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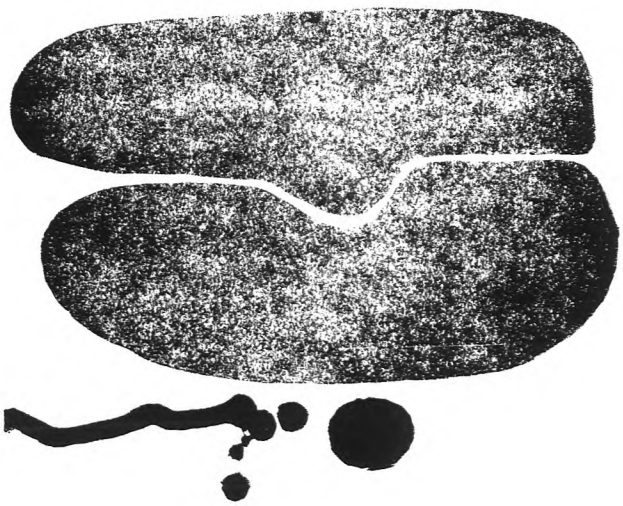

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Editor: Philip Hopkins

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Dr. Jack Norell with a special and well deserved award, the 'Pro Sanitate' medal, presented to him by Dr. Mihaly Kokeny, the Secretary of State of the Ministry of Welfare.

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.

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 32), and the Journal is circulated each year to all members.

Editorial

Time for congratulations again, first to Dr. Endre Schnell, Dr. Kornélia Bobay and Dr. Boga Balint, for organising a highly successful International Balint Centenary Congress in Budapest in May, this year, and for their remarkable achievement of attracting 227 delegates from 23 countries (page 51).

Congratulations also, to Dr. Jack Norell who received a special and well deserved award for his services to Hungarian medicine, and to other East European countries, in his capacity as the International Balint Federation Ambassador to Eastern Europe, at the Congress (see *Frontispiece*).

When Jack was President of the International Balint Federation, he reported in the 1992 issue of this Journal that there were then fifteen countries with Balint Societies affiliated to the Federation, and twenty-two others which were associated with the Balint movement.[1] Other countries have formed Balint Societies and have become affiliated to the Federation since then.

Almost half the delegates attending the Congress came from East European countries, where doctors are having to adapt to the upheaval of enormous social changes. They have found help by forming Balint-groups, as described in his country, for example, by Dr. Vladimir Vinokur, president of the Russian Balint Society (page 23).

The circumstances may well be different, but the underlying problems and difficulties in dealing with so many patients are remarkably similar. Here in the United Kingdom, a number of us accepted the Balints' invitation to attend their first seminars in the early 1950s, in an effort to find a way to adapt to the social changes which followed the end of the second World War, together with the introduction of our National Health Service when, for the first time, huge numbers of people were able to obtain medical attention without having to pay for it when it was needed.

Of course, many other countries followed our example when the news spread around the world that here was a method like no other, which could help doctors to recognise the importance of the doctor/patient relationship and learn how to make good use of it, even in the limited time usually available for each patient. The state imposed system failed from the start, to recognise the importance of the right setting and the need for adequate time for the consultation between the patient and the doctor.

This became clear to me after only three years in general practice,[2] and even more so, after working in Balint-groups for many years. Why have doctors in so many other countries overtaken us with regard the popularity of Balint-groups? If doctors under pressure in other countries recognise their value, why are British doctors different?

And is there any connection with this and the reported rise in doctors' stress?

Two other award winners also deserve our congratulations: the first is a well known member of the Society, Dr. Sotirios Zalidis, for his Balint Society prize essay for 1996, on *The Human Face of General Practice* (page 25); and the other, Dr. Tim Young, a 4th year medical student at King's College Hospital, for his International Balint Essay Award for 1996, on *Personal Dimensions of the Hospital Encounter* (page 33).

Congratulations must go to Dr. Andrew Elder and Dr. John Launer for their appointments as Consultants in General Practice and Primary Care to the Tavistock Centre. Perhaps we may look forward to the results of their efforts to encourage general practitioners to review the possible causes of their stress, and to find methods to deal with it.

When all the speakers have sent me the manuscripts of their Congress lectures, I will publish them all in a special Centenary Congress issue of this Journal. In the meanwhile, I am very pleased to print some of those lectures which are available, including the lecture given by Professor John Balint (see page 8), and which space allows.

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P.H.

Historical Leaders of the Balint Movement and the Leaders of Next Millenium: Continuity in Training*

Michelle Moreau-Ricaud
Psychoanalyst, Paris, France.

This year marks both the centenary of psychoanalysis in Vienna, and the centenary of the birth of Michael Balint in Budapest. It also marks a half-century of the Balint-group – Michael and Enid Balint's baby – the little monster half-Hungarian psychoanalysis and half English group-method, nurtured in the cradle of the Tavistock Clinic in London.

This Anglo-Magyar baby behaved like the famous 'wise-baby' (Ferenczi, 1923): he actually trained all fourteen doctors, ill at ease in the temple of medicine,and continues to train generations of doctors! Some of these enthusiastic 'guinea pigs' (Balint, 1957), still go on transmitting the Balint inheritance and are present at the centenary! I hope that Philip Hopkins and the 'old guard' will excuse this expression. Balint applied to them himself, when he referred to his own training in the Berliner Policlinic: we salute them for their courage of pioneers in this new medical Utopia.

At the Ferenczi Congress, held in Paris in 1992, organized by E. Brabant, the Centre d'Etudes Hongroises and the Centre Culturel Hongrois, I tried to reconstruct the origin of the Balint-group, born in the early '50s, a hybrid of the Freud-Ferenczi legacy and of the Harvard Business School training (Moreau Ricaud, 1992). A new science from old Europe mixed with the 'new look' of efficiency from the new world! I have only the time, here, to focus my paper on the training of the founders of the method, and the transmission of their training.

Historical leaders:

What was the cultural background of Michael and Enid Balint?

Michael Balint (1886-1970) was the son of a physician, Ignac Bergsmann, who lived in Baross utca, and was much esteemed by his patients. But his stern personality and severe education standards – and his orthodox Jewish beliefs – provoked conflicts and revolt during Michael's adolescence, as Michael recalled to a journalist (Swerdloff, 1965). But the father seems to have initiated his son into medicine by taking him along with him for visits to patients' homes. Growing up in this atmosphere, he knew, before commencing his medical studies, 'a lot of things from outside' (Hopkins, 1970). He described his choice of medicine as the path of least resistance: 'Why not medicine? It is open enough.' (Swerdloff 1965, Moreau Ricaud 1987). But it was not enough for his enormous curiosity. He was interested in biochemistry and physiology, working for a time as a 'demonstrator' (Institute of Physiology, then Institute of Hygiene). He got his medical doctorate in 1920,and a doctorate in science at the University of Berlin in 1924. Eventually, he became a psychiatrist in Budapest.

Meanwhile, he had met love and psychoanalysis in the person of Alice Szekely-Kovacs, daughter of Vilma Kovacs and 'adopted' daughter of Frederic Kovacs – an architect and sponsor of the analytic Movement who built the famous house, Meszaros utca, where the Balints lived and where the Policlinic was established. Alice converted Balint to the family disease: the analytic 'plague' by making him read *Totem and Taboo* and *The Three Essays on Sexuality* – two Freudian works which would continue to influence him throughout his life.

Another crucial influence was Ferenczi through his lectures given at the university during The Commune (1919), and by a second analysis with him (1924-1926). Was Balint torn between psychoanalysis and science?

In Berlin, he experimented: his first analysis and two analytic supervisions which helped him to consider every patient like 'E.T.', that is to say as someone 'integrally new' (Balint, 1927).

He treated psychosomatic patients at the Charity Hospital, and worked also in drug-testing at I. G. Farben!

His multidisciplinary approach enhanced the already wide-ranging fields of interest of his colleagues in the Budapest school. Let us remember Ferenczi, Hollos, Roheim, Kovacs, Alice Balint, Hermann, etc., from medicine, psychiatry, ethnology, anthropology and psychology.

He worked with Alice till her death in 1939, as a true little research team. They 'read, studied, lived and worked together', exchanging and mixing ideas (Balint, 1965), and he 'had the habit of elaborating with her all his tiny vague ideas' (Balint, 1940).

Furthermore (Moreau Ricaud, 1987) he had a medical practice (and even emergency work later in Manchester), he did laboratory experiments in biochemistry, he had a psychiatric practice, and ran a Policlinic; and he did even 'psychology', as he said ironically, after the research on infant nutrition – about sucking – which gained him a Master of Science degree in Manchester. Also two analytical trainings: one, orthodox with Hanns Sachs, in Berlin; the other (paradoxically more demanding!) with Sandor Ferenczi, in Budapest and two supervisions (Eitingon and Liebermann), which was for the present discussion, his most relevant training.

*Dedicated to Judith Dupont and John Balint.
*Address given at 10th International Michael Balint Congress, in May 1996 in Budapest.

Enid Albu (1904-1994) was born in London in a wealthy family. She studied at Cheltenham Ladies College, and then at London University where she gained a Bachelor's degree in Economics. She married a teacher of philology (Eichholtz) and had two daughters.

During the war she worked in the Citizens Advice Bureau, aiding people traumatised by the bombing. There she was confronted with irrational conduct and anxiety. It may be that she discovered the beginning of the solution of the enigma in her husband's study: Freud's *Interpretation of Dreams* (Sklar, 1995). She was first analysed by John Rickman, and later by Winnicott.

We should note here, the proximity of ideas of our historical leaders, which made possible their future collaboration: they belonged to the same School of thought, linked to the same brotherhood: Rickman was Ferenczi's analysand, and also Winnicott's analyst.

Enid Eichholtz began to work with the Family Discussion Bureau and trained social workers: she prepared them to help difficult and disrupted families. She used the 'casework' study method. A 'client' case is reported, by someone with a complete dossier, and the group discusses it, in order to find a collective solution. Imported from the Harvard Business School to England, this method was applied to the social field, to train students (Moreau Ricaud, 1995).

Both Michael and Enid had a strong psychoanalytic, academic and research background. They met at the Tavistock Clinic when she was 46, and he, 53. In addition to their 'affinités électives', they had in common their passion for analysis, for training, for social field. And for research and ... experimentation!

In the early 1950s, Balint proposed a seminar-system, which he had experienced in Budapest (M. Balint, 1926) and, as he recorded in the British Medical Journal (M. Balint, 1954), 'We started by advertising "introductory courses in psychotherapy for general practitioners" in the medical press ...' instead of courses of lectures, which he had observed to be 'useless.' He adapted the method he used with Enid for the social workers to use the therapeutic relationship, introducing the fundamental rule of psychoanalysis: free association.

Enid and Michael were the first couple of leaders (also a couple in private life – which complicated the transference!). They led the group in a 'complementary' way (Bernarchon, Clyne). He was open, outspoken, lively; but sometimes very tough, never letting the reluctant doctor go, pushing him to his limits. She was discreet, always available, spoke rarely; but she would intercede to reassure or relax the group. And, sometimes, she would bring Balint's theoretical flights down to earth! (Moreau Ricaud, 1995).

She told us, here, ten years ago, how exciting it was to interact with him all the time, on holiday and walking in Regent's park. He wrote that she helped to clarify his thoughts, to 'expand his ideas' (Balint, 1858) and bring them to fruition. For the second time, Balint found an 'accoucheuse' (midwife) for his ideas.

Reception of the method and following generations of leaders

Such formidable, exhaustive training, might have discouraged followers; but, on the contrary, it was stimulating: a lot of groups flourished and did original work:

In England: many books were written and Balint's original research was continued. Some examples follow: Balint, M. (1957), *The Doctor, his Patient and the Illness*; Clyne, M. (1961), *Night Calls*; Friedman (1962), *Virgin Wives*; Malan, D. H. (1983), *A Study of Brief Psychotherapy*; Lask, A. (1966), *Asthma*; Balint M., Gosling R., Hildebrand P., Balint E. (1966), *A Study of Doctors*; Courtenay, M. (1968), *Sexual Discord in Marriage*; Hopkins, P. (1972), *Patient-centred medicine*; Malan, D. H. (1963), *A Study in Brief Psychotherapy*; Norell J. & Balint E. (1972), *Six Minutes for the Patient*; S. Bourne (1981), *Under the Doctor*, Avebury Publishing Co.; and Greco H. A., Bacal, etc. As for the leaders; the first were co-opted by the Balints. They came from the British Psychoanalytic Society, some were researchers at the Tavistock Clinic, some were general practitioners from the Balint Society.

In Germany the situation was similar; some analysts kept a link with Balint, in spite of the war problems. They were very productive: many groups appeared and many books were written along Balint lines. In the university the curriculum integrated Balint training.

In France: here too, some authors were directly inspired by Balint research: N. Bensaïd (1979), *La consultation*, Paris, Denoël; Faure, F. (1978), *La doctrine de Michael Balint*, Paris, Payot; Guérin, G. (1988), *L'enfant inconcevable*, Paris, Acropole; Israël, L. (1968), *Le médicin face au malade*, Bruxelles, Dessart; Missenard M. & Gelly R. (1882), *L'expérience Balint: histoire et actualité*, Paris, Dunod; Raimbault, G. (1973), *Médecins d'enfants*, Paris, Le Seuil; Rosowsky O., Goedert J. (1976), *Une guérison impossible*, Paris, Payot; Valabrega, J. P. (1962), *La relation thérapeutique*, Paris, Flammarion. And P. Bernarchon, P. Benoït, Ch. Brisset, J. Cain, S. Cohen, R. Dufour, V. Gachkel, J. A. Gendrot, J. Guyotat & coll. M. Sapir wrote important articles. And many doctorates on the doctor-patient relationship – the first one by F. Sacco (1966), *Information et formation des étudiants en médecine*, Paris.

Such success may be understood through many factors and numerous problems in different fields: the generalist practice was discredited (Cf Le Livre blanc de la Médecine) and psychosomatics developed; the great 'patrons' from the hospitals, Profs Kourilsky and Gosset (from medicine and surgery) wanted to work with analysts; analysts were going through institutional difficulties about the Training Institute which was to

explode in the first schism of 1953. Balint criticisms on the training were welcomed.

On the institutional level, the story seems more complicated. As for psychoanalysis, it is obvious that a Balint Movement existed before the very first medical society was founded and named after him in 1967.

My own perception of Balint's reception is that there was a sudden interest in Balint. Balint became known by analysts for his book *Primary Love and Psychoanalytical Technique* (1952); which was reviewed in *Internat. J. Psychoanal.*, 1953, 34, pp328-329. In 1953, while revolt was simmering among analysts and their trainees in the then unique Société Psychoanalytique de Paris, about the creation of the Training Institute, Balint's article 'On psychoanalytical training' circulated privately.

After the first analytical schism, Balint was invited by Prof. D. Lagache, on the 25 May 1954, to lecture to the new society: the Société Française de Psychanalyse (1953-1964) on *Formation des Omnipraticiens à la Psychothérapie.*

The 'pupils' Smirnoff, Granoff, Valabrega were enthusiastic and proposed translations of his articles. In 1960 Valabrega translated his first book, *The doctor, his Patient and the Illness,* first edited at P.U.F. (then Payot), which made Balint's ideas accessible to everyone. He too began the very first Balint-group with J. Cl. Lavie. Since 1954, Emile and Ginette Raimbault went regularly to London to be trained by the Balints and began to direct a group (1959) and then with Gendrot (1962) in Saint Antoine Hospital, in Kourilsky's ward. Then Benoît (1962), Gachkel (1963) had groups. Groups expended in provinces: Israël (in Strasbourg, 1965), Guyotat (in Lyon, 1966), Cain (Marseille, 1967), Dupré & Guérin (Rouen, 1968), etc. In 1964, the *Second International Conference on Training* was held in Versailles, under the presidency of Kourilsky, one of the two 'Patrons', with Gosset, who were convinced that 'kindness, goodness, a pat on the adult back and a caress of a little girl is useless ... the doctor needs to be trained, not the patient'. They were near Balint's ideas but did not find the solution. And the French called, according to Gosset, 'cautiously' the training-cum-research group, 'Balint group'. Many groups experimented everywhere ... when during 1965-1967 something happened. It appears the first physicians' testimonies or Archives (Delasnerie's personal archives) that tensions disappeared among trainees, and between trainees and leaders (the Marignan Group); Rosowsky mentioned 'historical ambiguities, never elucidated', concerning the foundation of a Balint Society, which some general practitioners wanted. A little number of the trainees decided to found a Society of '*users of the Balint Groups*'. They wrote to Balint and before his welcoming answer they founded the Société Médicale des Groupes Balint (S.M.G.B.) in June 1967.

But such a success did not last.

Prospects for next millenium

There are many problems: some leaders have died, others are retired or discouraged, some have left the Balint Boat (S.M.B.). *How can these prestigious elders-who-have-met-Balint be replaced?* Every Conference denounces the psychosociological 'drifters' ... but rarely those who return to the common roots (*esprit de confrérie*). Nevertheless, both tendencies depart from Balint's originality: the study of preconscious or 'unconscious manifestations in doctors' attitudes, in practice.

Confessing to a journalist in the sixties, that he was 'considered as a revolutionary' and 'attacked' for that since the age of fifteen but 'hope(d) die so' (Swerdloff, 1965) can we apply it to the process of training he gave us?

It is obvious for the pioneers. Their style and the works of the first generation convince us. And, 50 years later it still appears so to many trainees and leaders. And Balint has fulfilled Ferenczi's wish to invent something for those who do not want to become analysts. (Freud Ferenczi Corresp). May I make some remarks:

Balint's pragmatism was quite an English habit; and the group technique was the basis of training at the Tavistock Clinic.

Since Bion worked at the Tavistock Clinic (1933), everyone was convinced that the group was the best therapeutic method (Foulkes), and the best training. Its 'process of transformation' was known since the 'genius Bion' (Anzieu) created his successful experiment in Northfield Hospital, during the 2nd World War.

Balint admitted the influence of the analytic method (Freud and the Hungarian supervision), but he never mentioned Bion's influence on his discovery. Why? It is true that he modestly spoke of the 'Tavistock method', before the 'training-cum-research' group.

On the other hand, what appeared 'revolutionary' to me, was to apply it in medicine where master-pupil relationship is at its worst. It is still a challenge to make ignorance acceptable to somebody who is called 'doctor' before he realises that *the master is the patient*! And the new setting, is a 'laboratory' for doctors, in collaboration try to develop insight in the 'deferred action' of his consultation. Generally this leads to the abandonment of traditional attitudes, and beginning of insight into one's own feelings and thoughts.

But others demand more than this 'limited though considerable change of the personality'. How far can we go? Did Balint foresee that his research would be a failure on an extensive level, but a success on the intensive one? It seems that once, in London, the 'virus' attacked general practitioners weakened by the training, and they longed to become leaders. In France, this type of contamination is very recent, but is extending to para-medical workers too. We have at the same time to be vigilant about the mode of transmission, but to realise that *things have changed*: after 100 years of 'latin' disdain, the 'young science' has taken in our culture. Physicians, nurses,

speech therapists, physiotherapists, social workers, etc., read Freud and other analysts work with difficult patients, psychotics, aphasics, drug addicts, and so on ...

Since the '50s many of them have been analysed, and sometimes the stimulus was the Balint-group (cf. Interviews Drs Delasnerie, Canet). Maybe this does not mean failure. And if everybody agrees that a certain percentage of trainees benefit of it for their practice (and, who knows? in their lives) is it impossible to imagine the group can help them to go through a little narcissistic ... but bearable upset?

We do not ignore this everlasting resistance: 50 years later, we continue to avoid thinking of the group in terms of 'psychotherapy'. But Balint was not a 'wild analyst': he knew that his group, *task-centred* as it is, had nevertheless indirect therapeutic aspects! What else is this famous 'change' in the doctor's personality which modifies communication with the patient? However, it took 30 years for analysts to decide to train themselves before training patients, and, then, they spoke of 'didactic' analysis!

Will succeeding generations have, after illness-centred medicine, and patient-centred medicine, a *'doctor-centred' medicine*? The change is limited because the regression is limited: happily, the group has a task to cope with. But may the trainees, in a containing group, find from time to time an unknown part of themselves, as in Karinthy's short story (Karinthy, 1993), his 'little I' who mocks his 'big I', and they get rid of him! Or the Freudian little polymorphous perverse hidden child, who plays tricks on the serious repressed adult, and particularly on the doctor-who-plays-the-doctor!

Essentially, whether he is taught or treated, a general practitioner, or a specialist, who intends to become a group-leader, can not 'economise' on a personal analysis, at least if he wants to be accredited: it is the position (of compromise) that we thought wise to adopt in France.

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The Doctor, his Patient and the Illness – Re-visited*

Forging a New Model of the Patient/Physician Relationship

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The patient/physician relationship has been a constant feature of health care until recently. It was essentially based on trust, some degree of paternalism, family involvement and evolving mutual understanding and at its best, it was a sound basis for medical care in its fullest sense. Decisions depended on medical indications, patient preferences, judgements about the quality of life, and other issues such as family and social circumstances, and religion.[1]

The rising preoccupation with the costs of medical care both in the U.S.A. and in the U.K., have led to the rapid development of various ways of controlling it, most notably by introducing managed care. Many consider this as creating a conflict of interest for the physician, who is expected to accept responsibilities towards society at large, as well as fulfilling his/her traditional role of advocate for the patient. This is clearly not well suited without modification, to a relationship which evolved at a time when there was little or no financial restraint.

I want to discuss with you the idea of a new model for the patient/physician relationship called the patient/physician alliance in the community, which retains the fundamental features of the old models and, in addition, takes in the acceptance by patient and physician of rational responsibility for the appropriate uses of resources, and to examine the historical and social forces which have contributed to these changes and the effects they have had on the traditional models of the patient/physician relationship.

The alliance can create the initiative in shaping the evolution of the health care system because it can speak with the united voice of patients and physicians.

Historical Overview

The current dilemma has been well described by Angell, who notes that pressures for physicians to become 'double agents' by having to act as agents for society and not simply as advocates for their patients.[2] Angell argues that physicians must work 'unstintingly' for each of their patients and at the same time work for health care reform to guarantee universal access under a global budget.[3] Even though this would ensure access to some level of care for all citizens, it is not clear however, how such a system would relieve the dilemma of double agency, and it would still be dependent on the size of the budget. At the same time, Brennan concluded that the physician could no longer treat individual patients without certain limitation, and asserts that they must recognise that decisions made about one patient affect all other patients, and that the idea that the concept of the 'moral interconnectedness of medical care' must be accepted.[4] He also recognises that traditional patient/physician relationships depend on altruism, trust and virtue, and agrees that these characteristics should be preserved and extended to the 'whole class of patients,' and he argues that the ethos of health care policy must be grounded in commitment to individual patients, provided orientation to the community, and that health care institutions such as hospitals and other managed care organisations must adopt the same altruistic and caring moral attitudes expected of physicians.[4] Wolf has made a good case, with a plea for the development of institutional ethics for managed care organisations, that will delineate their responsibilities and duties to patients so as to lessen the burden on physicians.[5]

Concern about the increasing influence of these external influences on the patient/physician relationship has been expressed by many, including Siegler, who has suggested that it is inevitably changing, and eroded by them.[6] This is true, of course, for all similar issues, especially access to patient/physician relationships and medical care occurring in all Western countries. The current crisis with regard the patient/physician relationship from the clash of: (i) the steady growth of the concept of individual freedom, and the increasing emphasis on individual autonomy; (ii) the enormous development of scientific medicine, especially in the past fifty years, with the increased ability for physicians to cure, and not only care, together with the increasing demands for physicians to do just that; (iii) the social forces which have moved medicine from a relatively elitist context to a democratic one, as evidenced by the National Health Service in the United Kingdom, and Medicare and Medicaid in the United States of America, with their implied promise of universal access to care. Governments have thus acquired an enormous stake in health care; (iv) the realisation that society's resources available for health care are limited, has resulted in the need to reduce expenditure on health care, with subsequent breakdown of the social contract

* Paper delivered at the 10th International Balint Congress, Budapest, 1996. Based on a new model of the patient/physician relationship, by John Balint and Wayne Shelton, in *Journal of American Medical Association*, 1996; **275**:887-891.

**Also Director of the Center for Medical Ethics.

implied in the legislation that established government role in providing health care, leading to a greater burden on recipients and restriction of their access to health care.

Medicine moved from a relatively elitist context to a democratic one at the same time as patients' rights and autonomy became the watchwords in both medical research and health care. The same period saw the rapid evolution of the biological and medical sciences. This provided physicians with tools such as instant metabolic information, antimicrobials, renal dialysis, and open heart surgery with which to significantly influence the outcome of disease. This was followed by the progressive evolution of managed health care' and the era of prospect payment for disease-related groups. The result has been a profound change in the patient/physician relationship and a remarkable loss of authority by physicians as decision makers in all aspects of health care.[6-8]

This loss of physician authority, as noted by Starr is all the more dramatic since physicians only gained this powerful position within the past 50 to 75 years. During this period there was also an increasing involvement of persons outside the patient/physician/family triad in the health care system.[9] Such 'outsiders' include among others individuals working for insurance companies whose prior approval must be obtained for admissions and some diagnostic procedures and who monitor lengths of stay in hospital. These changes in patient autonomy, physician autonomy, and the level of societal involvement have evoked varied responses. Some have hailed the rise of autonomy in the name of libertarianism, while others have bemoaned the passing of the era of the physician and the patient and the arrival of the era of the payer.[6] Yet others have made the case for a return to a degree of beneficent paternalism.[10,14] In this article, we want to make the case for a broader view of the patient/physician relationship based on an examination of the relationship of both the patient and the physician to each other and to society and the notion of an alliance between them for the benefit of both the patient and society.

Review of some characteristics of the patient/physician relationship

The traditional view of the patient/physician relationship was implicit in the Platonic description of the free physician, as quoted by Siegler,[12] where the physician examines the patient and then presents the findings and recommendations for management to the patient and the family. This essentially benign, socially accepted, and paternalistic relationship survived through the centuries with relatively little modification until the work of Michael Balint[13] and of Szasz and Hollander.[14] Balint's[13] work described three previously unrecognised aspects of the patient/physician interaction. The first was the recognition of the physician as a 'drug', or medication whose pharmacology was not then and is not now well studied and understood. This concept emphasised the dynamic nature of the relationship that could be benefited or harmed by the appropriate or inappropriate 'dosage' of the physician such as the frequency of visits or interactions. The second aspect was the 'deeper diagnosis', which was to include an understanding not only of the illness but also of the personality of the patient who has that illness, the interactions with family, the social setting, the influence of the physician on these relationships, and an appreciation of the impact of the patient and the setting on the physician. The third aspect of the relationship and one that profoundly influences it was what Balint called the 'apostolic function.'[3] The apostolic function of the physician encompasses the roles of teacher, trainer and moulder of the patient and the family so as to enhance the ability of the physician to help them achieve a beneficial outcome (ie, a fundamentally paternalistic yet beneficial relationship of the physician to the patient). Szasz and colleagues,[14,15] recognised the following three levels of interaction between patient and physician: the first, paternalistic where the physician makes all decisions as would a parent with a young child; the second, still paternalistic but seeking patient cooperation as a parent would with an adolescent; and the third, respect for person and partnership where the physician help the patients help themselves. This last foreshadows the accommodation model of Siegler.[12,16] In that model, Siegler describes the development of a mutual understanding of the goals of care between patient and physician, which is an accommodation that permits the physician to respect patient autonomy and allows evolutionary change over time.

All these formulations allowed for some insulation of the patient/physician relationship from the outside world, fostered a sense of freedom to do whatever was available and seemed best for the patient as long as the autonomy of the patient (or a surrogate) was respected. However, this latter caveat, which only became a major determinant in the past 30 to 40 years, has now become for many the overriding factor in medical decisions. This would lead to what has been called the 'informative' model of the patient/physician relationship by Emanual and Emanual.[17] In this setting, the physician provides information and the patient makes unaided decisions.

The democratisation of health care, the accompanying involvement of government, and rising costs have resulted in steadily increasing levels of intrusion by outsiders or 'strangers',[9] in the making of health care decisions and the imposition of new responsibilities on physicians.[2] These trends have been aggravated by the increasing prevalence of chronic diseases in an ageing population (eg, cancer, heart disease and arthritis) and consequent concerns about quality of life and questions as to who determines quality of life. Thus, the patient/physician relationship has been forced into a much more overtly complex form where the patient/physician/family triad becomes the focal point of forces represent-

ing government, insurance carriers, employers, society at large, and other members of the health care team. These concerns have recently been reemphasised by Emanual and Dubler.[18] These pressures can create a moral dilemma for physicians between their primary duties as their patients' advocate and their new responsibilities to society.

A view of the current models of the patient/physician relationship

Before considering how our proposal for a patient/physician partnership or alliance can be implemented, we must understand the nature of and the tensions within various models of the relationship. We will then examine how these models in the way patients and physicians deal with a common clinical situation.

The Libertarian Model

The trend since World War II has been to enhance patient autonomy. This was beneficial in encouraging physicians to educate their patients and enable them to be active participants in decisions about their care. However, the high level of patient autonomy sometimes advocated[19,20] has in many cases led to abdication of physician responsibility. Indeed, as Pellegrino and Thomasma have argued, this can result in minimalism in care and caring.[10,11] There is also the question of whether physicians have been asked to give up too much of their own autonomy. Too free an exercise of patient autonomy as proposed by libertarians[19] could reduce physicians to the role of technicians. Furthermore, such liberty for individual patients puts the patient/physician relationship on a collision course with society and its limited resources. Thus, this model in its extreme form has inherent tension between theoretical total patient autonomy in making health care choices and the dual role of the physician in promoting the patient's health and yet safeguarding health care resources.[21]

The Paternalistic Model

The paternalistic model had been the rule since the time of Hippocrates and Plato[5] until the rise of the principle of patient autonomy in the past 30 years. Some have argued that when properly used in a caring effort to enhance individual autonomy by educating patients, the paternalistic model is praiseworthy and responsible, much along the lines advocated by Pellegrino and Thomasma.[10,11] This view also goes back to Balint's[13] concept of the apostolic function of the physician. Indeed, if we accept the importance of the physician living up to the name of teacher, some degree of guidance in health care decisions is essential and unavoidable. A teacher cannot help but influence the students' view of things and thus influence their autonomy. This is especially true with sick and vulnerable patients and is consistent with Siegler's model of the patient/physician accommodation.[12,16] Therefore, the paternalistic model has the same inherent tensions as the libertarian model, but with physician autonomy as opposed to patient autonomy in need of modernisation. In other words, the physician must accept responsibility for the appropriate use of health care resources.

Beneficence-in-Trust

This proposal, which is put forward as an alternative to a model of the patient/physician relationship based on patient autonomy, contracts, and market forces, implies a level of physician beneficence based on mutual trust.[10,11] Physician beneficence in this model is based on the physician's understanding of the patient's view of the desired 'good' while the determination of this good that is the desired goal of treatment is based on the physician's understanding of the patient's values. The social factors involved in forming these values are viewed as limited. Indeed, Pellegrino[22] advocates a much more restricted view of the external factors that define a personhood than either Balint[13] (a psychiatrist) or McIntyre[23] (a philosopher). Furthermore, there is limited emphasis on the long-term evolution of the patient/physician relationship (ie, the narrative view of the illness and the relationship). In this model, both the physician and the patient must be educated to exercise prudence in the use of resources.

The Accommodation Model

The accommodation model of Siegler[12,16] assumes an evolving dynamic relationship between patient and physician but does not emphasise family and societal input. In this respect, it shares many features of the relationship as described by Szasz and Hollander[14,15] and by Tumulty.[24] The accommodation model raises similar questions to those noted, even though it too includes considerations of patient autonomy and some degree of physician paternalism. Like the model of beneficence-in-trust, the accommodation model also needs to be expanded to include advocacy for the patients' needs with third parties and recognition of a person's duty, whether patient or physician, to consider social utilities.

The Psychodynamic Model

The psychodynamic model of Balint[13] advocates a more complete or deeper diagnosis, describes the role of the physician as medicine, and describes the educational role of the physician through the apostolic function. While this model was developed from seminars with general practitioners in Britain and dealt mainly with psychosomatic problems, it has application to all patient/physician interactions because emotional, psychosocial, and moral issues enter all clinical situations. However, the model was developed before the era of patient autonomy, questions about paternalism, and 'strangers at the bedside'[9]; therefore, it needs adaptation to these social phenomena if it is to be applicable to current circumstances. Also, questions of patient and physician responsibility for stewardship of societal resources must be resolved.

Case Scenario

Let us briefly consider a case in the context of these models. A 52-year-old man has symptoms of lower abdominal pain that are worse with stress. These symptoms have been present on and off for more than 20 years. His father and paternal uncle developed colon cancer in their late 70s. The man had a screen flexible sigmoidoscopy and barium enema at age 50 years, and the results were negative. Results of annual faecal occult blood tests also have been negative. He now demands annual screening colonoscopy because of his family history.

This patient's concern is understandable and reasonable. He has read articles in the lay press suggesting that colonoscopic screening is a way to early diagnosis and cure of colon cancer. However, studies indicate that his risk of colorectal cancer is probably not significantly greater than average and that development of such cancers is a process that takes a long time. Therefore, annual colonoscopy is not cost-effective and carries an unfavourable risk-benefit ratio.

How would a physician approach this issue with the patient under the different models? In the libertarian model, takes to its extremes, it would be hard to deny the patient's request. However, such extremes are not likely, and a process of education could address the issue. But the physician would need to be willing to take the time and, if committed to the libertarian model, may be unwilling to do so. So in this case, the patient's financial resources or individual coverage would be the deciding factor.

In the paternalistic model, the outcome would depend on the physician's persuasion on the matter of colorectal cancer screening. The physician would educate the patient or merely tell the patient, for example, that a colonoscopy every 5 years, faecal occult blood tests annually, and flexible sigmoidoscopy every 3 years should be used. In this model, the patient would accept the physician's guidance without question, having chosen a paternalistic physician.

In the model of beneficence-in-trust, the physician would attempt to get to know the patient's hierarchy of 'goods'. Then the physician would fit these goods to what he or she believes to be optimal care. This process would involve patient education and some beneficent guidance by the physician and lead to a compromise acceptable to both patient and physician.

The accommodation model would lead to a process similar to the model of beneficence-in-trust. The psychodynamic model may require more detailed exploration of underlying fears on the patient's part and how the physician feels about this patient's concerns and family pressures. However, the end result likely would be similar.

In all these scenarios, however, the critical determinant is the interplay of the physician's understanding of what is effective management and the dynamics of the patient/physician relationship. We believe this interplay turned to advantage in a patient/physician alliance, incorporating evolving mutual comfort and, in addition, an understanding and acceptance of social responsibility.

Toward a new model of the patient/physician relationship

We need now to examine the new social context of health care in a secular, democratic and pluralistic society where individual autonomy has become increasingly important and in which there is now a rising tension between this personal autonomy and escalating concern about the costs of care. Engelhardt,[19,20] a supporter of autonomy, regards these influences as perfectly acceptable. He recognises that the old Hippocratic triad of the physician, the patient and the illness has changed to a pentad with treatment choices and societal input as the new factors. In Engelhardt's view,[19,20] the socialisation (democratisation) of medicine with Medicare, Medicaid, and other factors has led to the establishment or acceptance of civil rights for patients but not patient's rights to health care.[19,20] He further believes that health care can be properly and morally regarded as a market commodity and that health care for profit is morally acceptable.[21] Angell[2] and Siegler,[6] supporters of some paternalism and beneficence, have taken the opposite view and strongly urge that physicians retain their focus on their duties to their patients, although both have taken a pessimistic view of the feasibility of that proposal.

I think that despite the trends I have outlined, the essential basis and nature of the patient/physician relationship has not and must not be changed. Furthermore it must be based on mutual understanding in an evolving, caring and dynamic relationship that must include the family. Educated patient autonomy and responsibility supported by beneficence, trust and some degree of guidance consistent with the educational and advocative roles of the physician will be necessary features of this partnership. Guidance founded on the apostolic function of the physician is critical to patient education and ethically proper in today's health care setting.

At the same time, physicians have always had a duty to society that influenced their relationship with patients (eg, in the case of patients with tuberculosis and other communicable diseases that society requires to be reported, thus limiting the principle of patient/physician confidentiality). With the development of technology in diagnosis and treatment, physicians have an increasing responsibility to provide appropriate care and always to answer the question not of what we can do, but what should we do? Therefore, the educated and responsible patient and physician must include in their considerations of a care plan the appropriateness of the use of societal resources. These considerations can and will be increasingly based on probabilities of favourable diagnostic and treatment outcomes from the data generated by research on health care delivery.[21] These considerations are fully in

concert with the views expressed by Brennan[4] in which he suggests that physicians must learn to balance their responsibility to the individual patient and the other duty of proper stewardship of society's resources.

Maintaining this balance between obligations to the particular patient and the 'class of patients' is the challenge that must be met by the new model of the patient/physician relationship that is proposed. Brennan[4] argues that a just system of health care must recognise 'the moral interconnectedness of medical care because, within a limited budget, the decision to use resources in a given case must affect the availability of resources for other cases. Thus, the decision on the use of resources must be based on appropriate evaluation of medical indications, including outcomes, patient preferences, considerations of quality of life, and external factors.[1] This process of careful evaluation and decision can put the physician into situations of conflict of interest where personal advantage may clash with patient benefit,[25,27] or where the patient's needs and the insurer's rules may come into conflict.[2,4,5] When physician self-interest clashes with the patient's good, with professional duty, with Aristotelian virtue, and with the caring relationship, which are the basis of the patient/physician relationship, serving the patient's good must taken precedence so long as that good is based on appropriate consideration of all the factors involved. However, where the conflict is between the patient's good and a health care organisation's guidelines, two factors must be brought to bear. First, the physician must be a determined patient advocate. Second, as suggested by Brennan[4] and by Wolf,[5] health care organisations must be required to develop standards of ethical and moral decision making that are based on the same altruistic and caring attitudes expected of physicians. This line of argument relies on the assumption that patients, physicians and health care organisations will accept responsibility for the good of the 'class of patients'[4] or the larger society. This social responsibility on the part of patients, as suggested by Veatch,[28] is a part of the social contract that he believes should be one of the bases of the patient/physician relationship. However, an essential prerequisite for such responsible patient conduct is proper education of the patient by the physician about appropriate care – a form of the apostolic function.[13] This in turn requires an ongoing relationship in which this mutual educational process about patient values and guidelines to appropriate care can progress to a patient/physician alliance in the greater community. This model of the patient/physician relationship is the foundation of an alliance within the community that is envisaged as the basis for the elderly evolution of a system of health care.

Some will say that this goal of an effective patient/physician alliance is an idealistic and impractical dream, especially since it requires a long-term relationship in which mutual education can occur. However, we believe the means are at hand to attain our objective. First, there is already a realisation that there is a need for more primary care physicians. Next, we must ensure that these primary physicians can and do devote the necessary time to patient education that must at the same time promote patient responsibility in decision making. Enlightened self-interest on the part of health care organisations should support this trend. Educated patients will practise better health habits and thus reduce the costs of care. Furthermore, such patients will be more discriminating consumers of medical services, thus reinforcing this process. Third, we must follow the lead of those such as Ellwood[7] and Wennberg[21] who have demonstrated the feasibility of developing scientifically sound practice guidelines that can define appropriate care – a form of care that need not preclude allowance for patient preferences where they are legitimate.

The first duty of the physician must continue to be to act as the patient's advocate for appropriate care against all comers. At the same time, the physician as teacher must educate the patient as to what is appropriate care so that the patient can also be responsible and fully informed in making autonomous decisions. This is the basis for an alliance of patients and physicians in society that can effectively ensure the preservation of the essential basics of the therapeutic relationship and influence the evolution of our health care system so that it can indeed provide optimal care for all citizens while being responsible in the use of social resources.

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Ideas about Michael Balint*

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Michael Balint, without doubt, was heir and follower of Ferenczi. The psychoanalytic atmosphere, as it existed in Budapest, infiltrated his work. That can be shown by the choice of his subjects, e.g. clinging, and the main thrust of his work – which is, like that of Ferenczi, the psychoanalytic technique. Like Ferenczi, Balint also thought that psychoanalysis should have an impact on life, on training, on social issues and not be confined to the psychoanalyst's consulting room. Ferenczi's contact with his colleagues, and the artistic and intellectual world of Budapest, was characterised by marked informality. Until the early 1920, he lived as a bachelor in one of the grand hotels, the Hotel Royal, on one of the main boulevards near the opera, and in the city centre. It is in the café of this hotel that every evening he received his colleagues and friends, and this *'Tischgesellschaft'*, this table company, seems to be one of the precursors of what Balint institutionalised as the 'training-cum-research' groups for doctors which later, were to be called Balint-groups.

The idea of group case-discussions with doctors, and especially with general practitioners, to illuminate their psychological background, had already been put into practice in Vienna by Professor Sigmund Freud, in what was called the Wednesday Society. In the beginning these groups were almost exclusively made up by general practitioners, and slowly they were joined by other people from the literary and artistic world, and others who were interested in psychoanalysis. It can be seen that Balint-groups historically evolved from the best psychoanalytic traditions.

Ferenczi himself was preoccupied with the relationship between medicine and psychoanalysis. He had shown interest in the psychological aspect of medical practice even before meeting Freud, and had published several articles general survey of Freud's contributions to medicine. In one of his posthumously published articles too, we discover notes entitled 'Brief presentation of psychoanalysis for general practitioners'[1] (Ferenczi, 1936). He constantly sought ways to give a more favourable prognosis for certain organic conditions by systematic psychoanalytic observations.

Moreover, he observed that 'the personality of the physician often has a greater effect on the patient than the medicine prescribed' *(ibid.)*. This observation is the point of departure for Michael Balint's ideas on medical education.

Ferenczi had devoted considerable thought to the psychology of physicians and its repercussions on patients. 'Psychoanalysis demands on the subject (Lorin, 1983). One of his last articles is entitled 'Freud's influence on medicine' (Ferenczi, 1933), and is a physician untiringly sensitive to all of the patient's ideational associations, his emotions, and his unconscious processes. For this, it is necessary that the physician himself should have a flexible, plastic mind. He can attain this only by being analysed himself. How the future medical student will acquire this profound self-knowledge, is a difficult question to answer (Ferenczi, 1933).

In response, Balint set up 'training-cum-research groups' for general practitioners, on the lines of the Hungarian psychoanalytic training system. Before the development of the Berlin Institute's so-called 'tripartite' training system, which calls for personal analysis, and courses on theory and on supervision, the Budapest school made no such clear-cut distinction between these three aspects of training. Hungarian candidates associated freely in their own analysis around the cases they were treating.

Inspired by this experience, Balint thought that it should be possible to create a training for general practitioners that would bring about 'a limited though considerable change in the doctor's personality' (Balint, 1961), allowing a better understanding of the doctor/patient relationship. Balint's premise was that any emotion felt by the physician when treating a patient, should be considered as a symptom of the illness. Balint introduced into medical practice methods for exploring the unconscious of doctor and patient to understand the true meaning of the inter-personal communication – of the demand and the response.

The main features of these studies (apart from several precursory articles, e.g. Balint, 1926a and 1926b), were introduced in his article, *The Doctor, his Patient and the Illness* (Balint, 1955); this article was subsequently expanded and published under the same title in book form (Balint, 1957). The 1955 article focuses on the physician, on his 'apostolic function', on his role in organising the illness by his interventions, by what he says, and when and how he says it.

Whereas psychoanalysis creates the analytic situation, Balint created a forum, *a space*, where the analyst and the doctors can meet. He believed that groups moderated by a non-analyst would not accomplish the same purposes. Balint was a scientific thinker. It was his ability to avoid all hint of dogmatism that enabled him to make psychoanalytic thinking a part of medical and scientific tradition.

Ferenczi's work fell into fertile soil in Michael Balint's mind; Balint's main historical contribution is to have continued to develop

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Ferenczi's ideas, especially concerning regression and counter-transference, and having in more favourable, cultural and social conditions been able to consolidate and begin to establish some of Ferenczi's seminal ideas.

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The Future of Balint-training 'How to go Forward?'*

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I am sure that you all feel like I do today, being here at this Centennial Balint Congress. It gives me a sense of awe, a feeling of intense nostalgia and pride to be part of this Balint movement, and to celebrate its success at this 100th anniversary of the birth of its inventor, initiator and founder.

Balint-training, started by Michael Balint, advanced by Enid Balint, and then developed by all who have had the good fortune to participate in it, is not just a method, but a movement which has become a benchmark for reflective training in the doctor/patient relationship. It has, and will continue forever to change the way doctors, psychologists, social workers around the world see their relationships with those who seek out their help. We know that Balint-training allows the doctors to be available to their patient in the way the patient needs them to be at any particular time. It is not often given to us, to play a part in nurturing a permanent change in the way they view their professional life worlds. What a wonderful and awesome privilege!

On behalf of the Administrative Council of the International Balint Federation and all of you, I would like to give profound thanks to the organisers of this very important Congress.

During this paper, I ask you to consider with me the way the Balint Movement has developed and to consider some concerns and suggestions I have about our future development. My concern is prompted by the predominantly person-to-person way that the Balint philosophy and training method has developed, and probably will continue to develop.

I believe that this personal communication of the method has clear strengths, but also has intrinsic weaknesses. My concern is that lack of a central discussion forum for constant re-examination of the method of philosophy, combined with the personal way in which the method is communicated, discourages further development and innovation, rather than stimulates it.

Worse, it allows each of us consciously and unconsciously to pass on our limitations and distortions to future Balint generations without much in the way of checks and balances. My suggestion is a mechanism to encourage and capture enrichments, new insights and innovations, while at the same time decreasing the risk of incorporating unwanted changes introduced by our shortcomings as the leaders.

For that reason, I would like to focus the centre of our gaze during this lecture on the need for a system of checks in the balance between the philosophy and method as we know it on the one hand, and in the changes we graft on to the method – both enrichments and decay.

I would like to use my own introduction to Balint-training and Balint-group leadership to demonstrate my concerns and suggestions under the theme of 'How to go Forward?' To do so, paradoxically, I would like to take you back thirty-one years. I was in my last year of medical school and in my last lecture in psychiatry. Vera Buhrmann, the only Jungian analyst in South Africa, recommended a new book to anyone who was going into general practice. I dutifully purchased the book, which was, *The Doctor, the Patient and his Illness.*[1] I did not read it!

Four years later, when I had moved into my practice of the next twelve years, and we were moving offices, I stumbled across the book one evening, picked it up and started to scan through it. I arrived home very late for supper that night, because I just could not put it down. All of a sudden, so many of my experiences in my practice that had been totally mystifying, began to make sense through the new lens of Balint-training.

From there I was propelled along a course which has changed my professional and personal life and like many of you, I suspect, transformed my experience of patient-care. The book inspired me to embark on my first attempt to organise any collection of doctors and develop a Balint-group. I managed to find a psychodynamically trained psychiatrist to lead this first group in Africa, which ran for five years. After some initial scepticism, I managed to convince Stan Levenstein to join. Then followed a year with another group-leader, which was just as beneficial, but as this leader knew as little about Balint-training as the first, I felt just as lost from the world I had glimpsed through reading *The Doctor, his Patient and the Illness.*

It was then that we decided to invite Enid Balint to come to South Africa. After the formative experience of her leadership for a few days, Stan and I managed to persuade her to agree to supervise our co-leadership of a group, by transcript. Well, that was the sum total of my group experience and later group-leadership training experience.

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Let me now link my Balint story to the topic I was given on the theme of 'How to go Forward?' and explain my concerns and suggestions for the future of Balint-training. Taking myself as an example of the way some leaders have been prepared for their role – I have never had a formal analysis, I never co-led a group with a Balint-trained leader. I co-led a group with Stan Levenstein who had had the same experience in the same aberrant group. The only thing I did right was to be supervised by Enid Balint, but very intermittently by mail. How do you and I all know that I have not limited a new Balint generation by my shortcomings as a leader? How do I have some of the changes I have consciously grafted on to the method to adapt it to the training of residents, validated by others? Another component that we need to look at is that like many of you, I constantly felt constrained from making changes to a method which bears someone else's name, without a group of peers to whom I could turn to for validation of our innovations.

I know that quietly between individuals there has been a network of discussion about who is doing what kind of Balint-work, and how good or bad it is. I know that Michael and Enid Balint constantly worried about the 'bad' work that was being done by some leaders. In the development of the Balint movement, there has been a parallel process between the person-to-person development of the movement, the development of a group and in turn, a parallel process in the development of a group-member and hopefully the person to person development of a relationship with his/her patients.

This personal transmission of the ideas, concepts and skills of the movement has often been enriched by each successive person in the chain or lineage. In the same way, I would postulate that each successive person has also injected their own spin or distortions, limitations and blind spots into the method as they transmit it to the next Balint generation. I have no doubt that without any new kind of intervention by the Federation, the Balint method and approach will continue to spread to more and more individuals purely because its intrinsic merit is so obvious to those who participate in it. The dilemma is about encouraging and incorporating innovation, and then what about inadvertent negative change?

Like any other movement, the method can become stale, unattractive and lose its vitality, and even its value, as the world catches up and moves forward. A method and approach is, in my opinion, either growing or dying. The basic tenets of Balint-training are present in almost every modern view of general/family practice. Just like the concepts of the psychoanalytic movement have been rejected by the populace in many parts of the world, yet incorporated into their own language, and the very way they make sense out of their world. Yet in many of these places, the psychoanalytic movement is frozen.

I have been challenging the members of the Council of the International Balint Federation with a new vision. Up to now we have measured a leader's ability by his/her training, rather than by looking at their competence. We have looked at new ideas and suggested changes to the Balint method with great ambivalence. It is as though we have lacked anyone with enough authority to 'bless' any innovation.

My vision is a Balint world in which there is a forum for constant re-examination of, and reflection on the Balint method. An environment in which the movement can be enriched by encouraging and examining innovative ideas on how to add to and improve the method. A forum for presentation, validation and acceptance or rejection of new ideas. An opportunity to prevent decay of the method created by our own shortcomings as leaders. An opportunity for leaders to grow by exposing their expertise to their peers for critical evaluation and advice. This is in an attempt to improve everyone's ability rather than exclude anyone. A forum which will stimulate an examination of the outcomes of Balint-work. I know that outcomes research is what I have proposed as the greatest contribution of this process. I now realise that this may be less important outside my country.

I have also been encouraging the council to play a leadership role in creating this process and to ensure that the future of the movement is as bright or brighter even than its past. I do not enjoy being 'Johnny one note'. However I feel very strongly that the Administrative Council of the International Federation needs to be the centre of an organised process at the centre of which will be the process of accrediting leaders.[2]

In proposing this, we took the first step at Charleston in having qualitative or naturalistic researchers watch us at work, and offer some insights into how we could put an accreditation process in place. This process was proposed to take the form of a naturalistic or qualitative research study which fits well with the Balint-group process itself.

I feel that the accrediting process can be the engine which drives all the other activities and creates the forum I have mentioned. It naturally creates the climate for constant re-examination and reflection on the Balint method, enrichment by encouraging the examination of innovative ideas on how to add to, and improve the method, a forum for presentation, validation and acceptance or rejection of new ideas, which will stimulate an examination of the outcomes of Balint-work.

My most optimistic vision of the future Balint-training is very closely dependent on a new kind of role and future for the International Balint Federation, but this vision also raises barriers, the major ones being resistance to the thought of being measured, language, the cost of technology and people's time to create the forum and provide the process.

We can no longer measure our expertise in terms of our training for leadership and prerequisites. As John Salinsky has said, he knows many people with superb sounding education but who remain illiterate.[2] We need to define the competencies of leadership and measure ourselves up against them.

However, this component of our work is so important that I just live to trust that we will find a 'way to go forward with it'.

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The Human Face of General Practice

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A New Look at the Nature of the Doctor/Patient Relationship*

Mike Courtenay
Retired General Practitioner

The doctor/patient relationship is at the centre of Balint-work. But there is confusion between the ordinary understanding of this relationship and how it was perceived by Michael Balint. In traditional medical parlance, it is seen in terms of a social relationship, only tenuously connected to the professional contract between patient and doctor. So the traditional doctor will consider the doctor/patient relationship as 'good' when the doctor feels comfortable with the patient, who is seen as not making too many, or excessively heavy demands on the doctor, but who follows the doctor's advice and generally behaves in a way that is expected of a patient. These warm feelings are often expressed in terms of friendship in spite of the fact that the doctor's professional expertise will inevitably weight the relationship, in terms of power, in the doctor's favour. Even if the patient feels equally warmly towards the doctor, this emotion is bought at the price of conforming to the doctor's agenda. The patient's autonomy is compromised and any contribution towards self-healing will be hamstrung.

Michael Balint sought to change the situation radically in his early work with general practitioners. He thought that if the doctors gained psychotherapeutic insight they would be able to use the doctor/patient relationship, however warm or cool, in a professionally constructive way. He thought that bringing a psychoanalyst's knowledge and experience to a group of general practitioners could transform them into a new kind of psychotherapist, and so make available some part of his own expertise to a large number of patients who were unlikely ever to have access to a psychoanalyst.

For me, Michael Balint's greatness stands on his capacity to modify his aim in the process listening to the response of his general practitioner colleagues. He managed to immerse himself into their world so completely that I, personally, came to believe that he could practise better than I could in my own setting.

Being so close, but also being able to stand back and consider the work, he coined those splendid descriptions of aspects of the doctors' work: the *Apostolic Function* (encapsulating the doctor's idea of how a patient should behave), the *'Drug' Doctor* (showing how a human personality is able to effect a therapeutic effect), the *Collusion of Anonymity* (illustrating how the persisting effects of medical education by specialists can interfere with generalist patient care).

In *Treatment or Diagnosis* he concluded that a repeat prescription is often the apparent solution to the problem where no satisfactory diagnosis can be established and, in consequence, no rational therapy devised. Moreover, this quasi-solution is strongly defended by the doctor to prevent a return to the state of uncomfortable uncertainty.

In Max Clyne's book, *Night Calls,* Aaron Lask demonstrated that doctors related to the emotional crises of emergency work in the same way as they would react to their own emotional crises. This was not always to the patient's advantage, because sometimes the doctor understands his or her own emotional reactions as little as his/her patient's. The unavoidable conclusion was that it is not sufficient for the doctor to understand only the patient, he or she needs to understand himself or herself in relation to the patient. But, of course the patient *must* be understood. For instance, in his book *Asthma,* Lask portrayed asthma sufferers as either demanding-babies or those adopting a going-his-own-way stance and so addressed the need to understand the patient's agenda more carefully.

So the gradual accumulation of this experience in groups led Michael Balint to rethink the way forward. He sought somehow to integrate the psychotherapeutic insights gained during the work with the generality of patients, rather than to deal only with those who were apparently emotionally or psychologically dysfunctional. *Six Minutes for the Patient,* published after his death, set out his new thinking on the doctor/patient relationship, especially the awareness of the need for the doctor to tune in to the patient's agenda with increased sensitivity. This new approach was developed by Enid Balint in subsequent groups.

But it must not be forgotten that Michael Balint, in his earlier work with groups dealing with sexual problems, had accepted that physical examination, alien to his own psychoanalytic tradition, played a valuable, even central, part in many successful treatments. Altogether, the development of Balint-work had moved away from a formal psychotherapeutic approach in the doctor/patient relationship towards an increased awareness that the body played a part as important as the mind.

So where does the debate stand today? It is perhaps the right time to widen our horizons by calling on the work of Carl Edvard Rudebeck, a Swedish general practitioner who was a member of a Balint-group prior to moving into the post-graduate educational field in Stockholm. He became interested in the philosophical implications in the distinction between specialist and generalist work, in the course of which he has

* Address presented at the 10th International Michael Balint Commemorative Congress in Budapest, 1996.

produced memorable phrases analgous to those of Michael Balint. The concept of body-as-nature/ body-as-self illustrates the fact that for the doctor the patient's body has two aspects: the first is as encountered in the medical school in terms of anatomy, physiology, pathology, etc; while the second is as encountered in relating to a human person. While the doctor's role may be seen as principally as body-as-self interacting with the whole patient, it is important to realize that in addition to his knowledge of medical science the doctor's own body plays an important role too, because his experience of his own body complements his knowledge gained through his medical education.

I cannot help thinking that my patients gained from the fact that my own experience as a patient was considerable. Malignant tertian malaria, appendicitis, tropical bacillary dysentery, intestinal nematode infestation, cervical rib removal, haemorrhoidectomy, epididymitis and vestibulitis mark the milestones; while the experience of medical investigations such as barium meal, barium enema, intravenous pyelogram and electromyography collectively, led to a rich personal perception of the body-as-nature in relation to the body-as-self.

In another of Rudebeck's splendid images, this opens the door to what he calls bodily-empathy; the understanding of bodily perceptions involved in the dyad of body-as-nature/ body-as-self.

So what do we have? A doctor who observes how he and the patient are interacting in the consultation as it proceeds. Aware that feelings of warmth may be just as important as feelings of anger (is seduction by the patient not as important in clinical terms as aggression?), the doctor may gain understanding of how the patient relates to those in the world around him, so illuminating aspects of the problem of which he complains. The doctor will become more amenable to studying the patient's agenda, not only in terms of what concerns the body-as-self, but also adding the patient's perception of his body-as-nature to stand in bodily-empathy with the doctor's own experience and medical training.

If this model sounds difficult, may I suggest that the practice is simpler than the theory, so that it is really remarkably liberating. Instead of constantly feeling that one must be 'in charge' of the patient, the possibility of a more equal dialogue between doctor and patient emerges. The doctor will engage with the autonomous patient in a joint voyage of discovery, during which their respective bodies-as-nature/bodies-as-selves interact to allow bodily-empathy to develop while still allowing the doctor's body-as-self to stand back and observe the interaction as it develops. This last necessity is at the core of the professional activity which can be offered by the doctor, but take note that it is no longer an exercise of power but rather of responsibility. The doctor/patient relationship may be seen to have become a complex one, in that various elements are involved, but also one that is readily understandable because its principles are simple. And most importantly, the way is now open for patient and doctor to work together in freedom.

Balint-Groups, House Guests and the Doctor's Inner World*

John Salinsky
General Practitioner, London.

When I first joined a Balint-group 22 years ago, I was not sure how it was going to help me. Although the leaders were obviously very experienced and wise, they seemed strangely unwilling to share their secrets with us. My colleagues in the group were very eager to give me advice – but their advice never seemed very good so I took no notice of it. After a while we all realised what the leaders were trying to help us to do – which was to focus on the doctor/patient relationship and the feeling which it was generating. As we got better at doing this I would hear in the discussion some different views of the patient and what he wanted from me. And some thoughts about why I had reacted in the way I did. Sometimes this made sense and sometimes it didn't.

Nevertheless, after the group session was over I always felt better about the patient I had presented. He or she no longer felt such a problem, such a source of anxiety. I even looked forward to our next encounter to see what would happen. On my way home from the group I would often feel that I was carrying the patient around in my mind, even talking to him – in a much more relaxed way than was possible before the group discussion. So something had happened. But what?

General practice is a very busy kind of work with many patients crying out for the doctor's attention and trying to engage his interest. Michael Courtenay told me that Michael Balint once said to a group of doctors: 'Sometimes I think your patients have to hit you over the head with something before you take any notice of them.' Well, that was a bit extreme, but it conveys the desperation of the patient's need to grab our attention. Perhaps, rather than hitting us over the head, the difficult patient is knocking hard at the door, trying to gain admission to the doctor's mind, to be allowed into his Inner World. This idea of an inner and an outer world is a familiar one from psychoanalysis. Everything in the outer world of reality may have its inner representative in the world of the mind, conscious or unconscious. The British analyst Melanie Klein used the phrase 'projective identification' to describe the way in which a patient contrives to introduce a split off fragment of his personality into the analyst's mind so that the analyst feels it is a distinct presence, welcome or unwelcome, in his mental household. I prefer to think of my patients, not in fragments, but as whole people, who in their efforts to get my attention, enter through the door of my Inner World and ask permission to remain as mental house guests.

At this point, I am reminded that Freud would sometimes treat his analytic patients while they were literally his house guests during the summer. Of course, a modern psychoanalyst would find this outrageous. Perhaps only Freud himself would be allowed to get away with it. Imagine how difficult it would be to have to sit opposite your patient at breakfast as well as listen to him in working hours. But house guests in the Inner World – that is a different matter. It seems to me that whenever I present a patient to a group he or she is like someone who wants to be a house guest but has not yet been invited. He may be disturbing me by knocking at the door, or waving through the window or even ringing the doorbell in the night. Alternatively, he may already be inside illegally. He may have slipped through the door secretly without my noticing. And now he is sitting in my house pleading with me, even threatening me or making me feel guilty for neglecting him. All without my permission. This is where the group comes in. They act as a kind of committee, helping me to assess the patient's suitability to be taken in as a *bona fide* house guest. If they think he is trying to steal from me or do some damage to my inner house they may warn me to get rid of him. This sometimes happens but is unusual. More often, the group members help me to get to know the patient better as a human being who deserves a little space of his own inside my head. A place where he can be cared for and thought about and hopefully understood.

As my inner world fills up with patients it begins to resemble a small boarding house. After years in practice it grows and develops to accommodate more and more patients until it becomes a hotel – perhaps like this one. Some of the guests may even have *en-suite* facilities in their rooms. Of course my Inner World Hotel has some areas where the guests are not allowed – I need some privacy, I'm sure you will agree. But I can wander round the Inner Hotel and visit my patients in their rooms or perhaps take coffee with them in the lounge. The hotel also has a conference room which is occupied by members of the Balint-group. Naturally, they also have their representatives in my Inner World. Often, when one of these the patients consults me again, I am aware that my friends from the group are sitting in a semi-circle behind me, taking a keen interest and giving me courage when the consultation is difficult.

Here are two examples of patients whom I presented recently:

1. A middle-aged man from Afghanistan.
He is a rather fat very friendly man, always smiling. He doesn't have much English, but we seem

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to get on very well as I try to help him with hypertension and other physical problems. One day he came with a new wife, also aged about 40, but speaking much better English. She is attractive and seems very intelligent. She asked me if I could help my friendly patient with his lack of sexual potency. I tried to take a sexual history from them (neither had been married before) but I found it very embarrassing. It was as if I was being asked to give sexual therapy to my Uncle and Aunt. After two consultations in which we made no progress I referred them to a psychosexual specialist. A few weeks later they came back for him to have a BP check. I asked about the sex therapist and the wife said: 'Oh, we didn't take the appointment.' When I asked why not, she said, ' You didn't take any notice of us when we asked you for help. It doesn't matter now. Forget it.'

I felt upset because I thought I had taken a lot of interest. I couldn't get her to say anything else and he just sat there smiling.

This couple continued to occupy my mind and make me feel hurt. What had I done wrong? When I presented them to my Balint-group the other members thought that I had concentrated too much on the man's erection failure and failed to notice the wife's distress. I never really tried to get to know her as a person and to that extent it was true that I 'took no notice'. Using my hotel model of the mind I realised on the way home that day that the man was occupying a single room in my Inner Hotel but I had refused to accommodate his new wife despite her reasonable request. I decided to give them both a double room in which they could make love or not, whatever they wanted. I began to feel better. I was pleased to see that they had made another appointment to see me about his blood pressure the next week. This time the wife was smiling too and she seemed much more friendly. I checked her husband's blood pressure and gave him a prescription. Nobody mentioned sex but I felt that I was accepted as their doctor. After all they could have gone to one of my partners and they haven't. Perhaps one day we will talk about what they do in bed or whether they want children – or perhaps not. I can wait.

2. A man of 35; drug addict.

He is a difficult patient. He makes frequent demands for prescriptions I am unhappy to give him and he nearly always comes without an appointment at an inconvenient time. If I am busy, he shouts at the receptionist and insists on being seen urgently. Clearly he is not an ideal house guest. A few months ago, he turned up on the doorstep complaining of a pain in his groin. As usual he had no appointment and I was in a hurry to leave. I examined him quickly, found no evidence of a hernia or any other abnormality. I reassured him and told him that it would get better. He wasn't satisfied with this and said, 'Come on, man, there's something wrong there and I want it fixed.' I repeated that there was nothing to fix and he would just have to trust my judgement that it would get better. Or find another doctor. 'You're my doctor, man' he said, 'and of course I trust you.'

After he left I began to feel unhappy about him. In the next few days I convinced myself that he was going to have a burst appendix or some other surgical emergency. He might even die. And it would be all my fault. This time I presented my case to an *ad hoc* group consisting of the members of the International Federation Council who were meeting in Paris. The group showed me various new aspects of my patient and the way he wanted to relate to me. It seems that he needed me to care for him even though we both knew he could be dishonest and manipulative. I decided to let him have a small room in my hotel and just hope that he wouldn't use it to entertain drug dealers. After that I stopped worrying about him, and, when I did eventually see him again, his groin pain had cleared up (as I said it would – although I didn't believe myself.)

Conclusion

Both these patients ceased to cause me anxiety once I had accepted them as legitimate guests of my Inner Hotel. This hotel of the mind has many rooms in which guests or patients are permitted to live while I am treating them. From time to time, new arrivals come to the reception desk and ask politely or rudely for permission to have a room. In the conference room, the inner Balint-group helps me to decide who should be allowed to stay and under what conditions. Now you may find this hotel an extraordinary creation and find difficulty in believing in its existence. Well of course it doesn't exist in terms of brick and stone. It is more like a metaphor or a dream which I think has taught me something about the importance to the patient of being accepted and tolerated. And the corresponding feeling in the doctor that one's patients are asking for some sort of shelter which we can give them without feeling that we are being invaded. I hope that this idea will be helpful to you too; but whether it is or not, I would like to thank you for letting me share it with you.

Balint Groups in Russia – Similarities and Peculiarities*

Vladimir A. Vinokour
Psychotherapist, St. Petersburg, Russia**

I first heard of Michael Balint nearly 20 years ago. he was relatively unknown in Russia and was mainly quoted as the author of the assertion 'The physician himself is the best medicine'. The true philosophy and method of Balint-work were not familiar to the wider medical community in our country and were not used in the education and training of our doctors. His books were not even published in Russian.

Among many reasons for this phenomenon, the most influential was the political closure of our social system to many western ideas. The health care system was an important part of the establishment.

As you know, there are profound social changes taking place in Russia now, with corresponding changes in health care. We were quickly challenged by an increased awareness of the numerous difficulties in the doctor/patient relationship and the need for psychological training of family doctors. A lot of our physicians realized the need to change the character of their communications with patients because the common style of directive interaction was unsatisfactory for both doctors and patients. This style was built on accusations, demands, and evaluations of patients' feelings and behaviour. Very often as a result, situations of emotional tension, incomprehension and combat were created. This is why the movement to Balint-training was the real sign of new health care development.

Our Balint Society was founded in St. Petersburg in 1994. From the very beginning it was established on the base of the staff, trainees and postgraduate students of the Department of General Practice of the St. Petersburg Medical Academy of Postgraduate Studies. Then more and more physicians and psychologists were admitted to the Society.

Actually we have stable existing and working Balint-groups, two of them work within our Department. One of the on-going groups meets at the Centre for psychological emergency care and consultations. We are convinced that this is the first step of creating the 'critical mass' of a new method for thinking people which, according to the German scientist Max Planck, is the only way to convince society prepare it for understanding a new idea. Regarding those groups that consist of general practitioners, their leaders are the teachers and lecturers in our Department, and we are eager for the involvement of psychologists or psychoanalysts in our seminars. Of course, we have the same problem as other Balint Societies in European countries. Among them is the lack of experienced and skilled leaders who are able to facilitate the productive work of the group, simultaneously lowering the anxiety of members, and stimulating their feeling of security and self-awareness.

The group I am leading has its own experience of two co-leaders' co-operation and we consider it to be very interesting, although sometimes it is not easy. As I know, our English colleagues have the same experience.

Gradually our activity spread to other regions of Russia, where it was welcome and met with intense interest. Now I am pleased that Balint-groups are included in the curriculum for postgraduate training of general practitioners. We are also planning to establish special Balint-groups for teachers of general practice to discuss the solutions not only for doctor/patient relationship problems, but also of general practitioners postgraduate training and its influence on the quality of general practitioners' work and how it is affected by their new experience and skills in communications, and by a comprehensive approach. The principles of Balint and his work will soon be published in Russia and we are very very grateful to our English colleagues and friends for their kind attention and great efforts to help us.

The experience of our work during the last year showed that there were some peculiarities in those cases that were discussed at the sessions of our Balint-groups. Mainly they involve the feelings of physicians whose directive style of relationship with patients was ineffective, and very often counter-productive. Simultaneously with aggression, power and pressure towards a patient, many doctors feel a sense of guilt with resultant loss of professional self-esteem.

We discovered that the syndrome of internal burnout is very widespread among our physicians. This syndrome manifests itself with indifference, even apathy, emotional exhaustion, fatigue, reduction of interest in their patients and in their professional development and ambition, and leading to defensive behaviour. Among different outcomes of burnout are the unrealized wish to reduce the workload, to relate to patients more formally, to reduce the number of different interpersonal interactions, and the somatic presentation of professional emotional stress. Our findings were very similar to those reported by English researchers[1] (Monitor weekly/24 May 1995), who showed the significant prevalence among English general practitioners of high

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anxiety, poor coping strategies. Very often they were even more depressed than the patients they were treating.

One of the problems, discussed in our groups seems to be common. This is the problem of interactions with patients where the doctor's behaviour is based only on his/her status and formal professional duties. Very often our doctors cannot explain satisfactorily to themselves and to their colleagues who they are, and if they act according to their personalities their feelings and humnistic values, or are they just the wearers of professional uniforms, and thus they behave only as representatives of state institutions. Often this second approach predominates over the first and so it leads to the establishment of emotional distance between the doctor and the patient.

We often hear that our doctors consider this distance to be a convenient method of self-preservation and reduces their emotional relationships with their patients, who are seen as 'rivals' and who prevent doctors from feeling confidence in themselves. But it is not conducive to good relationships, and makes those doctors uncomfortable who are not oriented to empathy and partnership with the patient.

We have found that even very experienced doctors expressed the need for new information, in feedback and in the 'mirror' in the group regarding their professional behaviour. The degree of this need was often paradoxical – the more experience, the more desire and interest to share the experience and to get friendly critical views. It was conducive to their personal and professional development.

It helped also to avoid distortions of their professional behaviour and self-awareness, to reduce their rigidity, and the number of their 'blind spots'.

Of course, we know the human attitudes, especially medical, must be an open system, because a closed one will decay. We are convinced our Balint-work is the best way to organize this system well, to develop empathy, a readiness for the unexpected, open minds and freedom from rigid judgements. I think this is our contribution to the Balint inheritance.

Reference:

1. Monitor Magazine, 24 May 1995.

THE BALINT ASSOCIATION OF ROMANIA

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The Human Face of General Practice*

Sotirios Zalidis
General Practitioner, London

Introduction:
Perhaps it is human nature that when we are looked after well, we take good care for granted, just as we take the air we breathe for granted. We do not become aware of our need for air until its absence makes us suffocate. So it is only when medical care fails our patients and their carers in some respect, and their hurt feelings compel them to tell us or write about their experiences, that we find out about the medical attitudes which they experience as inhuman.

In a moving account, the next of kin of Jeffrey, a consultant surgeon who died at the age of 69, at home from acute myeloid leukaemia within five months from diagnosis, describes her experience of medical inhumanity.[1] The medical attitudes that she found most painful were, first of all an apparent lack of interest in Jeffrey's quality of life, lack of kindness and compassion, as well as understanding of their feelings, and with a team approach which has become a euphemism for a lack of continuity.

When Jeffrey was admitted to hospital for chemotherapy, her description of the ward round has a familiar ring. 'Once each week, the medical team visited the wards. They could often be heard marching down the corridor before they entered smartly without knocking. The consultant first, followed deferentially by the team. The members of the team were constantly changing, and it was impossible to keep up with who was who. They seemed hardly to look at the patient and appeared unmoved by his appearance, no matter how ghastly. After about four minutes, they all marched out of the room to visit the next patient.'

As Jeffrey did not respond he was discharged home where his friend was condemned to observe Jeffrey's suffering and rapid physical deterioration without any emotional support from his doctors. Although the regular general practitioner, Dr K had asked a few times about how Jeffrey was coping psychologically, at no time did he offer any help to make him comfortable.

On Jeffrey's last day, his breathing was noisy and he was distressed. His friend called the general practitioner, but Dr H who was standing in for Dr K arrived. Jeffrey wanted a tranquilliser for some relief of his distress, but Dr H was worried that it might depress Jeffrey's respiratory centre and he offered methadone instead. Even at this late stage Jeffrey did not want methadone because he was afraid that it might kill him, and he did not want to die. He insisted on a tranquilliser and Dr H left without prescribing anything. Later that day, Jeffrey's own doctor was contacted and agreed to administer the wished for tranquilliser. The patient died a few hours later.

Jeffrey's friend felt that their physical and mental suffering was not understood and therefore they were not treated with kindness even though from a technological point of view, the chemotherapy was administered according to the latest scientific evidence and the treatment itself was part of a survey of the efforts of cytotoxics on people over fifty years of age.

One of the problems in treating sick people arises when medical personnel ignore how patients are reacting emotionally while they are treating their physical condition. Traditionally medicine has a very narrow view of health. Our training concentrates mainly on disease, and ignores the patient's experience of disease which we can call illness. This inattention to the emotional reality of disease neglects a growing body of evidence showing that people's emotional states can sometimes play a significant role in their vulnerability to disease, and to their response to treatment and recovery.

Perhaps one of the most powerful demonstrations of the clinical power of emotional support was reported in groups for women with advanced metastatic breast cancer, at Stanford University Medical School.[2] After the initial treatment, often including surgery, these women's cancers had returned, and were spreading through their bodies. It was only a matter of time until the spreading of cancer killed them. Dr David Spiegel who conducted the study, was himself stunned by the findings, as was the medical community. Women with advanced breast cancer who went to weekly meetings with others, survived twice as long as those women with the same disease, who faced it on their own.

All the women received standard medical care: the only difference was that some went into the groups, where they were able to unburden themselves with others who understood what they faced and were willing to listen to their fears, their pain and their anger. Often this was the only place where the women could be open about these emotions because other people in their lives dreaded talking about cancer and their imminent death from it. Women who attended the groups lived on average for thirty-seven additional months, while those with the disease who did not go into groups died on average, in nineteen months. This was a life expectancy for these patients beyond the reach of any medication or other medical treatment. If it had been a new drug that produced this extended life expectancy, pharmaceutical companies would be battling to produce it. Such evidence suggests that a humane medical attitude that takes into consideration the patient's feelings, is not just a luxury, an optional extra, but constitutes good medical practice.

* The Balint Society Prize Essay, 1996.

An example of caring for a patient in general practice

Frank was 58 years old when he presented to me one June morning, complaining that there was blood in his urine. He had rarely attended the surgery before, and he was a strong healthy man. He was very frightened because the sight of blood in his urine made him think immediately of cancer. I was moved by his fear and wanted to reassure him. Even though cancer was a possibility and he had to be investigated urgently, there are many causes of blood in the urine that have a better prognosis. I explained all this to him, and sent a specimen of his urine to the laboratory for examination. I wrote a referral letter for an urgent appointment to the urology department and while waiting for the result of the test, I gave him a course of antibiotic in case his haematuria was due to an infection.

Three days later, he came back in a panic and said that he could not wait for the appointment, and wanted something done about his problem immediately. I responded to his distress by arranging for the specialist to see him urgently in Casualty later that day.

I did not hear anything about Frank until two months later, when I received a letter from the consultant urologist informing me that he had found a mass in his left kidney and that he was planning to remove the tumour in a month's time.

His wife, Irene, also a patient of ours, came to see me at the practice in a distressed state, two days before his operation. She told me that she could not take in that Frank had cancer. Her father had died of cancer of the brain twenty years earlier and she was aware of the awful prognosis. She was worried that Frank might die on the operating table, and said that some husbands you want to get rid of, but her husband was an angel. She did not want him to die. She asked me to sign her off work because she was too distressed to concentrate. I tried to comfort her and told her that cancer is not necessarily a death sentence, and that modern treatments are very effective, and that some cancers are curable. I invited her to come to see me regularly at the practice to talk about her fears.

She came back a week after Frank's operation, greatly relieved that God had answered her prayers, and he had come through. She remembered that after her mother's death, she had developed irritable bowel syndrome, which had lasted fifteen years; and after her father's death, she had developed tingling in her tongue for four years. She was now afraid that if Frank died, she would become ill. She had always relied on him for everything, for paying the bills and managing the finances. She could not imagine living without him.

Three weeks after the operation, Frank's son rang me at the surgery and asked me to visit his father at home because he had been feeling cold since the operation. He was abrupt and forceful, and when I asked him whether his father knew that he was requesting a visit on his behalf, he exploded at me and said angrily that he cannot discuss his worry with his father and besides, his father is not the kind of person who would worry a doctor with his complaints and would I go and visit him immediately.

I was annoyed with him for giving me orders, but on reflection I could understand his aggression as being related to the shock of his father's illness. I rang Frank up, to confirm that he wanted to see me, and went to visit him after the evening surgery. When I arrived at his home I found him looking fearful rather than ill. His wound was healing well, but was still sore on examination. I could find no evidence of infection, and encouraged him to talk about his feelings. As soon as he started talking, he burst into tears and talked about his frustration and rage that he could not do what he used to do. Every movement was painful and he was still not able to come to terms with the double shock of having cancer, followed by a major operation.

I acknowledged his feelings and read to him the consultant's letter confirming that he had removed the whole tumour and hopefully that would be the end of it. On my way out of the door he mentioned in passing, that he had had some pain at his right shoulder since the operation, for which the hospital doctors had given him pain-killers. I reassured him by saying that he must have hurt his shoulder during the operation. For the doctors to remove his left kidney, he must have been lying on his right side for some time. I invited him to come to the surgery with his wife regularly, to talk about their fears and worries.

Two weeks later, they both came to see me. Frank showed he his right clavicle which had become swollen. I examined him and felt dismayed. I said nothing to him, but I knew that the swelling could be nothing else but a secondary. I sent him for a chest X-ray immediately. The radiologist telephoned me the same day, to confirm that the X-rays showed destruction of the clavicle, with metastases in the lungs. I could not bear to tell Frank the bad news, so I arranged for him to see the urology registrar urgently at the hospital in three days time.

After their visit to the hospital, I had a telephone call from Frank's son in the middle of my surgery, furiously demanding to know why his father's secondaries had not been picked up earlier. He had been complaining of shoulder pain for several weeks and nobody had taken it seriously. The doctor who saw him at the hospital told him that he had secondaries, there there was nothing more should could do for him, and that he was going to die in a year! She gave him pain-killers and sent him home. The son said that he would not let the matter rest there, and demanded to find out why the doctors were so negligent. I was taken aback by this aggressive onslaught. I felt confused and did not know what to say. I felt guilty that I had not thought of secondaries when Frank complained to me of shoulder pain a few days before, and had not taken any action. I tried to say something comforting, and blurted out

rather inappropriately, that at least his father had had a few weeks of hope. That seemed to be the wrong thing to say. He was so besides himself with rage, that he could not talk to me any more. 'I cannot believe what the man is saying,' I heard him hissing as he passed the telephone receiver to his wife. I could hear him swearing in the background and I was frightened.

When I put the receiver down I was seized by a strong fear. I was afraid that this man could seek me out and attack me physically, or even kill me. I had heard of obstetricians who had been shot by the enraged husbands of women who had died in childbirth. I immediately telephoned the consultant to discuss the family's anger and distress. He responded by offering to refer Frank to an oncologist/radiotherapist for further treatment. I was afraid for my life for a week and I tried to modify my fear by reflecting on it. At the time, I thought of my fear of being killed as a result of the inability of the family to come to terms with the possibility of Frank's death, which aroused my own fear of dying.

It was not until a week later, when Frank, Irene and their son came to see me jointly, that I understood my fear of being killed as a response to the family's murderous rage. They were very angry with the registrar who, in a cold unempathic way, told them that Frank had a year to live. Frank felt that he had been given a death sentence, an execution order. He was not given any hope for any treatment. He felt that if he was a weaker man, he would have been tempted to finish it all there and then.

Elizabeth Kubler Ross had written all her patients were nourished by hope.[3] They showed the greatest confidence in the doctors who allowed for such hope – realistic or not – and appreciated it when hope was offered, in spite of bad news. This does not mean that the doctors have to tell them a lie, but merely that we share with them the hope that something unforeseen may happen, that they may have a remission, or that they might live longer than expected. It is a fact that we all know that we are going to die; what we do not know, is the exact time and way of our death. Were we to know the exact time and circumstances of our death we might be too afraid, to discouraged, too paralysed to live a meaningful life. These thoughts helped me understand my fear of being killed as my response to the murderous rage caused by the assault on hope.

Fortunately Frank recovered his hope with the onset of his radiotherapy which stopped the destruction of his clavicle. His experience with the registrar made him say that he had to fight for his treatment. As he had hinted at his intense mental suffering which he could not share with Irene, I invited him to come to see me on his own 'for a man to man talk,' as he put it.

During this talk, I heard that he was trying hard to be strong for Irene's sake. He could not discuss his fears with her, or cry in front of her. Since the registrar told him that he had a year to live, he had a recurrent dream. He dreamed that he went swimming in a sea of oil. When he was knee deep in it, a black cloud started to cover the sky from one end of the horizon to the other. The black cloud of despair, I commented. 'Yes', he said and burst into tears.

A month after he was told that he was going to die, Frank and Irene came to the surgery together. Irene said that she was going to pieces. After forty years of marriage, she had developed an allergy to the wedding ring! It had started burning her finger and she had to take it off. She showed me a ring of redness where her wedding ring had been. She had also been coughing all the time, and could not sleep. Even though I realised the symbolic significance of her symptoms, I decided not to make any interpretations. The combination of symptoms suggested the involvement of her immune system, and I treated her with inhaled steroids as though she had asthma. Her symptoms diminished quickly and after a few weeks she was able to put her ring on her finger again.

This was the only time Irene 'went to pieces'. She found the strength to nurse her husband and to keep her feelings at tolerable levels by keeping her house immaculate tidy and clean. However, black clouds were gathering on the horizon. Six weeks after their joint visit to the surgery, Frank complained of pain in his spine and a few days later, his left arm fractured spontaneously as he was getting into his car. This was obviously the effect of another bone secondary, and he was admitted to hospital where his arm was fixed with a plate and pins. A bone scan showed he also had spinal secondaries. When I visited him at his home after his discharge a month later, he was frightened and uncomfortable. His movements had become painful, and getting in and out of bed with a broken arm was difficult. He needed his wife's help more and more. He was started on Interferon injections, a new treatment for his type of cancer, which although it give him hope for a remission, it made him suffer with debilitating flu-like symptoms lasting two or three days after every injection. As he had two injections weekly he had very little time symptom-free. Thinking of the difficulties ahead, I suggested to him that I contacted the Macmillan team, the terminal care team, for extra support for his increasing symptoms and nursing needs. As soon as he heard the name he was convulsed with sobs. I reassured him that involving the Macmillan service does not mean that everything is lost, but rather obtaining extra help for his wife to look after him. As his fear was so severe I offered to visit him again, for another man-to-man talk in order to help him express his fears in words.

Even though Frank was so scared of the Macmillan service I discussed his problem with the medical director of the local hospice where the Macmillan team is based and asked for an application form, which would also put him on the waiting list for a bed at the hospice, in case he needed it when the time came.

Two days later I was asked to visit Frank because he was in great pain. I was dismayed; not again, I thought. As I was driving to his home, I came to a T-junction. Instead of turning left towards his home, I turned right towards the hospice which is in our locality. I was annoyed that I had not yet received the application form, and my conscious thought was to go to the hospice personally the fill it in on the spot. Suddenly I was struck by the absurdity of my actions. Even if I filled the application form that day, it would take several days before it was processed. I was simply wasting time. I was delaying the painful task of being confronted with my therapeutic impotence, and postponing the painful task of giving more bad news, of tolerating his fear, his anxiety and his despair, as well as his wife's. I wished I could admit him to the hospice immediately, so that this painful task was taken away from me. Or perhaps I wanted to take refuge into the hospice itself.

It was then that I thought of Christ's words to his father when he was praying in the garden of Gethsemane before his ordeal. 'My father if it be possible, let this cup pass from me; nevertheless not as I will but as thou wilt.'

When I became aware of my wish to avoid being confronted with all this pain, I realised that my task was indeed limited. All I had to do was assess his clinical condition and decide whether he needed admission or not. I was able then to turn my car round and drive to his home.

I found him in bed. He was unable to stand up. Examining his right leg I found that any movement caused great pain in his hip, and I wondered whether he had sustained another pathological fracture, or whether he was about to. Somehow the thought of his fracturing his femur as he was going downstairs was horrible. I told him that he needed to go into hospital to find out whether he had another secondary. He looked at me disheartened; 'How long have I got, doctor?' he asked me. I told him that I did not think he was dying now any more than he was dying when he broke his clavicle or his arm. They would treat him with radiotherapy and the pain would go.

At the hospital, his pain was controlled with a nerve block in his back which diminished the strength of his legs so that he could not get up without help any more.

He was discharged one month later and when I visited him after a few days, he looked at me with a sad expression in his eyes, 'Look at the state of me', he said. He was unable to get out of bed or walk; he felt like the old age pensioners, the eighty-year old who cannot walk. As he said that his was convulsed with sobs. I encouraged him to talk about his feelings, the rage at his diminishing powers, the humiliation of having his bottom wiped by his wife, his fear, his disappointment that he will not be able to enjoy his retirement, for which he had been saving in order to go to New Zealand and visit his wife's relatives. He felt helpless like a baby, except that he was much heavier than a baby and his wife could not lift him.

I listened to him attentively and at the end I touched him on the shoulder and said unconvincingly, 'Don't despair. There is hope'. I told him that just as the swelling of his clavicle disappeared after radiotherapy, so probably the secondaries of his spine and arm would go as well. I arranged to visit him regularly every Monday and I left.

For the following two days I felt unwell, having developed a headache and sore throat. I reflected on my symptoms and identified them as physical accompaniments of my sadness and, more disturbingly, as a regressive trend set in motion by an identification with Frank's helplessness.

Frank continued to deteriorate. The Macmillan service had become involved much to my relief, and Frank had another admission to hospital for correction of his anaemia and high blood calcium. Soon after his discharge, I was called to visit him because his legs had become suddenly swollen, an indication that an abdominal mass was interfering with the return of the blood from his legs.

I discussed the problem with the oncologist, who said that neither radiotherapy nor chemotherapy could shrink the tumour in his abdomen, and therefore further hospital treatment was not advisable. He had entered the terminal phase of his cancer and if nursing him at home became unmanageable, he should be admitted to the Hospice.

As I mentioned earlier, I had arranged to visit Frank every Monday after my morning surgery. The next Monday I was due to visit him as a Bank Holiday, and when I woke up, I started making plans to take my daughter swimming without any thought of Frank. As I bent over the sink to wash my face, I felt a severe pain in my lower back, and fell onto my knees. Every movement was excruciatingly painful. The only position that was comfortable was lying down.

I was shocked by the sudden onset of pain and I burst into tears. I did not know whether I was crying with pain, or out of frustration for my helplessness, or because I was so fed up with carrying such a heavy clinical responsibility from which I could not escape even on a Bank Holiday. The burden seemed too much. I had forgotten to arrange an alternative day to visit Frank, and realised he would expect me to visit that Monday as usual. I could have telephoned him to postpone my visit until the following day, but I was not at all sure that I would be feeling any better. I could not bear the thought of letting him down and not visiting the day he expected me to. As the day went on, my pain improved and by midday I could sit up. As my back was still too painful to drive, my wife offered to drive me to Frank's home at noon, the usual time for my visits.

Frank showed me his legs and burst into tears. He was afraid that he might not be able to walk again. Sometimes he felt he could lie in bed for another fifteen or twenty years, and some-

times he was not at all sure that he would be here next week. He felt weaker and weaker every day. He talked about his uncertainty and fear. He avoided crying in front of his wife because it upset her so much. So he bottled it up and had to let go from time to time. He was grateful to his wife who was so good and did everything for him. She was devoted, 'Perhaps too devoted', he said, sobbing. I was very moved and thought of my devoted wife who was waiting patiently for me in the car outside Frank's house. I encouraged him to take every day as it came and enjoy the things that still gave him pleasure, such as the sweets that he had developed a craving for. On my way out, I had a brief talk with his wife who did not know where she found the strength to cope. She wondered why Frank was punished in this way. 'He never did anything wrong. There are some bad people that no harm ever comes to ...', she said. I told her that cancer respects nobody. Innocent children can get it, good men and bad men alike. It is the luck of the draw. She told me how helpless she felt, witnessing Frank's prolonged agony. Some people die instantly with a heart attack. 'And yet', I retorted, 'this long illness has brought you closer. You are able to show him how much you love him. Your devotion and care are his greatest comfort, and you must not under-estimate how important you have been. You cannot cure his cancer, medicine cannot cure his cancer, we cannot put the clock back; but you are always there when he needs you, and this is the greatest help you can give him.' We were both in tears by then.

I was off work for one week with my back pain, and during that week the Macmillan team admitted Frank to the Hospice because it had become impossible for Irene to lift him without causing him excruciating pain. She telephoned me during my emergency Saturday morning surgery, to inform me of the events. I went to visit him at the hospice after the surgery. His deteriorating was visible. He had lost a lot of weight, his speech was slurred and he was too exhausted to lift his arms; he had to be fed. Irene was trying to persuade the doctors to investigate his calcium levels because last time when his hypercalcaemia was treated, he felt a lot better.

We had a talk. She could still not accept that Frank might die. She could not imagine life without him. It was all so unfair. Despite her saying that however, I was reassured to hear that she was thinking of visiting her sister in New Zealand when it was all over.

I visited Frank again on Monday, a week later, and he was very pleased to see me. He said that I was a doctor in a million for always coming to see him. Irene kept thanking me for being so good to Frank. I had another talk with her, praising her for her attentive care and expressing my admiration for her devotion. I again stressed that she could not take the cancer away, but her devoted attention to comfort him, was the greatest help she could give him.

A week later Frank had deteriorated dramatically. He could not swallow any more, and his pain-killers were give to him subcutaneously with a drive pump. They all thought he was going to die over the weekend, but miraculously he pulled through. When I next saw him, it was obvious that he had only hours to live. I wanted to burst into tears. 'Goodbye', I blurted out. He sobbed and squeezed my hand. 'No ... don't say goodbye,' he said. 'O.K.' I replied, 'I will not say goodbye ... see you on Monday'. 'Yes, yes, see you on Monday,' he echoed. I squeezed his hand. Irene was in tears. It was time to go. I expressed again my admiration for her courage, stamina and the support she was giving him, and asked her to let me know when Frank died.

He died the following Friday. His illness lasted eleven months, from the first symptom to his death. The urology registrar was right in her estimation. She had given him one year, but her approach was so insensitive. I also wondered what had I done to earn Frank's praise and gratitude. After all, compared to the hospital doctors, I was as helpless and impotent in the fight against cancer as Irene was. And again Elizabeth Kubler Ross's words come to mind, 'If the doctor sits and listens and repeats his visits the patient will soon develop a feeling of confidence that here is a person who cares, who is available and sticks around.' This function of the doctor has a holding quality. It helps to contain the anxiety, fear and despair of the patient and his family, so that they do not feel abandoned when they are so vulnerable. The doctor who can tolerate his own fear of death and reflect on the emotions which are aroused in him by the dying patient, is in a position to communicate with the patient at a deep level, relieving the sense of his isolation.

What is the basis of a humane attitude?

In the land of the sick, emotions reign supreme. Fear is a thought away. Our mental well-being is based in part on the illusion of invulnerability. Any disease, particularly severe disease, bursts this illusion, attacking the premise that our private world is safe and secure. Suddenly we feel weak, helpless and vulnerable. In general practice, we are constantly exposed to the emotional communication of our patients which evokes a lot of feelings in ourselves. The more serious the disease, the greater the intensity of the feelings that the patient will communicate to the doctor. The doctor may be called upon to recognise and handle feelings of violent intensity, such as revulsion, despair, the terror of abandonment, the horror of loneliness, humiliated fury, or the mortification of shame. Feelings of such intensity may well become intolerable for both doctor and patient. This is probably one of the most stressful aspects of being a general practitioner, and a task for which our medical education did not prepare us. This task involves the capacity to handle both our own feelings and the feelings of our patients. It involves the doctor's capacity to tolerate intense feelings without having to withdraw in fear, or retaliate for the pain they cause him, and the abi-

lity to soothe them both in himself and in his patient. These skills will determine to what extent our attitude to the patient will be experienced by him as humane.

In the middle of the century, Michael and Enid Balint and a group of enthusiastic self-selected general practitioners, began exploring the emotional difficulties in the relationship between the general practitioner and his patient. The results of their research were to provide medical education with a unique instrument for the development and teaching of emotional skills.[4,5,6,7]

This relationship like any other relationship, has to be built on understanding if it is to succeed. However, unlike any other relationship, the doctor/patient relationship demands a special type of understanding. Donald Winnicot has pointed out that becoming ill carries the fact of dependence. This very fact calls for the attitude of dependability in the doctor. As doctors and general practitioners, we are called to be humanly reliable. This attitude of dependability is based on the capacity to recognise dependence and the ability to handle the feelings that such a position creates in both doctor and patient.

Daniel Goleman in his fascinating book, *Emotional Intelligence,*[8] has brought together many strands of psychosomatic research and has identified a set of characteristics which are the result of an advanced state of emotional development. These are: being able to recognise feelings, being able to distinguish between them, being able to name them, being able to control the impulse, being able to delay gratification, being able to regulate one's moods, being able to keep distress from swamping the capacity to think, being able to hope, being able to motivate oneself, being able to understand other people's feelings, being able to persist in the face of frustration and being able to give credit to oneself.

What is empathy

These eleven characteristics are the skills of emotional intelligence, the emotional competences which help people develop harmonious relationships. Of all the characteristics I mentioned above, the ability to know our feelings and the feelings of the person we interact with, and to act in a way that shapes those feelings and makes them easier to bear, constitutes the core of the art of handling relationships. This ability to see things from the other person's perspective is a developmental achievement and depends on the capacity for self control. It depends on the capacity to dampen down our anger, distress and excitement and to restrain the tendency to express our feelings in immediate action, pausing to reflect about what we are feeling and why. The name we have for this ability is Empathy.

The word empathy was first coined by E. B. Titchener, an American psychologist at the beginning of the century. His theory was that empathy stemmed from a sort of physical imitation of the distress of another, which includes an unconscious imitation of his facial expression, and which then evokes the same feelings in ourselves. He sought a word that would be distinct from sympathy, which can be felt for the general plight of another with no sharing whatever of what the other person is feeling.

Empathy is possible because emotions are communicable. A person in the throes of an emotion is a broadcaster of emotion, and we observers resonate with his transmission. The contagious quality of the broadcast literally drags the observer into resonance. The intensity of the broadcast is decreased to the extent that this person learns to modulate the display of his emotion. This is the physiological basis for what later will be called empathy, the sharing of emotion that accounts for much of the quality of adult interpersonal relationships. We can observe this emotional contagion in a public auditorium when such emotional resonance is essential to the enjoyment of our entertainment. Because 90% of an emotional message is non-verbal, the key to the intuition of another's feelings, is in the ability to read non-verbal information, such as the tone of voice, gesture, facial expressions etc. Such messages as anxiety in someone's tone of voice, irritation in the quickness of a gesture, are almost always taken in unconsciously and responded to without necessarily an awareness that emotional communication has taken place.

Silvan Tomkins feels that it is from our awareness of the way the skin and muscles of the face have been rearranged or distorted by the affect that hits us, that we figure out what we are feeling.[10] We share the affect just triggered in the other person to the extent that we are willing to mimic the operation of these muscle groups. Whatever the source of the affect, we imitate purposively or the contagion we accept passively, it becomes the source of the affect we now experience. This is the basis of empathy; the sharing of emotion that makes so much of the pleasure of social experience.

Although empathy is vicarious emotion, i.e. feeling with the patient, it is much more than emotional contagion. Empathy builds on emotional self awareness. The more open we are to our emotions, the more skilled we will be in reading the feelings of others. Empathy is our ability to enter imaginatively and yet accurately into the thoughts and feelings and hopes and fears of other person. The ability to stand in somebody else's shoes and to allow the other person to do the same to us, is a developmental achievement and a sign of health.[10]

The failure to register another's feelings is a major deficit in emotional intelligence and a tragic failing in what it means to be human. All rapport, the root of caring, stems from the capacity for empathy. It is precisely the lack of these skills that can cause even the intellectually brightest to founder in their relationships, coming off as arrogant, obnoxious or insensitive.

Learning empathic skills

Some doctors have the ability for affective reso-

nance, of entering imaginatively into the thoughts and feelings of another person more developed than others. This ability however, when it is not educated can sometimes be a burden. Although when we are in a public auditorium, emotional resonance is essential for the enjoyment of an entertainment, it is frequently less than useful to be caught up in the anger or distress of a stranger. Affective resonance is so powerful, so distracting a system of interaction, that infancy is the only period in our lives during which we are allowed free range of affective expression. In every society, children are speedily taught how to mute the display of affect, so that they do not take over every situation in which they cry or become excited. Just as most or all of the affect we broadcast into our environment, must be limited by social and cultural forces, we adults are also obliged to learn a number of skills to help us manage the affect broadcast of others. Our whole concept of ourselves as private individuals is based on the idea that we can be alone, free from the intrusion of the emotions of others. Adult life requires some balance between privacy and communion. Our whole concept of what it means to be mature, is based on the expectation that adults can control themselves. Control of affective expression reduced the amount of affect broadcast into the interpersonal environment. It makes life easier for those around us.

So those of us who resonate easily with the contagious quality of the affect of their patients have to build a shield for protection from the affective experience of the other person, a mechanism which Donald Nathanson has called 'the empathic wall.'[11] This is a skill, a learned mechanism by which we can tune out of the affect display of others. One way of building an empathetic wall would be by refusing to mimic the facial or bodily display of the affect we see in other people. We might for instance learn to recognise the feeling of contagion, learn to sense the very moment that another person's affect begins to tickle our receptors. Then we might decide to shift attention to something else and stop the process of resonance. We can block completely the experience of affective resonance by this mechanism of distraction, or we can limit it over carefully graduated levels of connectedness. It is this empathetic wall that allows us to maintain our boundaries in the presence of other people when they are experiencing or display affect. The empathetic wall helps to preserve the unity of the self. Adults who do not learn how to shield themselves from the emotional lives of others, suffer greatly because they fail to develop a secure sense of identity. The skill of the empathetic walls which controls the phenomenon of affective resonance is perhaps one of the basic empathetic skills upon which a mature sense of empathy can be cultivated. Some lucky doctors are fairly natural at empathic skills. They learned, perhaps from their parents, to listen to others for their ideas, their feelings and their dilemmas. But the rest of us who have not been so fortunate, must learn these skills if we are to function as humane doctors and not simply as technicians or, as mechanics of the flesh, as one of my patients put it. Many doctors have difficulty in the area of empathy probably as the result of traditional medical training that is itself abusive and unempathic. We do not teach empathy by being unempathic to our students or teach kindness by being abusive. There are doctors who not only lack empathic skills but who are even unaware of their value. Fortunately unlike our IQ, which is genetically determined and some say cannot be improved by education and training, emotional intelligence can continue to improve throughout our lives with the right training.

For the purpose of teaching empathic skills, Frederick Platt, in his book, *Conversation Repair: Case Studies in Doctor-Patient Communication* distinguishes between affectively based empathy and cognitively based empathy.[12] The first type is a sort of vicarious arousal, a kind of contagious affect. During contact with the patient, the therapist experiences certain feelings and asks himself why he feels that way. He very soon realises that the patient has been feeling the same emotion and that the affect has been communicated from patient to doctor. Once this process is understood by the doctor, through an act of reflective self awareness, contagious affect allows him to act towards the patient with greater understanding.

Frederick Platt believes that unfortunately many doctors are not very aware of their own feelings. Most of us are more cognitively aware than emotionally aware. We even avoid feelings; our own and the feelings of others. In this case, we are more likely to succeed with a cognitive approach to feelings. If we think first that we have to include feelings in our understanding of the interaction with the patient, we will do better than if we depend on catching them from him.

The acquisition of empathic skills is essential because they facilitate a true understanding and true understanding leads to compassion.

In England, doctors have limited opportunities for the cultivation of empathic skills. Balint/groups and the student psychotherapy scheme pioneered at the Department of Psychological Medicine at the University College Hospital in London, are among the best established examples.[13,14]

However, a humane medical attitude that is based on empathy and understanding of the patient's experience of his disease is only a potential and has to be protected and defended against a variety of dehumanising influences.

The changing culture of medicine itself, as it becomes more responsive to the imperatives of business, is making such care increasingly difficult to make. The welfare of the patient is often subordinated to the concept of the patient as an economic unit.

Ivan Illich in a recent article has identified a new insidious dehumanising force which comes

from an unexpected source.[15] It comes from the spreading influence of the concepts of systems analysis which are fostering new notions and practices in health, which surreptitiously are affecting people's perception of themselves. The patient is at risk of no longer being considered a person with hopes, feelings, and dilemmas, and becoming a technological construct. This new approach is leading to the disembodiment of self-perception. The patient is now a life. He emerges from a gene pool into an ecology. We tend to speak of health as the state of a biological system, and of death as life's irretrievable breakdown. Disembodied people are those who think of themselves as lives in managed states, like the RAM drive of their personal computer. Lives do not die, they breakdown. Death is an interrupted memory. There are no dead around, only the memory of lives that are not there.

This attitude that leaves no room for emotions, leaves us ill prepared to face death and die. Ivan Illich reminds of the old Mediterranean norm that a wise person needed to acquire and treasure a friend who will stand by him and support him through his dying. Today it seems that the general practitioner with a humane attitude has the potential to become such a friend.

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The Balint Society Prize Essay, 1997

The Council of the Balint Society will award a prize of £250.00 for the best essay on:

"If there's nothing wrong with me, doctor, why does it still hurt?"

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.

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article.

All references should give the name and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of *Index Medicus*; year of publication, volume number, and the first and last page numbers.

We welcome the submission of documents on 3.5" computer disk. IBM compatible files only please. If possible, please send files in Microsoft Word for Windows version 6 or 2. Other acceptable files are WordPerfect versions 5.0, 5.1 or 5.2; Wordstar versions 3.3 to 5.5; Word for MS-Dos 3.x to 5.x. Authors should supply the name of the file on disk. Please send one hard copy with your file.

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 28th Annual General Meeting in 1997.

Entries must be received by **1st April, 1997** and sent to: Dr. David Watt
Tollgate Health Centre,
220 Tollgate Road,
London E6 4JS.

Personal Dimensions of the Hospital Encounter*

Tim Young
4th year Medical Student, King's College Hospital, London.

Introduction

I am a fourth year medical student in London and as such I have been in contact with patients for about a year and a half. Looking back, this period seems much longer as the clinical phase of our training has been so different (and more interesting!) than our pre-clinical teaching. Although, of course, I have much to learn about developing relationships with patients, I believe I have already noted many different approaches the medical staff around me have employed in their contact with patients. I will attempt to describe these approaches and apply constructive criticism to them to develop suggestions for helping future medical students in their relationships with patients. Finally I will consider how the rapport that a medical student builds up with a patient can be helped or hindered by different types of relationship roles which may have been formed with other members of staff. I will be concentrating on the influence senior doctors can have on this rapport as this is an area in which I have already experienced problems on a number of occasions. To begin with I shall start by describing in some detail the relationship I formed with one particular patient, and then move on to a more general discussion based on other experiences I have had, and on those I have observed.

Exposition

Joan Brown (not her real name) was a 41-year-old lady whom I first met on the gynaecology ward where she was waiting for a cone biopsy of her cervix carcinoma. Our first meeting was a brief one, as part of the consultant's ward round. Joan immediately struck me as a very open and friendly lady who had a good rapport with the surgeon (she had been under his care previously). I must confess it was this friendly aspect that suggested she would be a good patient to ask if I could clerk for the next morning's operating list. Obviously many patients are anxious the night before an operation and so do not always welcome the prospect of being clerked by a medical student after being already seen by several doctors. Furthermore, gynaecology patients sometimes feel uncomfortable about being clerked by men.

I went to see Joan in her side room soon after the ward round. Luckily she did not mind me clerking her at all. I went through a brief medical history with her, then came the potentially difficult part. As part of our training we are expected to have performed a certain number of vaginal examinations. Whenever we clerk a pre-operative patient we are always supposed to ask their permission if we can perform this while they are anaesthetised for the operation. Although I had asked about eight patients this before (all but one of whom had kindly agreed) I still felt rather awkward in broaching the question. Fortunately Joan said she did not mind at all. With this I relaxed quite a bit and was able to have a good long chat with her.

She told me about her job which was certainly not one I regularly encounter as she was drummer in a band! She went on to talk about her fears for the operation, which mainly concerned the possibility that she was have to have a hysterectomy. This was a point she had raised with the consultant and so I was able to repeat the assurances that he had given her, namely that the operation in the morning was only to find the extent of the cancer, so that even were a hysterectomy to be advised, she would still have some weeks to think about it with her boyfriend. As medical students we are often asked questions like this and we normally have to be quite vague in our answers for fear of misinforming the patient. In this case though I felt justified in reassuring as I had just heard the consultant being quite specific on the subject.

At this point Joan seemed relieved and she went on to explain why it was so important to her. Although she was now 41 and had two healthy children she still desperately wanted another as she had split up from her husband (the father of her children) and was now with a new partner. This much she had told the doctors on the ward round. That she told me more about her past I feel was simply due to the fact that I had time to listen: a luxury we medical students have and one I shall be sad to lose when I qualify. She went on to reveal that she had been often battered by her husband but that he had got the legal rights to look after the children, a fact that added poignancy to her great wish to preserve her uterus to have one more child.

I was interested to know why the divorce court had not allowed her to look after the children as she was their mother. To this question Joan went on to reveal that at the time she was being treated for manic depression. The treatment she was then on (Lithium carbonate) had necessitated an unwanted termination of pregnancy and she had later been raped at one of the mental health hostels she had been staying in.

I felt I had unearthed a can of worms and found these revelations hard to fit in with my initial, superficial, image I had formed of Joan as a happy, normal housewife. I felt she had had a very rough time and I felt myself desperately hoping that the operation in the morning would remove the full extent of the cancer making a hysterectomy unnecessary. Especially after hearing of her past troubles I was anxious to allay the blame she was attributing to herself with regard to

*International Balint Award, 1996.

her cervical cancer. She admitted to having many sexual partners when younger and seemed to think of the cancer as being entirely her own fault, or even a kind of divine judgement on her former behaviour. Of course there is no denying that increased numbers of sexual partners leads to an increased risk of cervical cancer but I emphasised that there were other factors as well, such as smoking (an unfortunate example as she promptly admitted to smoking 'like a Chimney'!). I tried to accentuate the positive things she had done, in particular the fact that she had turned up for her cervical smear appointments, which had led to the discovery of the cancer hopefully at a stage which it could still be treated.

By now I really feel we had developed a good rapport as we both seemed fully relaxed and open. At least for the moment Joan seemed to have stopped blaming herself for her current condition, and even joked about her youth, describing herself as 'sex-mad'! The arrival of a friend at this point provided a convenient moment to end our conversation. I got up and shook her hand and wished her all the best for the morning. Although I have clerked many patients, it still pleases me when I feel I have really got on with a patient, and I left the ward with a spring in my step.

The next day I assisted at Joan's operation in the time honoured way of medical students – by holding the retractors. A radical biopsy was taken in an attempt to provide a cure as well as a histological specimen. At one point in the procedure a major branch of the uterine artery must have been nicked as there was a sudden spurting of blood which poured warmth over my hand. Of course I would always hope that such bleeding would be quickly controlled, but having got to know Joan before hand gave an added urgency to this hope. As it was the surgeon quickly managed to tie the bleeding vessel and the procedure was quickly finished. I had not got to perform the vaginal examination (the surgeon was worried that such an examination could cause damage if the cancer had eroded deeply into the cervix). However, after the scare of the blood loss I was just happy that Joan was alright.

Following the blood loss Joan was kept in overnight as a precaution. I saw her briefly before she left the next day. She seemed tired as if some of her former sparkling character had been spilled with her blood. She seemed relieved now it was over and was already quietly steeling herself for the histology report on the biopsy which would come through in about a week. I realised now that a lot of her pre-operative laughing and joking had probably served to hide her anxiety, perhaps even from herself. I thanked her for her time, and really meant it, but I had to leave at that point as I was already late for the Outpatients clinic. This happened two days ago, and so at the time of writing we are still waiting for the histology report, and I am keeping my fingers crossed.

Reflexion

Looking back on Joan's stay at King's Hospital, I can see that several types of relationship were developed between Joan and members of the medical staff. For my own part, as perhaps suits my quiet and somewhat shy nature, I very much assumed the role of a sympathetic listener. Although if need be I can adopt a much more extrovert role (for instance when treating worried parents or taking blood, when a touch of the showman can be helpful to relax both parties), when I can play a more passive part in the relationship it suits may nature better. I believe that this was a big advantage for forming a good rapport with someone like Joan who was a bit of an extrovert.

It is of course not an absolute requirement that peoples' characters must dovetail for them to get on. My consultant also got on very well with Joan although he too would best be described as an extrovert. When they met it seemed to be an excuse for a tongue-in-cheek session of mock insults and jokes. In many ways Joan was the ideal patient for us to interact with as she was intelligent, open and friendly. As most of the patients I meet in the hospital are worried about their illness or forthcoming medical procedures, it is not to be wondered at that it is more difficult to form effective relationships with many patients. With such patients it may be desirable to tailor our approach to try and relax the patient, even though this is somewhat alien to my nature. In a similar way, I expect some patients would expect a more formal relationship with their doctor, and so might be offended with the intimate, laid back approach my consultant tends to adopt.

With regards to the team relationship and attitude towards Joan, I noticed that before her operation many of the doctors were making jokes about her somewhat different lifestyle (her drumming and the fact she had admitted to taking drugs in the past). This was a group of doctors who I believe were particularly caring and who I have grown to respect greatly. Such flippant attitudes to patients are of course common in the infamous black humour of hospitals. Already I myself have been guilty of it on many occasions, and I have grown immune to it until it is directed at a patient like Joan whom I felt I have got to know as a person and not just a patient.

Such discussion opens the broader issue of doctors sometimes distancing themselves emotionally from patients to protect their feelings in the event of the patient dying. It certainly would be unreasonable to expect doctors to grieve for every patient they have lost as they would a dead friend. If this were to occur maybe a couple of times a week the doctor would surely before long be emotionally shattered. This is not just out of consideration of the feelings of doctors, but to allow them to continue providing a good standard of care for future patients. This dilemma is particularly acute in the operating theatre where patients can potentially die in minutes, or be found to have inoperable disease immediately after opening the abdomen. Such suddenness and unpredictability may make doctors even more

prone than usual to build up a wall of black humour to protect their feeling. Such impersonalisation may allow the surgeon to perform to his best ability. Where this is impossible, as when the surgeon's relatives or close friends are the patients it is standard practice to swap with another surgeon to avoid emotions clouding their clinical judgement.

The big danger with the protection of feelings by not becoming too emotionally attached is that this can spill over into the doctor/patient relationship. If the patient perceives the doctor not to be truly sympathetic towards them they are unlikely to feel inclined to reveal their innermost feelings. Such feelings, and information of an intimate nature (eg. drug/alcohol/physical abuse or information of a sexual nature) can be vital in the satisfactory treatment of the patient. It is thus a balancing act that all physicians must perform with regards to their emotional involvement with patients. One indirect result of this can be to colour the opinions of us medical students who are as yet still forming the skills of forming relationships with patients. It is only with patients like Joan that I stop and think how much we students have already picked up from the doctors around us in the 'art' of being flippant and detached from patients behind their backs. It may be that all new doctors would eventually develop such emotional defence mechanisms on their own. However, it is equally possible that to some extent their attitudes are being corrupted by exposure to such behaviour so early in our clinical experience. Possibly the occasional tutorial to make us aware of these developing attitudes could be useful at this stage to prevent us blindly copying such approaches as the accepted status quo in hospitals.

Action

In my interaction with Joan I felt a number of demands had been placed upon me. The first of these I have already alluded to, namely Joan's worry about a possible hysterectomy. Although she did not directly ask me about this concern, as she talked about the possibility I felt strongly that she was seeking some reassurance on the issue. As I had just heard the consultant clearly state to the patient that she would not have a hysterectomy in the morning, just a biopsy, I was happy to echo his words. I have not always been in such a clear cut position. Often as medical students we are asked questions by patients that they have not asked the doctors treating them. This occurs for various reasons, not least because as students we have more time to talk and listen to the patients. Sometimes the patients openly confess that they felt it would have been out of place to ask the consultants questions!

When patients do ask us students direct questions about their condition or prognosis it can put us in a very awkward situation. Not only may we give the patient bad advice but also we may be breaking the etiquette of the established medical hierarchy by daring to tell a patient things that the senior doctors have not. In such situations we are usually advised to be vague or feign ignorance and advise the patient to ask the doctors who are treating them. The trouble is that such approaches can become so ingrained that they are still employed after we qualify; I have seen junior doctors doing just this even when they know the answer to the patient's question. Thus patients may be left in the dark as no one is willing to take on the responsibility for fully informing the patient. Langewitz[1] *et al* have identified the poor information given to patients as one of the central areas of the doctor/patient relationship which could be improved. Sometimes this approach to patients' queries may be due to the unwillingness of doctors to be the messenger of bad news and as such may be another example of trying to protect one's own emotions.

One pressure I often feel when talking with patients is the desire to disclose information about my own personal life which may be relevant, much as a friend would do in every day conversation. For instance, when Joan was talking about her problems with manic depression I felt the urge to tell her about a close relative who has had similar problems. However I resisted as I already feel that we were given good instruction early on in our course when advised not to disclose personal information to patients. I found this to be true for me at least after several 'disclosures' from me which I felt seemed to rather mess up some clerkings I conducted with patients in the first few months of our clinical training. For instance, one patient I was talking to was trying to lose weight to lower his blood pressure. I had recently been in the same position myself and embarked on a detailed description of my successful attempt to lose weight. I now feel that, while the doctor/patient relationship should be a process of sharing knowledge, it should very much be patient based. After all, usually the patient has not just come to the doctor for a friendly chat. Indeed, sometimes it may be that this difference the medical interview has from talking to a friend is one reason that patients can disclose intimate details to the doctor that they would never tell their friends. Possibly the disclosure of personal information by the doctor changes him from a sympathetic stranger into the role of a friend which may thus inhibit full disclosure on the part of the patient.

One perceived demand I felt strongly when I first started talking to patients was that of not betraying confidences. Of course this is a tacit understanding of the doctor/patient relationship, but at first there was a part of me which regarded sharing of a patient's intimate disclosures even to other medical staff involved in their care as a sort of betrayal. I realise that such information is vital to maximise the effectiveness of the medical team in caring for the patient, but I still sometimes have to wrestle with my conscience about whether to reveal certain personal disclosures. I feel this dilemma most acutely when I have to 'present' the medical history to the consultant in

front of the patient themselves. I also have to occasionally decide whether disclosure of such information is really needed, especially as it may only serve as fuel for some medical humour at the patient's expense. For instance, in the case of Joan I did not reveal that Joan had said she was 'sex-mad' in her youth with many sexual partners. This is of course a factor in the aetiology of cervical cancer, but it would not affect her treatment now it was known she had this condition and might have merely provided evidence for a joke at her expense.

One of the greatest problems I have experienced in my relationships with patients occurs when I am training under a senior doctor (usually a consultant) whose attitude to patients I feel is offensive. The great dilemma is that this is clearly the way they perceive the relationship with patients should be, and often try to instill this attitude into us. To be fair Joan's consultant and most others I have met are nothing like this, but when I have come across one who acts in this manner it really sticks in my mind. For some reason most of the doctors I have met that fall into this category seem to be surgeons. I do not mind so much if they lose their temper with us, but when they adopt a high-handed attitude to their patients I do get very angry. The greatest difficulties I have faced with such views have occurred in surgery out-patients. I must admit that often the consultants have had a tremendous work load, sometimes effectively doing two surgeries at once. But never the less they are often performing invasive procedures (such as sigmoidoscopy) and as such have a duty to try and prepare the patient as best as possible. My experience of such clinics is that the doctor may do nothing of the kind and be very abrupt and cold with the patient. I have on several occasions seen patients reduced to tears by such a brutal approach. The real dilemma I feel is when we have to clerk or examine the patient in about five minutes and are told off if we 'waste' time trying to be nice to the patient. Maybe I have been unlucky to have come across such doctors and I like to think they are rare exceptions. The one good thing I have gained from the experience is that the memory is so deeply ingrained on my mind that I believe I will always strive to do my best to avoid treating patients in a similar manner. As we often learn from our own mistakes, so we sometimes learn best from the mistakes of those around us.

Progression

I have so far mentioned several problems I have experienced in forming relationships, and in some cases how I have attempted to overcome such problems. In most cases I have slowly developed these attempted solutions by a rather haphazard process of seeing what best suited me and from the occasional advice from medical staff. In our two pre-clinical years we received plenty of lectures on the intricacies of anatomy and biochemistry, but little instruction on the art of forming relations with patients. Such relationship skills will be important for the rest of our career, whilst most of the anatomy and biochemistry will prove irrelevant for most of us unless we become involved in surgery or clinical biochemistry. One reason that this teaching paradox is that with factual subjects like anatomy it is fairly clear what one has to know and it is possible to memorise the facts on a short-term basis to pass the exams at the end of the second year. Relationship skills on the other hand seem much more nebulous topics to understand. There seem to be few of the facts that medical students are so used to learning, and there is the added difficulty that there is no black and white, right or wrong way. As we have to adapt such skills to each patient it can be tempting to believe that we all already possess these skills that we practise daily when talking with friends and colleagues. From my own experience I know many of us (including myself!) used these convenient arguments to justify missing some of the few lectures we received on the subject of forming relationships with patients. This was reinforced by the thought of anatomy, physiology and biochemistry exams looming large on the horizon, and which seemed so much more immediate and important to us at the time. This is a vital point to be considered when developing any strategy to improve the medical education concerning relationship skills. Unless it is felt to be important to them many students will simply not turn up to such sessions. This may seem terribly ungrateful but I think it is understandable in the context of a medical course which is littered with tests which must be passed in order to eventually qualify as a doctor. Students may thus be forgiven for concentrating on those topics they feel they had to master for such tests. Unfortunately, the development of exams to test such skills is much more difficult than designing a test of medical knowledge. Furthermore, compelling students to attend by use of registers immediately forms a barrier of resentment between them and their teacher. This may be overcome when simply teaching a factual subject, but when teaching about doctor/patient relationships it is not sufficient to ensure that the students are merely physically present or scribbling down notes. They must be willing to share in the discussion with their emotions and for this they should ideally actively want to be present and learning.

How should one overcome these obstacles? For a start, I would question the value of increasing the amount of teaching time spent on these topics before the students have really met a patient themselves. In my year this did not actually happen until the beginning of our third year, but more medical schools in the U.K. (including King's from next year) are trying to provide a more integrated course with, patient contact almost from day one. I believe it is important to give most of the teaching on relationships with patients *after* the students have met patients themselves as then any teaching can be more interactive. Ideally students could then present the problems they have experienced with patients

and discuss ways of overcoming these problems as a group. The other major point is a personal one, but one I believe applies to many other of the students in my year. This is simply that you may not really see the point in discussing relationships until you have come across difficulties with them on the wards. Furthermore, as I found with Joan, you get a wonderful feeling when you feel you have got on really well with a patient, and you actively want to find out how you can increase the number of patients this happens with in the future.

With regards to teaching methods I believe that the traditional lecture format has only a very limited role, such as in introducing the basic concepts of the medical interview. Past this introductory stage I feel group sharing of points of view, experiences and emotions is vital. For myself the most productive sessions I have done in this regard were role-play examples. These were performed as part of our general practice and palliative care courses. We had to play either doctor, patient or relative. The settings consisted of either trying to find out a hidden agenda the patient had or of breaking bad news to a patient. I personally found the role of the doctor breaking bad news to the 'patient' to be one of the hardest and most rewarding things I have done since I started medicine. This session was especially challenging as the student playing the patient had just in real life suffered a major bereavement. It felt intensely awkward at first performing in front of the rest of group but I quickly forgot they were even there as I struggled to break the bad news in the best way possible. At the first attempt I made many mistakes which I recognised even as the words were leaving my mouth. My major error was hiding behind medical terms and figures. Although it is always a bit difficult to take even constructive criticism from your colleagues, I realised that we learn from our mistakes and I tried again. The second time I really felt I had achieved the right balance and was greatly helped by the silent encouragement of my watching colleagues. When we had finished and left the room I must admit to feeling elated as if I had really achieved something.

Two weeks later I was clerking a patient when I sensed there was some great trouble on her mind. I gently questioned her and the story came out that she was terrified that she had breast cancer as her sister had just died of this cancer after months of agony. I can still picture the cubicle as she quietly sobbed and I did my best to comfort her. It was near the end of our conversation that I realised with a shiver that I have been subconsciously following my 'roles' of a few weeks before. It was then that I really felt I had indeed achieved something in the teaching session. When I went out of the cubicle I mentioned the lady's fears to the doctor concerned, who had not been told this when she had clerked the patient earlier.

I have so far praised the role-play model of teaching, but it does have serious drawbacks. For a start it is something many students are very reluctant to perform, perhaps aware of the intense emotion needed to really make it work. I certainly felt very much the same, and had to be almost dragged on to 'stage' to perform my role, but I am eternally grateful I did so. Possibly people like myself who have benefited from this technique should attempt to explain the benefits more to our colleagues to try and overcome anxiety about it.

The other major problem concerning role-play is that, as I found out, everyone present, even the observers, need to be totally committed. I have performed in role-play which has been utterly useless as one or more participant was not really taking it seriously. Possibly such humour may be used as a protective wall against the student's fear of exposing his emotions. Whatever the reasons though, I do believe that it is so essential that only committed people take part that I would far rather a few students turned up who wanted to participate rather than insisting everyone was present. This may seem a bit prudish, but as I have experienced both the potential for this method to succeed and to fail it is a belief I now hold very strongly. This should in no way set about excluding students. Possibly it would be a good idea to provide an optional role-play session every few weeks of our clinical course in the hope that at some point most students would attend at least once. This may then have two additional benefits. We come across difficulties with patient interaction at different times to each other and so could thus attend a role-play session when they felt it would be most useful to them. Furthermore, larger sessions are in danger of corruption by peer pressure. By this I mean that the presence of many colleagues may provide further inhibition to the ability to open out emotionally. Small group sessions in my experience tend to be more intimate and intense. Small groups have the additional benefit that naturally more reserved individuals (like myself) have more opportunity to voice their views. It is all too easy in larger groups to allow a few outspoken colleagues to virtually monopolise the conversation. By employing skilled counsellors to guide such small group sessions, students would know they always had someone they could go to, to discuss any further issues that have arisen from their relations with patients.

Conclusion

I have presented a highly personal account describing my own experience of interaction with patients. From first considering one patient in detail, I have expanded my discussion to try and cover most of the issues I have encountered in the eventful first eighteen months of my clinical course. By its very nature such a personal approach will lack the scientific significance of broader surveys, and I accept that my examples of the attitudes I have experienced from both doctors and students may not be representative. However, the subject matter, I have covered cannot be excluded from the emotional and personal feelings they arouse and so I feel justified in my

approach whilst accepting its scientific limitations.

By examining the problems experienced in developing a rapport with patients I have attempted to suggest solutions. These solutions include both those I have found best suit my own character, and those which could be developed to improve the medical education we receive as students on the subject. With regards to the education we do receive as students I believe there is a great deal of room for improvement. Whilst I have been realistic in admitting the high rate of absenteeism among students on such courses, I have given possible reasons for the reluctance students may have in attending these sessions, and how the sessions could be changed to improve the situation.

My final proposed teaching model is based around a fairly frequent, optional small group session which utilises role-play and group discussion. Such a model would, of course, be based along similar lines to the Balint model, such as has been successfully used for general practitioners in the UK.[2] I have argued that such sessions would be most useful only after we have begun seeing patients. Finally it would be worth pointing out in view of the attitudes of a few of the doctors I have described, that such a group framework could be extended to include doctors themselves. Thus it would be possible to continue medical education in this central area of medicine even after we qualify.[3]

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International Balint Award 1997 for Medical Students

For more than 25 years general practitioners, clinic doctors, staff members of universities and medical students have met for international seminars at the historical 'Monte Verità' (the mountain of the truth) in Ascona. Owing to their influence on medical training in medical schools these seminars are acknowledged as the 'Ascona Model' (WHO), and their main purpose consists in Balint teamwork, 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 the author 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. **Reflexion.** 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 (or 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.

Six copies of the written submission, each containing the author's name and **full address** should be posted, not later than **31st of January, 1997** to the following representative:

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

The presentation of prizes will take plce at the Monte Verita Centre, in Ascona, Switzerland on 12 April 1997

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

Enid Balint's Contribution to General Practice*

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For more than twenty years, Enid Balint held a unique position in the medical world, having gained an unrivalled body of experience as a psychoanalyst working with doctors. Her personal contribution to Balint work was untiring. Until well into her eighties, she continued to conduct research groups, demonstration groups, and to write chapters of books, as well as maintaining supervision by correspondence with colleagues in other countries.

Despite the length of her experience of this work, Enid Balint remained acutely aware of what was unknown, and what lay uninvestigated. In her written work, she always stressed how provisional any conclusions were and pointed the attention of readers to the future. This is clear from her preface to the last Balint book (E. Balint et al, 1993), in which she defines the aim of Balint-work as 'to get to the heart of the matter with general practitioners. And to study what is *intrinsic* to general practice: what general practitioners cannot avoid whether they *want* to or not.'

It was in the early 1950s that Michael Balint resumed the work he had started with general practitioners in the 1920s, in Budapest. (M. Balint, 1926). Enid joined him in thinking about this venture from the outset. One origin of the approach that the Balints took with general practitioners lay in the method that Enid had been developing in 1948 with social workers studying marital problems. Her emphasis in that work was on the unconscious communication in the marriage itself. There was little to be gained in seeking to understand the individual partners separately. Balint-groups are vehicles for observing the doctor/patient relationship (the marriage), and rapidly lose their way if they give too much attention to understanding either the patient or the doctor individually. In her work with marriages in difficulty, her focus was not on what should be happening, but in trying to understand what *is* happening. In the context of marital therapy, this may seem rather obvious nowadays, but this was 1948, and the distinction is certainly still arresting when it is transposed into its general practice context. Enid Balint was not concerned with what General Practitioners should do with their patients, and certainly not in providing them with psychological training. Her concern was with the difficulty of observing what it *is* that General Practitioners do, and whether a psychoanalyst could be helpful to them in their work.

From this partnership of mutual learning between psychoanalysts and doctors, Balint-work was born.

The initial access on training general practitioners to be psychotherapists soon shifted. From the beginning, there was an accompanying description of the need to observe the dialogue of offers and responses between the patient and the doctor, in order to evaluate the therapeutic or counter-therapeutic effects of the doctor's work on what was then referred to as the development of the illness. The work that began in 1965 and was published as *Six Minutes for the Patient* (E. Balint, et al, 1979) after Michael Balint's death, began investigating techniques that 'would enable the doctor to offer psychological help to any of his patients', and would fit more comfortably with the timescale and other demands of the doctor's daily work.

It seems to me that it is in the development of this latter strand of the work with a much enhanced understanding of the natural strengths of the General Practice setting, and the increasing shift towards a more receptive role for the doctor, that Enid Balint's particular influence lay. This resulted in a more modest, and perhaps a more sophisticated role for the General Practitioner, and one that is at greater variance to the usual axis of medical thinking, in which there is a cause for suffering, or a villain of the peace. The transition might be described as the move from one-person medicine to two-person medicine.

The seminars were always described as research-*cum*-training. Latterly Enid Balint wrote that 'the value of a Balint-group is to facilitate observations.'

In a Balint-group, there are three distinct but closely inter-related working relationships, where new ideas can emerge, and which are also the instrument through which observations are made:

the relationship between the presenting doctor and the other doctors;

the relationship between the leader and the group;

and most important, the relationship within the presenting doctor of that curious tandem, the patient and doctor together.

Enid remained actively interested in considering how a psychoanalyst can be useful in working in a group with doctors. In 1975 she drew attention to the richness of observing what she called at that time 'unnoticed happenings', but went on to make it clear that these were not the unconscious processes in the mind of either doctor or patient which cannot be reliably observed in this setting, and are therefore not helpful. She was referring to the less 'noisy' aspects of both the doctor's and patient's thoughts and actions. (E. Balint, 1993).

* Based on address given at the Scientific Meeting of the British Psycho-Analytical Society on 20th September 1995, and with acknowledgement to the Editor of *Psychoanalytic Psychotherapy*. (1996) **10.2**, 101-108.

The noise of medicine is often deafening. Just as doctors cover their ears and protect themselves by asserting their medical expertise, so the danger is in a Balint-group, that the psychoanalyst leader will retreat similarly to his own more familiar territory, by offering a form of group supervision or psychological understanding about human relationships.

She felt that psychoanalysts must allow themselves to be used by the group more 'like a clinician in a professional setting, not to teach theories, but letting the group do the work, helping perhaps by telling it what it has said, rather than by interpreting underlying meanings'. Her emphasis is always on the need for understanding to be gained from within and not imposed from without. This emphasis comes from the acuteness of her concern that the individual – the doctor or the patient – should have their autonomy strengthened as a result of the work and not as she put it, 'be neglected by being "understood", in a way which is not understanding but misunderstanding'.

Any comment that Enid made in a group of doctors had to be judged useful and made in such a way that it was compatible with the doctors' own thinking. This applied to content, language, timing and her whole manner of being as a psychoanalyst leader in a group. For her, this was an exercise in shared discovery, between equal but distinct partners; always guarding against intrusion, and the subtle undermining of professional functioning that could follow from the introduction of concepts derived from one setting but which might well be a foreign body in another, although no less eagerly seized on because of this. It was for this reason that she believed that psychoanalysts needed to work in a group with General Practitioners for some time before they could successfully lead Balint-groups – they had to 'subject themselves to the thinking, feeling, despair and pleasure of general practitioners.'

General Practitioners work in a setting where huge anxieties prevail, and where the heavy responsibility for the continuing medical care of one individual by another, lies. But within this setting, important conflicts which may have a significant bearing on the patient's current problem, can float close to the surface. Amongst the reasons for this are that patients can come to doctors at a time of need; often propelled by forces which are repeatedly looking for recognition; and that within a doctor's surgery the psyche doesn't feel too scrutinised (at least at present); and that the relationship with a doctor powerfully reproduces early patterns and that this is much intensified by the physical contact, care and attention given to the patient's body. The possibility of brief contacts within an unlimited long-term commitment allows the patient to use the doctor at a pace, depth and rhythm of his own choosing; as well as allowing the doctor to set the necessary limit on his own involvement as well. Enid Balint wrote in 1979, 'The therapy, we think, lies in a peculiar intense flash of understanding between the doctor and patient in a setting where an ongoing contact is possible, where neither the doctor nor the patient gives up his self-esteem. The patient's ego functioning is enhanced, rather than diminished. One could say he becomes more "full of himself", accepting, though not necessarily condoning, his failures, weaknesses and strengths.' (A. Elder et al, 1979).

If such a moment occurred, she later thought that it was not always necessary for the doctor to verbalise this to the patient. She felt that for the patient to be able to change in relation to the doctor, and therefore possibly in relation to himself as well, it was necessary for the doctor to allow a moment of imaginative perception about the patient's experience – sufficient to change his view of the patient – to live with him for a while; not necessarily verbalising it, since the receipt of it by the doctor, may well mean that the change for the patient has already occurred, and that the verbalisation, therefore, would then by mainly for the doctor's benefit, and run the risk of threatening the patient's self-esteem.

These therapeutic changes are not the direct object of Balint-training, but arise when doctors work with their attention on the relationship, and how the patient uses them rather than looking for causes. It is not an aim but a result.

General practitioners who become interested in working this way may develop their capacities to make connections which often lie in relatively unseen territory. These may become visible in the doctor/patient relationship but also may lie between body and mind, or between different periods of time in the life of the same individual; or within that individual, between different areas of function which are often only examined through the techniques and understanding of more specialised colleagues. Our theory when consulting as general practitioners is to be without theory.

For Enid Balint, theories were a necessity in some respects, and could be helpful in making observations, but also must be constantly suspended to allow fresh observations to occur.

It always seemed to me that Enid possessed a deep respect for the method of observation, the necessity of that structure, and the seriousness of the task, but within that had an extraordinary fluidity, and capacity for tolerating unknowing, without passivity. Her firmness of purpose seemed to derive from a great confidence and belief in the creative value of bearing the discomfort of not knowing. And her fluidity seemed born of a deep knowledge of the paradoxical and contradictory in life and, perhaps, from a love of the unique and unusual.

She was adept at bridging different areas of thought in a deceptively simple way. In a group of doctors, it was Enid Balint who most completely embodied a totality of listening in which there was no division between mind and body. She seemed more familiar with the voice of the body than any of us who work with it and through it every body. She held a great belief in the impor-

tance of the difficult work of general practitioners, which was heartening for us who do a job that people often think is easy. She often commented on how hard general practitioners find it to see when they have done something well. She enabled us to articulate those aspects of our work which are least easily noticed, and are often overlooked by general practitioners themselves, but are perhaps most characteristic of our work.

As this only easily emerges in the description of a case, I will briefly describe the history of a patient I saw last Friday:

Maude is an 86-year-old woman who has been a patient of mine for twenty years, but of the practice since 1948. She has a rather reddened face, now walks slowly and with effort, and is short of breath. She has two sons both of whom have families and live at opposite ends of the country. Her husband died in 1968 and she has not remarried. She has a kind face which easily breaks into pleasant humour. I feel warmly towards her and I feel that she regards me with the fondness she might feel towards a son.

Over the years, I have treated her for many conditions – she has been in heart failure, and needs regular medication for her blood pressure. She has what seems a depressive core, and many consultations over the years have touched on this. There is a sparing quality in her relationship with me, and a little help seems to go a long way. Ten to fifteen years ago she had quite frequent episodes of what we both came to know and refer to as Roger's disease. There were urinary tract infections that happened almost invariably when she was staying with her son, Roger, and his family. This realisation had led us to considering different aspects of her relationships with her two sons and their families.

Last Friday morning was the first time I had seen seen her since returning to work after six months' sabbatical leave from my practice. During the five weeks since my return, I have found it interesting to observe the various different ways in which people have missed me, or not, and the different shades of meaning conveyed in the way that they comment on my absence, or on my return, but I don't think I have made any use of this information with a patient, other than by noticing it, and enjoying chatting about it with some.

But as Maude came into my room, there was no doubt (in my mind) of the genuineness with which she said how pleased she was to see me again, and she added, that she had wondered, would I ever come again? She had been to see a colleague, accompanied by a friend, because she had lost her voice and had felt tearful and depressed. He had said that he dare not give her anything because of all the other medicines that she takes.

'What do you think, doctor Elder?' Her voice had broken while she talked and many thoughts had gone through my mind as I listened. I encouraged her to talk on if she wanted, and to cry if that was how she felt. 'Not with you just back, doctor', adding, 'I'm slowing down so much'. And later, 'maybe it's how lonely I feel'.

I was especially struck by the intensity of the feeling conveyed in her worry that she might not see me again and her relief at my return. After a while, I said that I had a thought, but didn't known whether it would help – saying that when I had noticed how relieved she was to see me, I had wondered about her sons, and was she worried that she might never see them again?

She replied, 'It's funny you should say that, Doctor, because they never leave my mind at present'. She had spent time with both families quite recently, and went on to mention things about them and what she had said to them. I then said that 'with all their love and attentiveness, the thought might have been at the back of your mind, how much you will miss them, and they you, when the time for parting comes'.

There followed a few moments of great intimacy between us, and she wanted to hold my hand as she sat and spoke a little. After a while, we talked on.

I didn't prescribe anything to her, but said that I would like to see her in one week's time. Amongst other things, I wanted to see what the effect of this consultation had been on how she was feeling. I cannot complete this report, because that consultation will be in two day's time. But I can tell you something of why I have included this snapshot of general practice in this paper.

After this consultation, Enid Balint came into my mind; partly because I was writing this paper, partly because of my relationship with this patient and the content of the consultation, which clearly has many resonances. I was aware of some of them while I was with the patient, and some which will have become apparent to you while listening.

For all general practitioners who worked closely with Enid Balint over the years, and certainly for myself, she was the mother of our professional efforts, and there is great sadness in being parted from her. But for other reasons too.

As I thought about this consultation more, it seemed to have so much of the 'heart of the matter' of general practice in it, and therefore Enid's view of Balint-work. And perhaps, I would like to think, her love and interest in this kind of general practice work.

It also seemed to me misleading to try to talk about general practice without a case-history; to talk about it in theory. And particularly so, when it comes to discussing Enid Balint's influence on our work, as she would have distrusted any purely theoretical exposition of Balint-work, perhaps more than anyone I can think of.

And lastly I thought, can I really present this? Is it a bit of a risk? But then I decided to do so because of that early phrase of Michael Balint's with which he used to describe the necessary driving force for the groups that general practitioners needed to contribute – they had to have the 'courage of their stupidity' – meaning that they needed to risk their personal hunches and thoughts, rather than hiding behind medical safety. We might alter the phrase and make it kinder to general practitioners in the 1990s, and perhaps put it more into Enid's language, by referring to 'the courage of their imaginations'.

And so I felt I couldn't find a better way to talk about Enid Balint's contribution to general practice; which was not made by teaching us any 'right' way to do things, or in teaching us the uses of psychological understanding, but by helping us to be more fully ourselves in our work, and therefore more comfortable within it and satisfied by it.

I would like to give Enid Balint the last word. In her Freud Memorial Lecture, Psychoanalysis and Medicine, given in 1975, she reported a doctor as saying, 'The group has given me a preparedness to be daft, to make irrational observations and then to try and make sense of them'. She then adds, 'It would be good to think that psychoanalysts can free physicians and physicians free psychoanalysts too, to feel 'daft' sometimes, to alter their habitual ways of looking at people ... and bear the temporary loss of orientation and the bewilderment that may ensue; and then to work, not at finding easy ready-made answers, but to see what is there to be seen ...' (Balint, 1993).

If this can continue to happen, then the relationship between psychoanalysis and medicine will continue to grow and be creative, and benefit not only ourselves, but our patients too.

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The Enid Balint Institute of Psychoanalytic Psychotherapy (E.B.I.P.)

Background

In 1980 a Three-Year Training Course in Psychoanalytic Psychotherapy was established at Queen Mary's University Hospital, since then, it has met the training needs of 70 students. That Course was created as an essential aspect of the activities of the Association of Psychoanalytic Psychotherapy in the National Health Service, which was formed also in 1980 by a group of Psychoanalysts holding Consultant Psychotherapist posts in the National Health Service.

Over the years, the Course has developed in many ways and these developments are now incorporated in the E.B.I.P.

Administration of the Training

The Course is organised and provided by a Training Committee consisting of psychoanalysts and psychoanalytic psychotherapists. It is based at the Enid Balint Centre, which is a separate building within the grounds of Barnes Hospital, South Worple Way, London, SW14 8SU. The academic part of the training extends over three years. Following qualification students are admitted to membership of the Enid Balint Society of Psychoanalytic Psychotherapy (E.B.S.P.).

Applicants must possess a University Degree (or equivalent) in a relevant discipline and should be between 25-55 years of age. (This rule may be varied in exceptional cases).

Intake is limited to a maximum of ten students per year.

Full details and Application Forms are available from:

Barnes Hospital, South Worple Way, London, SW14 8SU.
Tel: 0181 878-4981; Fax: 0181 876 5471.

The Enid Balint Psychotherapy Trust

The Trust was established in September 1994 in Enid Balint's memory and the funds are used for the promotion of psychoanalytic psychotherapy, including grants to assist in the training of students.

Research and Hermeneutics*

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It is rather disappointing that so many research projects in general practice follow the received model of statistically-legitimated numerical comparisons more appropriate to the technologically-based specialities. It is disappointing because the richness of information contained in the discourse of general practice resides far more in narrative, myth and metaphor than in the sanitised data that can be squeezed through the categories of epidemiology and other imposed frameworks. Perhaps what is perceived to be lacking is a philosophy of science that is able to respond critically to the kinds of information and versions of truth that emerge so copiously from general practitioners' daily engagements – in other words to the 'poetics' of practice.

Conventional medical science is concerned with a search for positive knowledge appropriate to the natural world of physical objects. The body as a natural object is properly examined by an objective, natural science according to the paradigm established by Immanuel Kant in his work for the conditions for the possibility of knowledge. In the mid-19th century, August Comte and John Stuart Mill saw no reason why the social and human sciences should not also be bound by the methodologies and truth criteria of 'positivist' natural science.

A hundred years ago, Wilhelm Dilthey criticised the prevailing positivism of his age and suggested that, as the objects of the human sciences were constructed rather than natural, they required a scientific methodology special to themselves. He contended that the human sciences were concerned with understanding, whereas natural science was concerned with explanation and prediction. Dilthey looked for an 'hermeneutic' methodology that would enable understanding of the intentions of the authors and creators of human artefacts and expressions, which he called 'objectifications of life'.[2]

Hermeneutics began as a science of interpretation with its roots in the ancient practices of philology: the interpretation of classical writings, and exegisis: the interpretation of religious texts. Whenever an expression is fixed in writing it occupies a situation in history and becomes increasingly distant from the advancing present, eventually requiring an act of interpretation if it is again to become meaningful. To Dilthey hermeneutics was not just to do with written texts but with all human expression, including ordinary conversation, facial expression, gesture etc. He drew on the work of Schleiermacsher, an early 19th century exegist, who wanted to establish methods for overcoming the alienating distance between author and interpreter to reconstruct the context of authorship, and to approximate as closely as possible to an understanding of the author's intentions.

In many ways, Dilthey's model of hermeneutic method and validation fits with the aspirations of the human-science aspects of medicine and psychology, where the patient as whole person, rather than as mere set of functions, is the object of interest. On the other hand, the patient is still an 'object' the doctor clings to the position of neutral observer from a privileged, 'Archimedial point', and the whole methodology rests upon objectifications that are ultimately reductionist, depending upon the assumption of a 'real' reality, grounded somewhere far from the ordinary realities of immediate experience. We now know that not even physics itself can be grounded in such a way, and that sciences that assume such a reality are only making use of a convenient illusion. During Dilthey's lifetime his colleague, Edmund Husserl, was looking for an alternative basis for human reality in the actual encounter of human consciousness with the world. He was investigating the possibilities for invariant structures in the way consciousness engages with phenomena and his work established the beginning of the science of phenomenology. He remained, however, bound to the assumption that the Cartesian self or 'transcendental ego' is a fundamental given and starting point for the investigation for any kind of reality.[8]

Martin Heidegger, a pupil of Husserl, became interested in phenomenology, whose insights he used to propose a radical transformation of the whole enterprise of understanding. Heidegger was concerned with the meaning of being, and particularly of human being, whose uniqueness consists in the capacity for such a concern. Leaving aside all legitimate astonishment at such an ambitious enterprise, the important feature of Heidegger's work for the development of hermeneutics was his contention that understanding is neither an act nor a method but actually an aspect of human being itself. Understanding is not what we do, but what we are. According to Heidegger, the primordial understanding that we are finds itself thrown into a particular situatedness in the world and in time, but also with a sense of projectedness into its future possibilities. It follows that all interpretations, meanings and information are derivative of the understanding that is part of our being. Human being and its meaning is, therefore, fundamentally hermeneutic.[7]

Heidegger's work represents a break with the idea of empirical events somehow 'carried' as knowledge to within a Cartesian self. After

*Address given at the meeting of the Balint Society on 24 October 1995.

Heidegger, the self is a derivative construct. The nature of human being is to be in its world: to be identified with its situation of being-in-the-world, of which it already possesses understanding. The split between subject and object thereby becomes healed.

Heidegger gave no indication as to what his 'fundamental ontology' (philosophy of being) might imply for the human sciences, but his pupil, Hanz-Georg Gadamer – still living and working in Heidelberg at the age of 95 – has undertaken to develop a philosophical hermeneutics that might serve as a fundamental grounding and response for the practice of human science. Gadamer regards the interpreter as working from within finite horizons determined by her or his position of being situated within a given tradition. This situatedness of the interpreter's pre-understanding means that the text is approached with initial pre-judgements or prejudices that may be open to modification. Although the horizons of the tradition-bound interpreter are finite, they can be open to fusion with the horizons of the text, which then becomes appropriated in a way that allows a mutual belonging, and avoids an alienating 'distantiation' which would be typical of the objectifying methodologies of traditional hermeneutics, and, of course, of the positivism of natural science and some social sciences.[3,4]

According to Gadamer, the temporal and or cultural space between text and interpreter need not represent alienation, but rather provide the continuity through intervening historical traditions that connect that than separate the horizons of interpreter and text. Each consciousness is shaped by the effect of history in a way that can never be completely appreciated or compensated, but consciousness of the effect of history needs to be reflected upon, or the effect takes place 'behind one's back'. All the structures of Gadamer's version of primordial understanding: tradition, prejudice, horizons, texts in the broadest sense, and consciousness itself, are entirely constituted in language. Language, in its broadest sense, is the matrix within all human understanding of the world is contained. It is only through language, says Gadamer, that we have a world at all.

A conflicting branch of hermeneutics emanates from the Frankfurt School of Critical Theory and is principally represented by Jurgen Habermas. In Habermas's view tradition and prejudice are aspects of ideology that should not be accepted lightly, but should be subject to criticism. We are all liable to false consciousness through distorting forms of communications, either as a result of an ideology acting for a certain interest, or from unconscious repression. Habermas identifies a technological interest concerned with exploitation (representing the present dominant ideology), a communicative interest concerned with 'historical/hermeneutical' human science, and an emancipatory interest concerning the critical social sciences. False consciousness may be corrected by critical social sciences such as psychoanalysis and the critique of ideology. Habermas aims towards human emancipation by means of the critical exposure of ideologies that work to distort communication through their ultimate recourse to violence. The goal of emancipation would be the ideal discourse, free from all distortion. Habermas sees interpretation as a critique of the ideology represented by the text, or as a 'depth-hermeneutics' in the case of psychoanalysis, in which the desymbolisations that have resulted in symptom-formation are retraced, and resymbolisation established.[5,6]

Gadamer's philosophical hermeneutics and Habermas's critical hermeneutics are both philosophies capable of providing a response to the truth claims of a narrative or interpretative science. Gadamer looks for truth in an ontology of understanding and Habermas measure truth according to emancipatory power, but the trouble is that these two forms of grounding appear to be widely divergent, if not antagonistic. How is one to make use of such philosophies that diverge from each other, as well as from Dilthey's more traditional enterprise of methodological hermeneutics?

Paul Ricoeur acknowledges that philosophical and critical hermeneutics start from two very different standpoints – Gadamer from situatedness in tradition arising from the past and Habermas from anticipation towards enhanced emancipation in the future – but that they have sufficient common ground to constitute together a useful philosophy for the human sciences.[9]

Ricoeur contends that there are moments of critique in Gadamer's situated interpretation and a traditioned, even ontological, basis for Habermas's critique of ideology. He says that there can be no interpretation without a degree of distance from the text. What is said achieves autonomy from the circumstances of the saying, from the intentions of the author and from the intended audience. There must be a degree of explanation in terms of the structure of a discourse, even though it is read from an ever-changing historical situatedness. Although the neutral subject is untenable and the self exists only by interpretation of its world, the self is enlarged by appropriating the world unfolded in front of the text. The change in the ego and de-reification of the self that takes place before the text has an affinity with Habermas's critique of false consciousness.

According to Ricoeur, Habermas's 'interests' must be dependent somewhere upon a philosophical anthropology and ontology akin to Heidegger's analysis of human being, that is, open to a theory about the fundamental nature of the human relation to the world. Habermas's acknowledgement of consciousness made finite by ideology has something in common with Gadamer's finitude of prejudice, both ideology and prejudice being open to modification through reflection. The emancipatory interest in free communication would be empty without a tradition from which to anticipate it, and the future projec-

tion of an emancipatory interest requires the ability to interpret the past. Exposure of the dominant technological ideology and the way it achieves legitimation through distorted communication requires the creative renewal of cultural tradition. Finally, the appeal to critical reflection must emanate from a tradition. Critique is also a tradition that of the rational enlightenment. Ricoeur concludes by questioning any fundamental conflict between an ontology of prior understanding (Gadamer) and an eschatology of freedom (Habermas). Both philosophies work in common opposition to the instrumental, technological and positivistic interest that tends to reduce truth to the status of exploitable information, and therein lies their implicit unity.

But of what use is all this hermeneutics for our project of an interpretive science? Taken together, the insights of Dilthey, Heidegger, Gadamer, Habermas and Ricoeur indicate that we are released from the pursuit of positive knowledge or certainty in the field of human studies. We are concerned with objects of study about which we cannot be certain, positive or predictive. We may be persuaded with with Gadamer that the consciousness of any interpreter is shaped by history, culture and tradition and begins in prejudice. This persuasion does not allow us to assume the existence of a neutral observer, nor even of an autonomous self, so every research project will need to include reflection upon the prejudiced consciousness from which it proceeds, and from which its data are interpreted.

If we accept the insights of Habermas we cannot avoid the obligation to be critical, not only of our own consciousness, but of those ideologies and interests that underlie all enquiries and claims to knowledge. Ideology is bound to enter the motivation for any research project as well as into the assumptions from which its data became interpreted. In particular it is important to develop awareness of the current dominant ideology of technological exploitation and the ways in which it distorts communication towards the enhancement of its own legitimacy. Although Paul Ricoeur's struggle to achieve a degree of compatibility is sometimes hard to follow, it liberates us from the limitations of regional and antagonistic hermeneutic philosophies so that, in our actual practice, we can find ways of applying hermeneutics as a whole resource.

Finally, as an example of hermeneutically-informed research, I commend to you a paper by Nancy Scheper-Hughes (1990) on 'Mother-love and child-death in north east Brazil' in which she makes a critical, anthropological study of a culture's apparent complacency in the face of heavy infant mortality resulting from an exploitative economical system. She says: 'my theoretical and methodological approach is derived from critical or Marxist phenomenology. It has its intellectual roots in European critical theory, particularly in the Frankfurt School ... I see my role as that of the negative intellectual, the one who tries to turn received wisdoms on their heads and inside out ... The jester, the negative intellectual, works at the margins, 'pulling at loose threads', deconstructing, looking at the world from a topsy-turvy position. Hence, the questions to be raised are the negative and oppositional ones that point to contradictions, inconsistencies and epistemic breaks in the logic of the established moral and social orders.' Thus she launches her critique, but in doing so acknowledges that she proceeds from pre-judgement, tradition and consciousness that shapes and motivates her work.[10]

Scheper-Hughes's paper is an example of critical and narrative research, towards which a set of integrated hermeneutic philosophies can probably offer the most appropriate evaluation. Surely general practice could develop from its special understandings a tradition of narrative research whose truth and critical potential would be suited to the evaluational power of hermeneutics.

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The Break In

Ian A. A. Tod
General Practitioner, Cumbria.

'Come,' pleaded the son
alarm mixed with resignation in the call
'come, she can't manage through the night.'

I went, resigned but not alarmed
at this familiar rupture of my dreams.
The dreams continue, you know, as you drive,
the story of the self,
in the silent glimpses
fading from dreams into consciousness.

The old fell house was smart, renewed,
its worn stone staircase varnished.
A woman laid alone in the large bed,
straight and white in the linen sheets.

The room was ordered, ready,
bare, maybe a guest's room.
She was ready, braided hair pulled tight
over her skull,
hands folded on her chest.

She said, 'My doctor says it's
a hiatus hernia but it's
a tight angry feeling up here.'

'A pain or a discomfort?' I asked in hope.

'Just a feeling up here under the ribs.'

'Just a feeling,' I echoed,
woken up and suddenly weary.

'My mother says,' she said,
'got to, the business. I just can't,
angry knot up here,
all last night awake.'

I asked about weight loss and was she tender,
establishing parameters, taking temperature,
pulse, reading the spines of the books:
Nabokov, London, Beckett and Hesse,
Kerouac there but not Ibsen.

'You are using words for emotions in your
description of your pain.'
This startled her and she asked, 'Are you Doctor
Fox?'

Who did she think would come into her home
at 1.30 a.m. and put his hand
on her belly?

I raged and swallowed bile – silence came
I am the Doctor and I'm here
but I am also a man, axe in hand.

The inner admonishments of my seniors came
uninvited:
'Soothe and dissemble, soothe and dissemble.
Stomach what she cannot, your are the guest,
swallow and smile, swallow and smile.'

Bitter milk, stringent nurture.

The books could tell her if she
could listen, but this is her home;
she is busy, her mother, the business,
mustn't let them down or her visit will end.

The silence was there, a deficiency
full of unsupported ideas. Panicking
she filled it again:
'This feeling of being ill,
husband away, business to run,
how difficult it all is.
I mustn't...'

I baled out, 'Your doctor is right,
it's a mild hiatus hernia but
your problem is putting up with being ill
and feeling you are failing your family.'

Suddenly, freely she recognised
me and perhaps a little of
herself. As I left she raised herself up
and loosely shook my hand.

Outside, going down the familiar valley,
I stopped, for the moon and mists
were shifting, changing,
creating new topography
in shades of grey.

'You see Mrs there's
being ill
and bearing being ill.'

Obituary

Berthold Hermann, MD Vienna, LRCS Ed, LRFPS Glas, MRCGP

05.02.1902-10.04.1995

Although Berthold Hermann was born in Bukovina, Rumania, he qualified in Vienna in 1925, and when he started practising there as a physician, he had no intention of moving, but with the rise of the Nazi party, his freedom to practise became increasingly limited. As he had cured an SS officer of gonorrhoea with the then, new sulphonamides in 1938, however, he was given an advanced warning of his impending arrest and was able to escape. With the help of an influential patient, he went to Albania, where he became well respected for his work in the hospital at Tirana. He soon had amongst his patients, both the prime minister and the family of King Zog. His fame was such, that a letter once reached him simply addressed to Dr. Hermann, Albania.

His freedom of access to the royal family led to opponents of the king trying to persuade him to administer poison. He refused, then found himself under house arrest, only to be summoned urgently an hour later to treat the police chief's granddaughter. When the Italian army invaded Albania, he was invited to become the chief medical officer for the occupying army, provided he agreed to pretent to be Catholic. He refused, and decided it would be safer to move again.

One of his sisters had been killed by the Nazis, but his other sister and her husband, both doctors, had left Vienna in 1936 for Edinburgh. They had registered him as a student at Edinburgh, as a result of which he was able to obtain an entry visa to the UK. He arrived in August 1939, and was initially interned on the Isle of Man as an enemy alien. After four months he was released. He requalified in Edinburgh and was sent to work in the hospital in Dumfries.

After the war, while awaiting British citizenship, he joined the United Nations Relief and Rehabilitation Agency (UNRRA) and, being German speaking, was sent to Germany. Although he was offically working in camps and hospitals for Displaced Persons (DPs), he found it impossible not to treat the local population as well. On one occasion, he had two children with meningitis, one a DP, the other local. He was only given penicillin for the DP, and threatened to resign unless he was given penicillin for the local child as well. He was, and both recovered.

After 18 months, he returned to the UK, where he established a general practice in London, in partnership with the late Dr. Bill Munro, whom he had met in Scotland. He ran the practice from 1948 until his retirement in 1986 at the age of 84; for the last 26 years, his surgery premises adjoined his house, allowing him to be continuously accessible to his patients, something not always appreciated by his family. One of his daughters followed him into medicine and joined him as a partner until her early death from cancer at 39.

He was a thorough and conscientious clinician at dealing with physical ailments, but he was also an early believer in the importance of the psychological aspects of illness. He became a member of the late Dr. Michael Balint's first group, participating in its entire run. He was a naturally modest man, but he was quietly proud of his involvement in the work which resulted in Balint's now classic book, *The Doctor, his Patient and the Illness*. If asked, he would show his copy of the first edition of the book, signed by all the participants. When he was in his seventies, I became a medical student and I was very proud of my grandfather who had been practising holistic medicine before the term was invented. Yet, in spite of this, he never seemed to have lost touch with the physical and technological aspects of medicine. Whenever I met him, he would quiz me on recent advances on whatever speciality I was studying at the time. This is well illustrated by a question he asked me in 1978, when I was attached to the oncology unit. 'Have you seen any patients treated with cisplatin?' I had only just heard of the drug myself. Nor were his clinical skills any the less impressive. A cousin of mine, in his forties, complained of acute backache, and was referred to hospital with a correctly diagnosed leaking abdominal aneurysm. Another patient was sent with the clinical diagnosis of favism; I, the up-to-date, informed student in the centre of excellence, had never heard of it and had to look it up! All this makes him memorable, but for me he is especially memorable because he was my grandfather.

After his retirement, despite deteriorating eyesight, hearing and mobility, he maintained a keen interest in medicine, as well as the activities of his family, friends and former colleagues, until his final illness, pneumonia. He is survived by his second daughter, a psychotherapist, ten step-grandchildren and grandchildren, one of whom is an orthopaedic surgeon (me), and three great grandchildren

STEPHEN J KRIKLER
(Consultant Orthopaedic Surgeon, Coventry)

Obituary

Joseph Leopold Trent, MRCS Eng, LRCP Lond

14.11.1912-01.12.1995

Joe, as he was to many friends, attended preparatory school at Peterborough Lodge, Hampstead, London, and then at University College School, until he was ready to start his medical training at University College Hospital, where he was an enthusiastic member of the Rowing Club. He qualified in 1938, and after a series of house jobs, he settled in general practice in Taunton. He joined the Royal Air Force at the outbreak of the war, first serving as a medical officer in stations around England, then on a troop carrier for one year, followed by three years in India and Burma, where he became an Acting Wing Commander.

He was discharged from the R.A.F. in 1945, and settled in general practice in Kentish Town, London, just before the National Health Service was introduced. Here he remained until the change in the regulations concerning the age at which general practitioners should retire resulted in his enforced retirement when he was seven ty-nine years old. He did not feel he was ready to give up medicine, and returned to private practice, which he enjoyed until very shortly before his death at the age of eighty-three years.

I first met Joe at a meeting of the Huntarian Society, where he attended regularly.

He was an enthusiastic founder member of the Balint Society, and was a member of the Wednesday-afternoon Balint/group. He was well known and liked for his ready wit and ability to tell an appropriate joke to counter those moments when it was most needed! He was always very popular, and was affectionately called 'Uncle Joe'.

He is sadly missed by his devoted wife, Muriel who supported him so well through the last weeks of his terminal illness, his three children, one of whom is a general practitioner in a group practice in Surrey, four grandchildren, and his many patients and friends.

PHILIP HOPKINS

Balint Prize for the Field of Health and Nursing Care, 1997

To promote relationship-orientated care, based on the Ascona Model (WHO), prizes will again be awarded for papers in 1997.

This model has its foundations in the work of Michael Balint, in whose honour for the first last five years a prize has also been donated in the field of health- and nursing-care and annually awarded in Ascona, Monte Verità.

The award of Sfr. 8,000 – has been made available by the Foundation for Psychosomatic and Social Medicine in Ascona and by the Swiss Red Cross.

Papers of max. 20 pages (30 lines per page and 60 letters per line) will be judged according to the following criteria:

1) Exposition: Papers presented give an account of a personal experience within a nursing care reltionship to a patient and its possible development.
2) Reflection. The author should take into account in his/her reflections, his/her own feelings, fantasies (which are often suppressed) and manner of behaviour as well as the relationship to coworkers, institutions and to the patient's relatives.
3) Action and Progression. The author points out the knowledge gained by the analysis of the experience and shows how this can be integrated into everyday care.

Closing date for entries: 31st December 1996.

Three copies of each paper in German, French, Italian or English should be submitted to:
SWISS RED CROSS, Department of Vocational Training, P.O. Box 3001, Bern.
The awards will be presented on **12th April 1997** in the Monte Verità Centre, Ascona, Switzerland.

Book Reviews

MICHAEL BALINT: OBJECT RELATIONS PURE AND APPLIED. Harold Stewart. Pbk: 160pp. £13.99. ISBN 0-415-1446603. London, Routledge, 1996.

This is the 25th title to be published in the New Library of Psychoanalysis, which was launched in 1987, in association with the Institute of Psycho-Analysis. One of its stated aims is 'to provide a forum for increasing mutual understanding between psychoanalysis and those working in other disciplines,' and Harold Stewart certainly succeeds in doing just that, as we might well expect of him, for he is no stranger to the Balint Society.

He gave the 9th Michael Balint Memorial Lecture in 1991 on *Why Regression in Psychoanalytical Psychotherapy?* His very concise survey of this difficult subject helped us to see the importance of understanding the underlying psychopathologies and the techniques associated with them, that the advances have come in dealing with regressed patients.[1]

It is this conciseness, which makes Dr. Stewart's book so readable which is of primary importance for a non-psychoanalytical reader, with such a complicated subject as that dealt with in *Part 1* of his book. In it, Dr. Stewart examines Balint's theories of human psychological development, and defines such difficult concepts as *primary love, ocnophilia and philobatism*. These words may be awkward and difficult to remember, but nevertheless, they are useful terms well worth understanding and is one of the very sound reasons for studying this book.

But more is to come. There is a brief biographical sketch of Balint's life, and an introduction to his work in psychoanalysis, together with his work with general practitioners. *Part II*, is concerned with *Applied Psychoanalysis*. Dr. Stewart describes how Balint, 'from his early years as a psychoanalyst in Budapest, had always been a keen exponent of the value of the application of psychoanalytic principles and insights to other fields of medical and social practice...' (page 83), influenced no doubt by Freud's and Ferenczi's earlier interest in the psychological aspects in medical practice. Ferenczi observed that, '... the personality of the physician often has a greater effect on the patient that the medicine prescribed.'[2]

Indeed, on the first page of the first chapter in his book, Balint states how, in the first setting, 'The discussion quickly revealed – *certainly not for the first time in the history of medicine* (my italics) – that by far the most frequently used drug in general practice was the doctor himself.' He continues how, '... this seemed to us a very elevating discovery, and we all felt rather proud and important about it.'[3]

Even though this was over forty years ago, I remember the moment well, we felt exactly that – not because Balint *told* us this was so, but because it was our first experience of his extraordinary facility for encouraging members of the group to discover, and to experience for ourselves these important phenomena.

The last three chapters also make fascinating reading. Two of them were written by Dr. Robert Gosling, who was former director of the Tavistock Clinic and worked with him in the early development of his groups, on *The Development of the General Practitioner Training Scheme*, and *General Practitioner Training and Psychoanalysis*.

The last chapter, *Moments of Change*, was written by Dr. Andrew Elder, a general practitioner well versed in Balint-training, and a consultant in general practice and primary care at the Tavistock Institute, briefly outlines something of the intricacies and stresses of the work of today's general practitioners, as well as the benefits of attending a Balint-group.

Dr. Stewart is to be congratulated on his new book, and on the timing of its publication – when doctors all over the world are enthusiastic about, and very interested in Balint's ideas and training which all the evidence shows, are so helpful for doctors, especially at times of stress – but are not attracting doctors to them in the United Kingdom!

I cannot emphasise enough, just how useful this book should prove to be for all doctors, especially those who feel stressed, as well as those involved in training present-day medical students, our future doctors, and all who are involved in helping people in other fields of health and social care.

PHILIP HOPKINS

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THE COGNITIVE NEUROSCIENCES. Edited by Michael S. Gazzaniga. (Hardback, pp.1445. £64.95) ISBN 0-262 07157 6. The MIT Press, London & Cambridge, Mass. 1995).

The sight of this impressive volume on your self will certainly jolt the Vocational Training Course Organiser into seeing you in a whole new way! It is also heavy enough, at 3.5 kg, to stun the occasional surgery burglar. But seriously – this is a comprehensive new reference book, described by Richard Gregory FRS, as 'physically huge and intellectually hugely successful.' It provides a fascinating review of up to date research into a rapidly evolving field – the relationship between the structural and physiological mechanisms of the brain and nervous system and psychological reality of mind. We are living in exciting times in this respect, now researchers are getting nearer to

providing expositions of *how* memory, emotion and imagery play their roles in the mind/brain.

Perhaps we are approaching some kind of meeting place for 'organic' neurophysiology and analytical/psychological theory. It would be good to look forward to a truly psychosomatic approach, and transcend all those sterile arguments about drugs versus therapy.

Each section of the book grapples with the most fundamental problem of science – the problem of the explanatory gap. Topics covered include: physical reasoning in infancy; origins of human social competence; somatic sensation; multiple memory systems; attention, intelligence and the frontal lobos; anatomical basis of memory disorders; imagery and memory; stressful experience, brain and emotions; consciousness and the neurosciences, philosophical and theoretical issues. It is really valuable to find a book that both cites Freud and discusses *how* the unconscious affects conscious behaviour, and also describes how PET scans can make 'pictures' of emotional activity in the brain.

THERAPISTS ON THERAPY. Edited by Bob Mullan. Paperback, pp. 402, £15.95. ISBN 1-85343 336 5. Free Association Books, London, 1996.

This book contains interviews with twenty therapists from a wide and diverse range of traditions: Jungian, existential, gestalt, rebirthing, psychosynthesis, psychoanalytical, transpersonal, cognitive-behavioural, personal construct psychology, and neuro-linguistic programming.

Topics explored include the origins of the therapists' own careers, the economics of therapy, therapist 'burn-out', client/therapist dependency, 'false memory syndrome,' the theoretical basis of their work, and the outcomes of therapy.

The interviewees, some of them famous through their own books as well as their clinical work, are very open and frequently humorous, critical of sloppy practice in the profession, and refreshingly free from sectarian dogmatism. They display genuine enthusiasm about their work and their patients, 'they had the most wonderful metaphors ...' '... we're all very, very good at talking about our own experience provided we feel the person we're talking to is actually interested ...' '... The thing ... I think I'd be wanting to do is to show people how interesting their lives are ...' Surely it is this enthusiasm that is one of the powerful mutative factors in therapy.

This is an accessible book and I enjoyed reading it. It could also provide some useful background for the general practitioner choosing a practice counsellor, and discussing their on-going work.

THE BROAD SPECTRUM PSYCHOTHERAPIST. By Wyn Bramley. Paperback pp. 275, £15.95. ISBN 1-85343 327 6. Free Association Books, London 1996.

This excellent and practical book addresses the needs of psychotherapeutic provision for a wide range of patients. Therapists need to be increasingly versatile and flexible, adapting their techniques to different time frames, a multiplicity of diagnoses, and a variety of settings. The author places great emphasis on extended assessment – providing a sound basis that would be especially helpful for therapists working in primary care setting. Bramley's approach is described as 'operating as GP to the mind' and is always realistic and humane. As she aptly writes, 'sometimes the essence of a treatment turns out to have been its management,' and she recognises that sometimes it is wise to 'accept gifts of home-made jam as sincere expressions of gratitude ...' and 'the GP to the mind has an educative function on top of the interpretive one'. And ultimately, 'we therapists must try to preserve all the best aspects of the analytic tradition while adapting it to present-day conditions.'

Those interested in the Balintian tradition of applied psychoanalysis will readily identify with that objective. This is a really well-written book with vivid case-history 'illustrations'.

SUE HOPKINS

International Michael Balint Centenary Congress, 1996
10th International Balint Congress
9th Hungarian National Balint Congress

The International Balint Centenary Congress was held in Budapest, Hungary, from the 1st to the 5th May 1996. This Congress was held to commemorate the centenary of Michael Balint's birth in his home city of Budapest. It was simultaneously the 9th National Conference of the Hungarian Michael Balint Psychosomatic Society and the 10th International Congress of the International Balint Federation. Three Conferences rolled into one: a magnificent occasion! The programme cover design showed the Budapest Chain Bridge and London's Tower Bridge, linking together to symbolise friendship between the two cities which Michael Balint made his home. For those of us who knew only about his work in London it was especially moving to be able to go back and celebrate his life in the city of his birth.

Now, let me tell you about Budapest! It consists, as you probably remember, of two cities, the old town of Buda and the largely turn-of-the-century Habsburg baroque city of Pest. They are separated by a broad sweeping curve of the Danube river and linked together by a series of beautiful bridges which, when illuminated at night look like so many garlands of pearls. Buda, high on its hills, is a place to wander round and savour the colour-washed 18th century houses interspersed with shops, museums and coffee houses. From the romantic ramparts and towers of the Fisherman's Bastion there is a superb view of the neo-Gothic parliament building (like the Palace of Westminster with a dome) and all the other buildings of Pest which now include modern hotels familiar from the West and the inevitable presence of McDonalds and Burger King. Western capitalism has arrived but Budapest takes all invasions in her stride and survives with independence and style.

Our conference took place in the comfortable Hotel Agro, tucked away, high in the Buda hills. The air here is clean and fresh and the views of the City and the surrounding hills are enchanting. The conference was attended by 227 delegates, of whom 56 were from the home country. The table shows the numbers and countries of origin of the remainder:

Country:	No.:	Country:	No.:
Armenia	1	Netherlands	3
Austria	1	Norway	1
Belgium	7	Poland	1
Croatia	39	Romania	28
Denmark	1	Russian Federation	1
Finland	10	Slovak Republic	1
France	7	Slovenia	2
Germany	27	Sweden	14
Hungary	56	Switzerland	6
Ireland	1	United Kingdom	12
Japan	2	United States of America	4
Latvia	2	TOTAL:	227

It was also a pleasure to see about twenty medical students from various countries: all full of energy and overflowing with youthful enthusiasm.

First evening: Wednesday

On the first evening there was a welcome party with a delicious buffet supper at the hotel. It was a great pleasure to meet so many old friends in quick succession. Nearly everyone in the world of Balint seemed to be there to greet us! And there were messages from some of those who were unable to make it. I hope this report will give them at least an impression of what it was like to be at the Congress in Budapest.

The first day: Thursday

On the first morning, we assembled in the hotel's large and well equipped lecture theatre. Most of the conference was conducted in English, but some speakers used their native Hungarian and there was simultaneous translation between the two languages. We were welcomed by Dr Marianne Szatmári who has been a fervent advocate of Balint ideas in Hungary throughout her career as a family doctor, adviser to the Health Department and Hungarian representative at the World Health Organisation. She told us that her mother and Michael Balint used to attend Freud's lectures together in Vienna before the first world war. Then we came even closer to the Balint family with the first plenary speaker of the morning who was John Balint – the son of Michael and Alice. He is a former gastroenterologist and now professor of Medical Ethics in Albany, New York. John described himself as 'a conference child' who was constantly being dragged around the medical and psychoanalytical congresses of Europe by his parents. He is getting on a bit himself now (in his late 60's at a guess) but he is still a passionate defender of the doctor/patient relationship which he sees as more important than ever, in view of the changes which our health care systems are now undergoing.

The president of the International Federation, Professor Frank Dornfest spoke next. He was concerned that in passing the Balint method on from one generation to the next we should be enriched by the valuable innovations but not encumbered by the distortions which would inevitably creep in. He shared with us his vision of an accreditation process for leaders which would be a forum in which everyone could learn and from which no-one need be excluded. The next three speakers all shared with us their memories of Michael Balint from different periods of his life. Dr Endre Schnell, a general practitioner in Budapest for 40 years, talked about his life and work in Hungary with his first wife Alice, up to 1939 when he moved to England. Taking up the story, Philip Hopkins (UK), a gene-

ral practitioner in London for 47 years, took us back to the Tavistock Clinic in the 1950's and the first Balint seminar for general practitioners – of which he was a founder member. Finally, Dr Imre Zador (Hungary) gave an account of his conversations with Michael Balint over the course of 30 years and all over the world.

After the coffee break, we had a second group of speakers. Dr Michael Courtenay (UK) described how Michael Balint had helped family doctors to understand what was really going on in the doctor/patient relationship and how it might be used constructively. Part of his genius lay in the way he was able to change the emphasis from formal psychotherapy to the use of a psychotherapeutic approach to the everyday brief consultation. And now, following the work of Rudebeck in Sweden, we have the chance to move to a truly psychosomatic approach by the use of 'bodily empathy'. John Salinsky (UK) then described the way in which his patients seemed to occupy a sort of 'inner hotel' in his imagination, a place where he was able to give them sanctuary while he tried to offer them understanding. Michelle Moreau-Ricaud (France), who is a psychoanalyst and Balint historian, traced the story of the Balint method from the training of Michael and Enid through the development of the Tavistock seminars to the rapidly changing ideas of today.

Next came Professor Muradif Kulenovic (Croatia) who organised the 8th International Balint Congress in Zagreb in 1993. He referred back to the recent and terrible war in ex-Yugoslavia and described the important role played by Balint-groups in helping both the victims of war and those who were looking after them. He saw the Balint-group as, above all, a place where people can be heard and can share their experiences (however terrible) in order to grow stronger. Finally, Dr Maria Rohde described how she was able to make use of the group-analytical theory of S. H. Foulkes in understanding the group process in a Balint-group. She ended her talk with a vivid account of a case discussion which brought up uncomfortable feelings about the Holocaust in the members of the group.

Now it was time for a leisurely lunch in the hotel dining room and a chance to talk to friends old and new. The congress returned in the afternoon, with a demonstration group led by Erica Jones and John Salinsky. The group had to struggle with the painful case of a general practitioner colleague who had begun to abuse drugs and whose son had tragically committed suicide. Feelings were deeply divided about whether it mattered that the patient was also a doctor and whether the presenting doctor could ever penetrate the defences of such a deeply disturbed and withdrawn man. After the group had finished, the discussion was thrown open to the audience; they continued to be horrified and fascinated by the case and there was very little discussion of how the 'British Balint style' compared with other ways of conducting a group. I thought this was a pity, because that is really the purpose of demonstration groups,

After a coffee break there was a chance for everyone to participate in a small group with a choice of styles and languages (English, French, German and Hungarian). Once you had chosen a group you were able to stay in it for three sessions on successive days so there was a real opportunity for group-members to get to know each other and work together creatively. Some of the groups were a little crowded (the one led by Erica and me had about 18 people at one stage). But somehow the group magic still worked, and by the end of the third session we felt we had really begun to achieve something. All the group contained a potent mixture of different ages, professions and nationalities. Ours included family doctors from Sweden, Finland and Britain, psychotherapists from Germany, Sweden and Argentina and two students from Romania. One of the students presented the case of a former classmate who had asked her to check his blood pressure and had then talked with alarming bravado about his suicidal life style. I noticed that while her seniors were very ready to offer advice on this case, they had accepted her ideas about their own cases just as readily. There is no seniority or hierarchy in a Balint-group – everyone from student to professor is struggling with the same human problems. That evening we were spiritually refreshed by a concert on the magnificent organ of St. Stephen's cathedral in Pest, culminating in a wonderful performance of Liszt's prelude and fugue on the notes making the name of BACH. (Bach being to music, what Balint is to the doctor/patient relationship).

The second day: Friday

The first speaker of the day was Dr Imre Szecsödy from Stockholm. He described the supervision seminars which he uses to give general practitioners a psychotherapeutic insight into their consultations. Next, Dr Ante Gilic (Croatia) showed us how a psychiatrist could use patience and empathy to help someone with a psychosomatic problem. We then heard some interesting accounts of the growth and development of Balint-work in a number of different countries. Dr. Petter Knutsen described 10 years of work with two Balint-groups in Norway, and Dr. Vladimir Vinokur (St. Petersburg, Russian Federation) told us how the Balint philosophy was helping doctors adjust to the profound social and political changes in his country. Dr Dusan Zagar (Slovenia) brought a message from our old friend Dr. Ziata Kralj who was unable to be present because she is busy producing something even more important than a Balint conference paper. With the help of her colleagues, she was nevertheless able to tell us about how Balint-groups are being used by a variety of workers in the helping professions in Slovenia: including nurses, social workers, priests and prison welfare workers. Then Drs Albert and Eva Veress described the rapid growth of the Romanian Balint Society in Transylvania, and told us about

some research they had been doing on the effects of Balint-training on those who join groups. Lastly we had a lecture from Professor André Haynal, a distinguished Balint doctor of Hungarian origin who works in Switzerland.

After coffee, there was a 'round table discussion' involving senior members from various National Balint Societies. Information was exchanged about the kinds of Balint activities currently to be found in the various countries. Some groups and some leaders seemed to be less 'orthodox' than others, and Professor John Balint asked us not to be too strict in our judgements about what was or was not a Balint-group. 'Make sure,' he advised, 'that you keep the tent big enough to contain everyone.'

In the afternoon the International Balint Federation held its General Assembly. But before the Assembly, there was a surprise appearance by Dr. Mihaly Kokeny, who presented Dr. Jack Norell (UK) with a special and well deserved award for his services to Hungarian medicine in his capacity as Balint Federation Ambassador to Eastern Europe. The small groups in different languages continued after coffee.

Then, in the evening, we were treated to a buffet-banquet in the amazing Art Nouveau ambience of the Gellért Hotel. There was music and dancing and singing, in particular from a vibrant baritone who bore a strange resemblance to a much loved professor.

The third day: Saturday

On the last morning we started with a session devoted to the Ascona prizes for students and nurses. Dr. Margarethe Stubbe (Germany) introduced the newly published collection of best prize-winning essays of the last 20 years which she has edited with Professor Petzold. Students from Germany, Poland, Slovenia and Romania then came to the microphone and told us how much they had enjoyed and valued their experiences in Balint-groups. It was very heart-warming for us veterans to see and hear the enthusiasm for Balint of these young representatives of the future! Then the 1996 prize citations were read out and the prizes awarded by Professor Luban-Plozza. The first prize for students went to Tim Young from London, England. Well done, Tim! Unfortunately Tim was not able to come to Budapest so I collected the award for him. I hope to be able to track him down in London and enrol him in our Society. Further award ceremonies followed: Prof. Luban-Piozza and Prof. Haynal were made Honorary Consuls of the Semmelweis University Medical School; and a number of delegates from abroad were given honorary membership of the Hungarian Michael Balint Psychosomatic Society – together with a handsome silver medal to commemorate the Congress.

After coffee, there was a choice of three alternative sessions. Professor Luban-Piozza chaired a discussion about Monteverita groups. Dr. Imre Szecsödy gave a demonstration of his group supervision method for general practitioners and Dr. Margarethe Stubbe (assisted by Dr. Erica Jones) led a demonstration group in English. After lunch, the conference moved off in buses to the City centre and the house where Michael Balint had lived and worked. Addresses were made by Dr. György Vikár and Dr. Gábor Paneth and a wreath was placed on the commemorative plaque in honour of Michael Balint's one hundredth birthday.

Then back to the Hotel Agro, for the last of the three small group sessions. Our group had bonded so well by this time that we were sorry we could not go on longer – the life of the group seemed to be only beginning! But it was time to return for the closing session of the congress.

Closing session

Dr. Kornélia Bobay congratulated all those who had produced the excellent posters which had been on display throughout the Congress. She awarded the prize for the best poster to Dr. Albert and Eva Veress from Romania. Frank Dornfest then began the rather sad process of bringing the Congress to a close. We had all enjoyed ourselves and were unwilling to depart. The mood was lightened by the buoyant optimism of Dr. Peter Graham (UK) who reminded us that there was another International Congress not far in the future and invited everyone to get ready for Oxford in 1998.

Photograph by Dr. Philip Hopkins

Dr. Kornélia Bobay with her well deserved bouquet.

And before that we should remember the Conference in Miercurea-Ciuc, Romania in 1997 – see page 24.

Votes of thanks were offered to the Congress organisers, André Schnell, Bóga Balint and, especially, Kornélia Bobay. 'Nellie' as she is affectionately known to her many Balint friends all over the world has been the spirit of the Congress for all of us outside Hungary. She has been the person who travelled abroad to meetings to tell us about the Congress, planned it with us and, together with her colleagues, made it all happen. Her bouquet of flowers was warmly applauded and richly deserved. Thank you Nellie for inviting us to the beautiful city you love so much, and for giving us a wonderful time!

Postscript

On the last evening, about 50 of us enjoyed a concert of Viennese and Hungarian orchestral sugarplums played with great panache and enthusiasm by a youthful orchestra in the delightful little rococo concert hall in Pest. Followed by an evening cruise up and down the floodlit Danube with a champagne buffet supper laid on. This event was entirely planned and managed by Dr. Heather Suckling and Dr. Lenka Speight from England. Thanks to both 'Course Organisers' for a lovely finish to our visit to Budapest.

JOHN SALINSKY

Dr. Kornélia Bobay writes:

The International Balint Centenary Congress was one of the events which were organised as part of the Millecentenary of Hungary. The high patron of the Congress was Dr Árpád Göncz, the President of the Hungarian Republic. The other patrons were György Szabó, Minister of Welfare, Dr Bálint Magyar, Minister of Culture and Education; Dr. Károly Lotz, Minister of Transport, Communication and Water Management and Sándor Kálnoki Kis, President of the Hungarian State Railways Corporation, which sponsored the Congress by providing half-price railway tickets for participants who travelled from the Hungarian countryside.

The Hungarian Michael Balint Psychosomatic Society cast a Balint Centenary Plaque in Bronze and Silver. The Bronze was given to all delegates to the congress and will be presented to all new Hungarian student Balint-group members at future Hungarian annual Balint Conferences. The silver plaquette was given to delegates from outside Hungary who helped the development of the Balint movement in Hungary and in the neighbouring developing democracies; it was also awarded to those Hungarian colleagues who helped to develop Balint's ideas by organising postgraduate courses and student-groups. The silver plaquette was also the prize for the best poster displayed at the Congress.

The post Congress tour to the Danube Bend, took place by bus, on Sunday. The first stop was in Esztergom, a nice town on the Slovakian border. This was the first capital of Hungary and the fortress of the first Hungarian kings, the Árpáds, eleven hundred years ago. The Basilica of Esztergom has been the seat of the Hungarian Catholic Archbishops ever since that time. In the Basilica there is a wonderful jewellery with gothic and baroque memorials and a beautiful baroque chapel in red marble. The next stop was Visegrád, another fortress and citadel on the river Danube. The last stop was the attractive old Serbian-Hungarian country town of Szentendre. This is one of the leading centres of Hungarian fine arts and is full of shops and museums displaying fine arts and folk arts. The weather was bright and the whole day was a very pleasant opportunity for visitors to get together and gather new and interesting experiences of Hungary.

Finally it has been a great pleasure for me that you felt good in my beloved motherland and birth-city. I hope that everybody who was here became good friends and that you will continue to spread Balint's ideals all over the world.

NELLIE BOBAY

Nurses Balint Study-Day

16 May 1996

The Society held a meeting for the benefit of Practice Nurses again this year, at the Conference Centre of the Hospital of St. John & St. Elizabeth in St. John's Wood, London.

It had been decided last year to invite only nurses, rather than a mixture of doctors and nurses. Participants came only from practices with members of the Balint Society working in them, despite wider advertising in the Nursing Times, to both Practice Nurses, District Nurses and Health Visitors. One group was formed with six nurses led by myself and Mary Burd, psychologist in Tower Hamlets, who worked for many years with Erica Jones on the London Hospital Vocational Training Scheme Group (which Mary and I continue to lead). The group was very lively with a wide range of cases, both typical of general practice, and particularly to practice nursing.

In the plenary session, the participants hoped we could run another group sooner than next year, but agreed that participation might realistically only be improved by word of mouth, both by themselves, the nurses who came last year, and by members of the Balint Society.

Don't be backward in encouraging your nurses to come along to the next Nurses Study Day!!

DAVID WATT

The Oxford Balint Weekend

15th - 17th September 1995

This year's Oxford Weekend took place again at Lincoln College. It was the largest meeting for some years, with 50 participants. Remarkable was the large number of psychotherapists and psychiatrists, giving each of five groups one therapist as a member at least, as well as three groups co-led by psychoanalysts. Only one medical student, Teng Jin Ong, attended, from Dundee. His impression appears below. From abroad, Heide Otten, Secretary of the German Balint Society, attended, and two psychiatric colleagues from Denmark who have worked there with Jon Sklar.

The form of the weekend was as before, with a demonstration group, led by Jon Sklar, on Friday evening, followed by four group sessions spread over the weekend, with a very valuable break on Saturday afternoon for relaxation.

The plenary session was shortened, to the taste of most people, to allow time for a General Meeting of the Balint Society at the end of Sunday morning. This was to discuss matters before 1996, when the Annual General Meeting of the Society will take place at this time.

Topics discussed included raising the subscription fees (positively received), the slight worry of dilution of the general practitioner membership of the Society with the increasing interest in Balint-work from psychiatrists, and the general approval (to be voted on, in 1966) that attendance at a specified number of weekend meetings could constitute enough group participation for full Society membership, thus allowing a broadening of the membership base to those unable to take part in ongoing groups.

I hope many members will attend next year, both for a great conference and to attend the Annual General Meeting.

DAVID WATT

An introduction to the *other* side of Medicine

I arrived at Oxford on a wet Friday evening, without knowing what to expect from my first Balint meeting, and hoping that the depressing weather was not a premonition of the sessions that were to follow. Even though my initial apprehension had evaporated when I discovered during the supper reception, how warm Balintians were in welcoming novices and guests. A small degree of anxiety remained within me as I waited in anticipation of the group discussions. Later that evening, Dr. Sklar led an excellent demonstration session that set the scene for the next day's work, which gave me an insight into an aspect of medical practice that is crucial and yet often overlooked.

The cases discussed during the four sessions were intriguing and varied; these reflected the heterogeneous make-up of the ten-member group to which I was assigned. As each case-study generated enthusiastic deliberation on the topic, with multitudes of hypotheses, ideas, questions and suggestions, it was with reluctance that every session had to be concluded, primarily due to time constraints, and to a lesser degree the sumptuous meals that awaited us. Lincoln College definitely lived up to its reputation as a college with delectable cuisine.

I was impressed by the conviction held by Balint Society members in their approach to the doctor/patient relationship, and the strategies employed in addressing potential controversies that were likely to arise. It was brought to my attention also, that every encounter between the doctor and his/her patient is unique, and that the option of exercising psychological analyses to medical conditions should not be neglected. The group discussions demonstrated clearly the underlying principles, and the tremendous support rendered to each member were indeed commendable.

An issue that puzzles me still, and perhaps others too, is regarding its (Balint-work) appeal to medical practitioners, particularly in the United Kingdom. Could our medical training be blamed for indoctrinating students with the concept of *20th century Medicine*, which stresses the importance of disease processes and symptomatic cures. I do no know whether there will be a *renaissance* in medical practice and philosophy as we approach the next century, but I am very grateful to the Balint Society for affording me the privilege to experience the *forgotten art* of the physician and the splendid hospitality at Oxford.

TENG JIN ONG
4th-year medical student,
Dundee University.

Programme of Meetings of the Balint Society for the Twenty-seventh Session 1996-97

The following meetings will take place at the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London, SW7, at 8.30 p.m., preceded by coffee at 8 p.m.

Dr. Jennifer JONES, Psychoanalyst, London (Title of lecture to be announced)	22 October 1996
Professor Lesley SOUTHGATE, Whittington Hospital, London **Assessing the Consultation; can we do it, and should we?**	26 November 1996
Dr. Daphne LAMBERT, Jungian analyst, London, and Co-leader of the Cambridge Balint-group (Title of lecture to be announced)	February 1997
Dr. Andrew ELDER, Consultant in general practice and primary care, at the Tavistock Clinic, London, NW3 (Full details to be announced)	March 1997

Other Events

The Oxford Balint Weekend, 1996 Will take place at Lincoln College, Oxford: from Friday, at 6 p.m. to Sunday, at 1 p.m. The Annual General Meeting of the Society will take place at 12 noon on 22 September 1996.	20-22 September 1996
London Balint-Day for Practice-nurses at the Hospital of St. John & St. Elizabeth, London. (Full details to be announced)	May 1997
Annual Dinner, 1997 (Full details to be announced)	19 June 1997
The Oxford Balint Weekend, 1997 Will take place at Lincoln College, Oxford from Friday, at 6 p.m. to Sunday, at 1 p.m.	September 1997

All meetings are PGEA approved.
Further information is available from Hon. Sec. Dr. David Watt.

Guidance for Contributors

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

Style

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

Abbreviations should be avoided.

Use approved, not proprietary names, when referring to drugs.

References

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article.

All references should give the names and initials of all authors; the title of the article; the title of the journal abbreviated according to the style of *Index Medicus*; year of publication; volume number; and the first and last page numbers.

We welcome the submission of documents on 3.5" computer disk. IBM compatible files only please. If possible, please send files in Microsoft Word for Windows version 6 or 2. Other acceptable files are WordPerfect versions 5.0, 5.1, or 5.2; Wordstar versions 3.3 to 5.5; Word for MS-Dos 3.x to 5.x. Authors should supply the name of the file on disk. Please send one hard copy with your file.

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