thought that one day I would be the doctor in these complex doctor/patient relationships. I felt excited at the challenge of tackling these problems with the ultimate aim of helping the patient, but also fear of failing the patient and failing at coping myself when constantly presented with the mess in people's lives. I felt great respect for the doctors in my group who seemed to achieve the former admirably, and still felt the desire to spend a precious free weekend learning how they could improve still further.

At no time was I made to feel uncomfortable about not having a case to present, or not saying as much as the others, and I am grateful to my group for that. At the same time, I felt that those who did present were helped by the discussion, so I would advise students to present, if they have a case in mind.

A free afternoon exploring the delights of Oxford and a sumptuous meal on Saturday evening provided a break from quite intense thought and perhaps, a time to reflect on what had been said. Either way, they were both most welcome.

I would like to thank the society for providing me with an introduction to the work of Michael Balint and his followers. I feel that the onus is now on me, as well as on the Society as a whole, to tell my contemporaries about the work of Balint-groups in the hope that this work will be continued in the next generation of doctors. Without this, I feel that many doctors and thus many patients will be missing out. I also feel that it is important to take seriously a point made at the plenary session — why should only doctors have Balint-groups? Are there valid reasons other than just historical ones?

Tabby Winnifrith
Final year medical student,
Royal London Hospital Medical School.

The International Balint Federation

The General Assembly of the Federation met in Aachen, Germany on 4 April 1993.

The following were elected to serve as officers on the council:

President: Dr. Frank Dornfest (USA)

Vice-presidents: Dr. Michelle Lachowsky (France) and Dr. Margarethe Stubbe (Germany)

General secretary: Dr. John Salinsky (UK)

Treasurer: Dr. Roger van Laethem (Belgium)

Dr. Jack Norell was appointed Special Ambassador to the East European countries.

Federation News

Croatia and Slovenia now have national Balint Societies which have affiliated to the Federation in the last two years. Austria, Romania and Luxembourg may also be joining shortly. There has been a welcome revival of Balint activity in the Netherlands and it is hoped that a Balint Society will be started again soon.

The 8th World Congress of the International Federation was held in Zagreb, Croatia, in July 1993 and was a very successful event, although it was unfortunate that more people were not able to attend from Western Europe (see Congress report, page 38).

The 9th International Congress will be held in Charleston, South Carolina, USA from the 9th to 12th of November 1994. The weather will still be pleasantly warm there and it will be an excellent opportunity to meet our lively American colleagues as well as delegates from Europe and the rest of the world.

The theme of the Congress will be 'Balint training in the New World: a time and place for re-evaluation, re-affirmation and change.

The organisers plan to invite some experts on qualitative research methodology to observe the proceedings and advise on the application of their methods to Balint research and evaluation.

Travel to Charleston and accommodation can be arranged through Wendy Allison, Charleston Travel, 1525 Sam Rittenberg Boulevard, Charleston, SC, 29457 USA. Tel: 803 556 8646 Fax: 803 556 3365.

Booking through this official agency will enable the organisers to obtain discounts to assist delegates from Eastern Europe to attend the Congress.

JOHN SALINSKY
General Secretary
International Balint Federation

Balint Weekend at Ripon

18th to 20th May, 1993

The fourth Balint Society weekend took place at Highfield House, College of Ripon & York St. John, Ripon, and was the smallest meeting so far, with nine participants staying at the luxurious conference centre. They formed one group led by John Salinsky and Erica Jones.

Amongst us were two Russian guests from the Institute for Advanced Medical Studies in St. Petersburg, visiting England under the auspices of the Royal College of General Practice to study general practice in Britain. It does not exist in Russia and they are at the forefront of those trying to teach and introduce it to improve an extremely cost limited health service. One, Yuri Gubachov, was able to present a case, interpreted by his colleague, Alexander Kusovo, and both were useful participants. The other delegates knew each other, so there was a very good group ethos from the start. The leaders will write up the work of the group at a later date, using follow-up reports.

Catering arrangements worked out well and yet again the weather was kind to us, so all enjoyed a beautiful Saturday afternoon in the Yorkshire countryside. The small number of participants is explained by a new group, starting in Manchester in September, spawned by last year's Ripon and Oxford meetings, and arranged by Dr. Dennis Price from Handforth in Cheshire.

At the moment we are not sure whether to run another course in Ripon, or to hold one in another part of the country, equally far distant from London.

DAVID WATT

The Eighth International Balint Congress, 1993 in Zagreb

The eighth International Balint Congress was held in Zagreb, Croatia, from the 18th to the 21st of July 1993. It was planned and organised by the Croatian Assocation of Balint Groups and the Clinic of Psychological Medicine in Croatia. Zagreb is a beautiful Baroque City with handsome palaces, museums, a Gothic cathedral whose twin filigree spires dominate the skyline, and an old town with many delightful quiet streets and squares.

The Congress was held in the modern Intercontinental Hotel which is very comfortable and well equipped for conferences. Most of the 200 delegates were from Croatia; there were relatively few visitors from abroad, probably because of the recent war and the continuing fighting in neighbouring Bosnia-Herzogovina. In fact, Zagreb was entirely peaceful, although the presence of UN advisers and soldiers in battle fatigues was a reminder that the war was not so far away. The terrible effects of the fighting were also addressed by the Congress which included special sessions on the psychological rehabilitation of wounded people, refugees, traumatised children and violated women.

Britain was represented by Jack Norell, the retiring president of the International Federation, Erica Jones and myself. Among the other visitors we met some old friends (Kornelia Bobay from Hungary, and Zlata Kralj from Slovenia) and acquired five new ones from Transylvania (we were careful not to ask them about Count Dracula). We were all made very welcome by Professor Muradif Kulenovic and his enthusiastic team of organisers, who all treated us as very valued participants. After a display of folk singing and spectacular dancing on the first day, the conference programme opened with speeches of welcome, including one from the WHO director of Mental Health, Dr. N. Sartorius. The main plenary sessions were devoted to a variety of papers about many aspects of Balint-work from the pragmatic to the philosophical. Although time was provided for discussion, the Croatian doctors were a little reluctant to speak from the floor due, it seemed, to a degree of deference induced by their medical education, and not helped by the large expanse of carpet which separated the platform from the audience.

Plenary Session

In the first day's plenary session, there were papers by Drs. Norell and Jones from the UK, Dr. Flego from Croatia and Professor E. Klain of the Department of Psychiatry, University of Zagreb. Dr. Norell spoke about Balint Philosophy, and Dr. Jones gave some guidelines for effective group leading. Dr. Flego's paper described Balint's contribution to contemporary understanding of man, and Prof. Klain spoke about the relationship between Balint-groups and group analysis. Dr. Salinsky read a letter from Dr. Roger van Laethem, in which he traced the history of the International Balint Federation.

There was also a session in Croatian which included papers on listening, non-verbal communication, the doctor/patient relationship, secondary gain as a therapeutic goal, and work with oncological (cancer) patients. On the second day, there were papers on the application of the Balint-method to a wide variety of different fields. These included, besides general practice, the use of groups for kindergarten teachers, medical students, nurses, marriage counsellors and alcohol counsellors. Balint research was also the subject of two papers. All these were in Croatian only.

The second day's plenary session began with an address by Dr N. Sartorius, secretary of the WHO Mental Health division. He pointed out that psychological problems account for a large proportion of the work of general practitioners, but they often remain undiagnosed or untreated. Dr. Buda (Hungary) gave a paper on some theoretical considerations concerning the Balint method and helping relationships; Dr. Salinsky (UK) described some patients who made him feel angry and Professor M. Kulenovic spoke about the relationship between therapy and education in Balint-groups.

On the third day, the plenary session was devoted to accounts of Balint-work in different countries. Dr. Kornelia Bobay described how the Hungarian Society was building Balint-bridges with doctors in the neighbouring countries of Slovakia and Romania. Dr. Zlata Kralj gave an account of Balint-work in Slovenia, where groups have been set up for medical students, nurses, social workers and prison staff as well as for general practitioners. Albert Veress reported from Romania, where doctors in small towns and villages in Transylvania are now meeting once a month for Balint-groups which are greatly appreciated.

These papers were followed by a lively discussion which covered the subjects of leadership training, who should be a leader, the evaluation of leadership and whether students can benefit from Balint-training. The visiting students from Slovenia left the congress in no doubt that they could benefit and had benefitted. This was further demonstrated by their lively participation in the afternoon small group sessions led in turn by each of the British contingent.

Small Group Work

In the afternoons there were three Balint-groups in English, led respectively by Dr. Salinsky, Dr.

Norell and Dr. Jones. Professor Kulenovic also led a group in Croatian. The English leaders felt that although their groups were enjoyable and productive, it would have been better if participants could have stayed in the same group for a number of sessions so that they could get to know each other better and thus work more effectively.

Additional Symposia

During the Congress, there were also Symposia (in Croatian) on the themes of psychological treatment of child and adolescent victims of war, helping displaced people and refugees, and the violation of women in war with the help of a small team of personal interpreters (charming young women who sat next to us and whispered English into our ears) it was possible to sample some of these interesting and often very moving papers.

These sessions were of particular significance in view of Croatia's recent war experience and the many refugees (over four hundred thousand), whom the country has received and to whom its doctors, nurses, psychologists, teachers and social workers are giving desperately needed help. Balint-groups have proved effective for helping the health workers to cope with the tremendous emotional strain that this work inevitably involves.

Erica Jones and I were able to visit a refugee camp where a large contingent of Bosnian Moslem refugee children were being cared for, and helped to piece together their shattered lives. We are grateful to Dr. Milivoj Jovancevic, a Zagreb paediatrician, who does voluntary work at the camp five days a week, for showing us around and answering our questions. It was quite heartbreaking to see a kindergarten apparently like any other, and then to realise that many of the 3- and 4-year-olds had lost one or both parents, or brothers and sisters as a result of the war. This kind of work inevitably puts a terrible strain on the doctors, nurses and social workers involved, and it was gratifying to learn that the Balint-group has proved to be a useful way of helping them to deal with their own disturbed feelings.

At the final session of the Congress, we took it in turn to come up to the podium and summarise our impressions. Jack Norell made his presidential farewell à la Francais, with a salute for the gentlemen and a delicately blown kiss for the ladies. However, it is not really 'Adieu' because he will continue travelling around Eastern Europe as the Federation's special ambassador, leading groups and assisting in the development of new Balint Societies.

Like any good conference, this one provided opportunities for play as well as work. The cultural programme included a wonderful organ recital in the Cathedral and a tour of the city's Baroque museum under the expert guidance of its curator. In between the conference sessions, we had pleasant warm weather in which to wander around and admire the city. Then there was the food and drink. We were introduced to all sorts of delicious Croatian specialities, and the buffet lunch in the 18th century palace of the Prefect (Mayor) of the City was only one of many memorable feasts. We made many friends whom it will be a pleasure to meet again at future conferences, and our thanks are due to Professor Kulenovic and his committee for their hard work and warm hospitality.

Conclusions

At the end of the Congress, the organising committee published the following conclusions:

1. Since the last Congress, the ideas of the Balint movement have been spread all over the world, especially in the East European countries. The Federation has a duty to encourage and assist the inclusion of new members.
2. The Congress participants have agreed that Michael Balint's ideas can be applied to professions other than medicine, and that
3. Balint-training should be included not only in the education of doctors, but also of nurses, teachers, social workers and allied professionals at both undergraduate and postgraduate level.
4. The experience of the participants from Croatia confirms that the Balint-method is one of the most applicable in the psychological care of persons afflicted by the war.
5. The Congress recommends the Federation to concentrate on shaping an educational programme for the conductors (leaders) of Balint-groups between now and the next International Congress.

JOHN SALINSKY

The American Balint Society

24th April 1993

The American Balint Society's annual Workshop was held in the Hyatt Regency Hotel, San Diego, California, on April 24th 1993. As in previous years, the workshop was attached to the much larger conference of the Society of Teachers of Family Medicine (STFM) which began in the same venue, on the following day. This arrangement enables those members of STFM who are interested in learning more about Balint to attend the workshop simply by arriving at the conference a day early. In addition there were, this year, a number of contributions by Balint Society members in the main conference programme, which I shall describe later.

The Saturday afternoon workshop was attended by about 60 family doctors and clinical psychologists, all involved in family medicine training programmes. After a welcome from the president, Dr. Frank Dornfest, the workshop opened with a talk by Dr. Rex Pittenger, perhaps the most senior of American Balint doctors. He worked with Michael Balint in England in the 1950's and has been running groups in Pittsburg ever since. Dr. Pittenger described the history of Balint in America and outlined the main aims and methods of Balint-training. Dr. Laurel Milberg, the society's secretary/treasurer, then gave some practical advice about how to start and run a Balint-group for family practice residents (see page 17). She was followed by Dr. Paul Scott, a psychoanalyst with long term experience in Balint-groups, who spoke about the role of the group-leader. These three papers were followed by question and discussion with many contributions both from those leading groups and those hoping to do so. There was general agreement that Balint-groups were well attended and much appreciated by the residents (trainee family doctors). One common problem was the tendency of residents to bring to the group a lot of the problems of the junior doctor's life — including conflicts with consultants, anxiety about professional identity and the stressful effects of an excessive workload (sounds familiar!). Everyone agreed that these concerns needed to be given space somewhere and they emerged in the Balint-group because it was the 'softest' (ie. least structured) part of the curriculum. One suggestion from Professor Don Ransom was to build into the curriculum something even softer than a Balint-group. There was an interesting divergence of opinion over whether residents did better in groups with colleagues from their own year, who were at the same developmental stage, or whether a group was more likely to benefit from a mixture of juniors and seniors.

The next part of the programme was a demonstration group led by Dr. Bob Dozer from Santa Rosa, California, and myself. We had a single case, presented by the only woman in the group, about a wife who had returned to live with her violent husband, despite the misgivings of her doctor. For a long time the male group-members seemed to want to protect their female colleague by not accepting that the husband could also be seen as a patient with human feelings needing to be considered. However, towards the end of the session, he was 'allowed in'. By this time, those in the outer circle were, of course, desperate to have their say and there was a general discussion of the case and of the leaders' contributions. During the demonstration I could see Don Ransom making a note every time I opened my mouth! In the end, I felt that I had not done too badly, and was certainly treated very respectfully, although not uncritically! The workshop concluded with the Annual General Meeting of the American Balint Society, in which Professor Clive Brock of Charleston, South Carolina, was elected to serve as the next president.

On the following day, the full conference of some nine hundred STFM members assembled to discuss many aspects of family medicine and its teaching, including the changes to the American health care system which might be anticipated from the Clinton administration. However, Balint was not forgotten. On Sunday morning there was an excellent paper on Balint-groups for medical students given by Dr. Alec Chessman, based on his work with medical students at Charleston.

On Monday morning there was a 'Balint-breakfast' at 7 a.m. (a little early for your correspondent, although it was still only 11 p.m. the night before according to British Summer Time). This was one of a number of 'common interest breakfasts' in which conference members could share a cup of coffee and a bagel with some kindred spjirits around a circular table and discuss their particular professional passion. The Balint-breakfast proved so popular that a second table had to be drawn up next to the first in order to accommodate all those who wanted to join in. They included a number of people who had missed the workshop the day before but were eager to learn more about 'how to do Balint' in their training programmes.

Later on that morning there was a 'Meta-Balint' group whose aim was to provide a supervision experience for existing group-leaders and help them to overcome feelings of isolation. Participants were invited to bring tapes of their own groups for analysis — but in the event nobody produced one. We divided into three small groups of about ten people in each and everyone was invited to present their group and its problems as if it were a 'case'. At the plenary session that followed everyone seemed to agree that this had been an illuminating and rewarding

way to spend the time. I came away impressed, as usual, by the vigour and enthusiasm of our American colleagues. I strongly recommend a visit to the International Conference in Charleston, South Carolina.

JOHN SALINSKY

The American Balint Society

The American Balint Society will host the

9th International Balint Congress

Balint Training in the New World

in Charleston, South Carolina, U.S.A.

9th-13th November, 1994

To obtain further details about the Congress, will all those interested in attending, please inform as soon as possible:

Mrs Odessa Ussery
Office of CME
Medical University of South Carolina
171 Ashley Avenue
Charleston, South Carolina 29425-2201
United States of America

Report from the South African Balint Society

Annual Balint Weekend Workshop: 30th May, 1993

The weekend was held in Capetown, and started with a registration cocktail, when Dr. Furman welcomed all those present. He thanked Fisons for their continued support of the Society, and thanked Sara Kennedy, the Area Manager, for being present and asked her to convey to the company the appreciation of all its members for making this annual event possible.

There was an interesting mix of people at the weekend workshop. There were three final-year students from UCT and also three vocational trainees. There were two doctors who had never been exposed to Balint-work and there were two other doctors who had only previously been at a Balint workshop at the 8th GP Congress in Sun City.

Stanley Levenstein explained that the workshop was really a 'taste' and not a 'meal'. Most Balint-groups need a long period of time to become cohesive, so this may not be possible over the weekend where some people observe other groups. The weekend workshop gives us time to look at how other groups work which we do not do too often. It also gives us the opportunity to look appropriately at the process of the group. He stressed that the format of the weekend was going to be case presentations where the presenting doctor would present cases of difficulty in relating to patients, not necessarily psychological problems. He stressed that Balint is not psychiatry or psychotherapy. We are about the doctor/patient relationship.

He said that each of us had different problems and different kinds of patients who bring us different problems that can be useful to work with. We do not present theoretical topics. In this way the group can become more meaningful for us. He stressed we are not therapy-groups and we are not at the weekend to analyse each other. We prefer to keep the discussion within the context of doctor/patient relationshop. He said obviously there is an overlap, therefore the trust in the group is important to enable the doctor to feel safe. He stressed that the group is not to give advice to the presenting doctor. He also stated that the expectations of the facilitators were often too high in participants. The facilitator does not always have the answer as there is no right way or wrong way, only different ways. The group facilitator can help focus the group on important issues. Often this is not very structured. Our medical school training gives us a systematic, structured and didactic approach which does not enhance the understanding of the doctor/patient relationships. He asked doctors not to use notes as Michael Balint pointed out that what was not said by the presenting doctor was often important.

It was decided to change the format of the weekend from previous years and to try to adopt the Oxford system, ie. the first night to have a 'fishbowl' group and then on the following day, for each group to work separately and then meet again for a feedback session. The first fishbowl group was Stanley's ongoing group where a doctor presented a case of a patient with whom he felt very uncomfortable. She first was his friend and then worked with him before becoming his patient. The case revolved around his problems in getting to the core of what was worrying her. She also gave him a gift which made him feel very uncomfortable. It was interesting how some people interpret a gift, from gratitude, affection, specialness, to anger, hostility, resentfulness and abandonment.!!

It was a very interesting case to start the weekend, and a lot of people felt that the group was over-protective of the presenting doctor.

On the following day we were divided into three groups, each having two co-facilitators. In one group, a doctor presented a lady of about fifty years of age, who liked to phone continuously and did not like coming to see him. When she did attend, she presented as burnt out, but did not want anybody to know that she had psychological problems. She did not want to come across as weak and tried to get the doctor to give her a physical diagnosis for the illness. She used to come often without appointments and virtually barge in on the doctor. Her boss was not happy with the doctor's management and referred her to his own general practitioner who, in turn, referred her to a physician. Then she came back to her original doctor who found it difficult to set limits with her.

Another case involved a 24-year old female with a terminal illness. The doctor had never discussed death with her and when she had summed up the courage to do this, she went to pick flowers on the way, to give to her. When she arrived at the patient's bedside, the patient was in a coma and died the next day. She felt this had been a 'missed opportunity' in their relationship.

Another case in that group was of a 20-year old man who had been involved in a shooting accident and had a spinal cord injury at the T8 level. He was very demanding and the doctor felt did not treat him with respect. The doctor was not sure whether the patient was really in pain and if he was, what was causing it. He was worried that the patient was becoming addicted to morphine. The doctor's therapeutic regime was exhausted and he found it very difficult to cope with the patient.

Final case in this group was of a doctor presenting a patient who he felt very uncomfortable with. She was a female patient who tended only to come when it was really necessary as her husband had been retrenched.

She tried to make contact as much as possible over the telephone which usually was towards the end of the day which irritated the doctor. He suspected there was more underlying her facade and that she was scared to come and talk to him in case the facade broke down and then he found out what really was the problem although the patient denied there was anything 'wrong'.

In the feedback session it was generally agreed that this was the preferred way of running the workshop, going into the small groups. It was found to be more successful. One member who had previously been at a Balint weekend felt that as the group got to know each other, it was easier to work and one could cover more ground in subsequent cases. Another doctor expressed that it was a better opportunity to be in different groups and to see how other facilitators worked. It was decided to run future workshops on the same format.

Dr. Furman once again paid tribute to Fisons and informed the meeting that he had received the fax from Jenny Price, Product Manager, wishing us a successful weekend. He also thanked the Fisons team for giving up their time to be with us at the cocktail party and also at the lunch on the Monday. He also thanked Rose Jonker for her help in administrating the weekend. The doctors were asked to fill in feedback sheets which would help in the planning and the timing of the 1994 workshop.

SAVILLE FURMAN

International 'Balint' Award 1994 for Medical Students

For 20 years general practitioners, clinic doctors, staff members of universities and medical students have met for international seminars at the historical 'Monte Verita' (the mountain of the truth) in Ascona. With their function as university influence, they are known under the name for 'Ascona-Model' (WHO) and their main purpose consists of Balint teamwork. This means an examination of the doctor-patient relationship in a group setting.

Medical students are invited to submit a paper based on their personal experience of relationships with patients. An award of Sfr. 10'000 will be made to authors of the best description.

The criteria by which the reports will be judged are as follows:

1. Exposition. The presentation of a truly personal experience of a student/patient relationship. (Manuscripts of a former medical thesis or diploma cannot be accepted.)
2. Reflection. A description of how a student actually experienced such a relationship, either individually or as part of a medical team. This could reflect multiple relations between students and the staff of various specialities, and working routine within different institutions.
3. Action. The student's perception of the demands he/she felt exposed to, and an illustration of how he then actually responded.
4. Progression. A discussion of possible ways in which future medical training might enhance the state of awareness for individual students, a procedure which tends to be neglected at present.

Three copies of the composition, each containing the author's name and **full address** should be posted, not later than **January 31st, 1994** to:

Prof. Dr. med. Dr. h.c. Boris Luban-Plozza, Collina, CH-6612 Ascona.

The presentation of prizes will take place in Ascona on 23rd April 1994, Monte Verità.

All information can be obtained from Foundation of Psychosomatic and Social Medicine, CH-6612 Ascona.

Programme of Meetings of the Balint Society for the Twenty-Fourth Session

1993-94

The following meetings will take place at the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London, SW7, on Tuesday evenings (except 22 October) at 8.30 p.m., preceded by coffee at 8 p.m.:

Dr ANDRE TYLEE, Senior Lecturer, Devision of General Practice & Primary Care, St George's Hospital:
The Recognition of Depression in General Practice. (Friday) 22 October 1993

Dr ROB HALE, Consultant, Tavistock Clinic:
General Practice Work at the Tavistock Clinic. 16 November 1993

Dr SOTIRIS ZALIDIS, General Practitioner, Hackney:
Hyperventilation in General Practice. 15 February 1994

Dr ALEXIS BROOK, Psychoanalyst, London:
The 11th Michael Balint Memorial Lecture
Psychological Aspects of Eye Disorders. 15 March 1994

DAVID FREEMAN, Rabbi & Jungian Analyst:
Problems of Guilt in General Practice. 19 April 1994

(Non-members are welcome, free of charge.)

Other Events:

LONDON DAY CONFERENCE:
(Full details to be announced) 19 May 1994

The ANNUAL GENERAL MEETING, 1994
will take place at the Royal Society of Medicine: at 7.30 p.m. 14 June 1994

The OXFORD BALINT WEEKEND, 1994
will take place at Lincoln College, Oxford:
from Friday at 6 p.m. 16 September 1994
to Sunday at 1 p.m. 18 September 1994

The Annual General Meeting, 1994

will take place at the Royal Society of Medicine at 7.30 p.m. 14 June 1994

The Oxford Balint Weekend, 1994

will take place at Lincoln College, Oxford:
from Friday at 6 p.m. 16 September 1994
to Sunday at 1 p.m. 18 September 1994

All meetings are PGEA approved.
Further information available from the Hon. Secretary, Dr David Watt.

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.

The Balint Society motif kindly designed by Mr Victor Pasmore, C.B.E.
Produced by Haverstock Publications, 249 Haverstock Hill, London, for the Balint Society

Printed by The Galloway Gazette Ltd., 71 Victoria Street, Newton Stewart, DG8 6PS