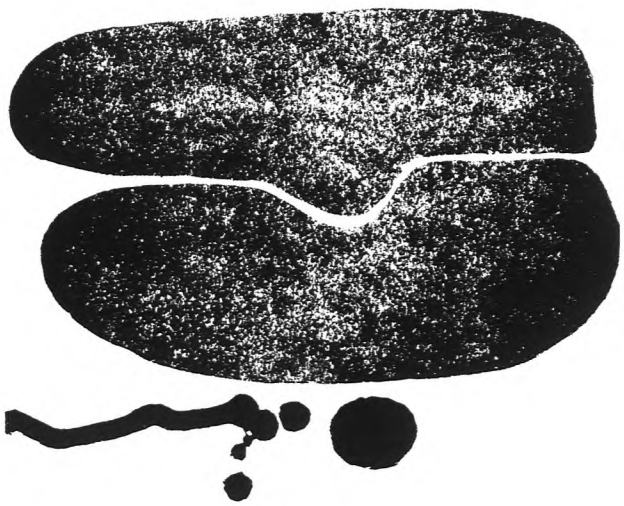
Journal
of the
Balint Society

2011



Vol. 39

JOURNAL OF THE BALINT SOCIETY

Vol. 39, 2011

Editors: John Salinsky
Tom McAnea

A New Editor for the Journal.

The Balint Society:

The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help general practitioners towards a better understanding of the emotional content of the doctor-patient relationship. The Balint method consists of regular case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research.

Membership of the Society is open to general practitioners and all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year. These were held at the RCGP premises in South Kensington until the College moved to temporary headquarters in 2010. Since then we have held a reduce number of lectures other London venues and we hope to be able to use the new College premises in Euston Road when they are opened. Balint weekends are held each year in Northumberland, Whalley Abbey, Lancashire and Oxford. There have been two February Balint Study Days in London in 2009 and 2010 and we hope to resume these at a future date.

The Society is always ready to help with the formation of new Balint-groups. The Group Leaders' Workshop provides a forum for all Balint-group leaders including GP Course Organisers to discuss their work. Leader training groups are also available as part of weekends.

The Society is affiliated to the International Balint Federation which co-ordinates Balint activities in many countries and organises an International Balint Congress every two years.

The Journal appears annually and is circulated to all members. There is an annual Essay competition with a prize of £500.

The Balint Society (UK)
Diary of Balint Society events
2011-12

Joint study day with the Association for Psycho-analytic Psychotherapy in the NHS
Friday 4 November

Joint study day with the Institute of Psychosexual Medicine **Saturday 5 November**

LECTURES (Venue to be announced)

'The Emperor's new drugs: medicine, placebos and the therapeutic relationship'
Dr Irvin Kirsch, associate director, program in Placebo Studies and the Therapeutic Encounter, Harvard Medical School. **Wednesday 16 November**

Lecture by Dr Gaeroid Fitzgerald **Tuesday 20 March**

The Group Leaders Workshop will meet at the Tavistock Clinic, Belsize Lane. London NW3 at 8.00 pm on 29 November, 21 February and 24 May

The Lancashire Balint Weekend will be held at Whalley Abbey, near Clitheroe, from 9-11 March 2012

The Northumberland Balint Weekend will be held at Longhirst Hall, near Morpeth From 15-17 June 2012

The Annual Dinner will be held at the Royal Society of Medicine **Friday 25 March**

The Oxford Balint Weekend 2011 will be held from 28-30 September at Corpus Christi College

Further information from the Hon. Sec. Dr. David Watt

THE BALINT SOCIETY WEBSITE

The Balint Society website can be found at www.balint.co.uk.

Pages include:

- NEWS of recent events and forthcoming meetings and conferences.
- FAQ (Frequently Asked Questions) about Balint: helpful for newcomers.
- GROUPS: How to start new groups and get help with leader training.
- INTERNATIONAL PAGE: Information about the International Federation and news about the next International Congress.
- There is also an INTERNATIONAL BALINT FEDERATION WEBSITE at www.balintinternational.com
- JOURNAL. This page shows the contents of the current issue and the editorial in full.
- BOOKS. A bibliography of the best Balint books in English. Plus a handful of recommended papers.
- LINKS. From our site you can easily go to the American, German and Finnish Balint Society websites. More are coming all the time.

The Website will be undergoing extensive expansion and remodelling in the next year

Meanwhile please have a look at it, if you haven't yet done so and refer anyone who is remotely curious about Balint to www.balint.co.uk

Editorial: a farewell to the editor's chair

This year we can celebrate 40 years of the Journal of the Balint Society. The first issue[1] appeared in June 1971, eighteen months after the foundation of the Society and six months after Michael Balint's death. Not surprisingly, the tone of that issue was sorrowful and its content dominated by tributes to Michael and his achievements. There was also a firm intention for the work to continue and for the Journal to be 'the medium with which the Society will talk to the profession'. The first editor was Dr Max Clyne who was also celebrated for his tireless travelling in France and Germany to lead weekend groups. He was succeeded by Dr Philip Hopkins, the founder and first president of our Society and a single-handed GP for over 40 years. There was no Journal in 1972, but everyone that year was preoccupied with the first International Balint Congress which took place at the Royal College of Physicians in London and attracted 427 delegates from 17 countries. The proceedings of this very successful conference were collected and edited by Philip Hopkins under the title *Patient-Centred Medicine*[3]: a phrase which now seems like a universal aspiration. (A few copies of this book are still available from the Secretary.)

Philip went on the edit the Journal until 1998, after which I succeeded him. Since 1973 we have brought out an issue every year; it's not very often, but we believe that our readers look forward eagerly to each September appearance and think that it's well worth waiting for.

Philip's last year in charge was also the year of an International Balint Congress in the UK: this time held in Exeter College, Oxford and launched in the magnificent setting of Christopher Wren's Sheldonian Theatre (1664). The 1998 issue of the Journal was extra large (a record 70 pages) and included several articles about the history and architecture of the University as well as a full programme for the Congress and the all the usual regular features. Since then, I have tried to continue the tradition of the Journal's founders, letting the Journal be the medium through which the Balint Society speaks to 'the profession' which now includes psychotherapists, counsellors, nurses and anyone who has ever been puzzled and intrigued by human relationships. Of what do we speak in these pages? We present our research projects; we share our thoughts about the Balint process, how it works, what it means, what it can do for our patients and ourselves. We discuss the groups we are leading and the art and science of being an effective Balint group leader. We consider the state of the NHS and worry about the survival of the professional values that we hold dear; those of emotional awareness, whole-person medicine and continuity of the doctor-patient relationship. We also report on the enjoyment and enlightenment we have experienced at Balint weekends, now held in three different parts of the country every year, and conferences abroad. Our Society participates actively in the meetings of the International Federation and our own Paul Sackin has just been elected general secretary in succession to our own Heather Suckling. The Journal also has an international flavour with regular articles from Balint enthusiasts in several other countries, including notably the United States.

Over the years, has the flavour of our articles changed? There are more research papers (though still not enough); there is perhaps a deeper and more extended exploration of what goes on in the Balint group through the experience of two new generations of leaders; there is less recalling of the past and greater expectations for the future. One thing that has not changed is the appearance of the Journal. In spite of the editor's rather half-hearted pleas, the council and the AGM have firmly voted to retain the small format, the shiny white cover with its inscrutable logo (designed specially for us by Victor Pasmore) and the visually challenging 8-point type. However, we do now have pictures in colour, having discovered, belatedly, that they are no more expensive than black and white.

But it is time for a change of editor. Having occupied the chair for 13 years I have decided to retire and pass on the editorship to a younger man, in the shape of Dr Tom McAnea. Tom has been a GP for only a few years but he has had the benefit of a training which included a regular Balint group and has subsequently spent time in a group for established GPs. Furthermore he knows and cares about the clear and grammatical use of language. I wish him all the best and feel sure that I am leaving the Journal in safe hands.

John Salinsky

1 Journal of the Balint Society Vol 1, No. 1. 1971
2 Clyne M. and Lask A. *The Organisation of the Meetings of the Society*. Discussion paper presented to the Balint Society's AGM, 1971
3 *Patient-Centred Medicine*. Editor Philip Hopkins, London: The Balint Society and Regional Doctor Publications Ltd, 1972

An Introduction from the new Editor

My first experience of a Balint group was as a new GP trainee joining the Whittington Vocational Training Scheme in North London. This scheme is distinctive for two reasons: a strong Arts theme in the teaching programme, with weekly Balint group sessions facilitated by the programme directors, including one John Salinsky.

Like many trainees, and Balint novices, I felt some trepidation in the early weeks in the group. There was a clear contrast between those who had been in the group for a year or two, and those of us just beginning. To be able to talk openly, and honestly, about our feelings towards our patients, and their response to us, can make you feel exposed. In time though, our group leader helped nurture a feeling of safety and security where we could express ourselves without reservation.

Over three years I came to understand how rewarding and therapeutic regular Balint work can be. As we develop as clinicians, it can feel bewildering and emotionally exhausting dealing with all our patients, and trying to understand their needs. Having a forum where one can share thoughts and difficulties about patients, with colleagues, is a real privilege. It has helped sustain me and I believe made me a better doctor, which in turn confers a benefit for my patients.

It is a great honour and responsibility to take on the role of Editor of this journal. I know you care about its content and indeed it relies on your contributions and interest to keep the Balint community around the world informed about ongoing work and research. I have much to learn and know I can consult the honorary 'Executive Editor' for advice. I also welcome your thoughts, comments and ideas about the journal and how it will evolve in future.

Finally, I wish to express my thanks and gratitude to our departing editor. He has successfully guided the journal through 13 years with thought and creativity. I have been privileged to have him as my teacher and mentor, and been inspired by his writing in both this journal and elsewhere. I look forward to continuing our working relationship in the years ahead.

Tom McAnea

Balint Group Leaders in Israel: A mixed method study of the goals and roles of the group leader

Ruth Hakim [1,2], Benyamin Maoz [3], John Yaphe [4], Stanley Rabin [3] and Andre Matalon [1,2]

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Introduction

Group support for health professionals, including family doctors, has been found to be an effective method for professional development and for preventing burnout[1]. In the 1950s, the psychiatrist Michael Balint developed a program of seminars for general practitioners, which dealt with the psychological aspects of the doctor's work. Regular meetings of Balint group leaders in Israel began in 1992 and at present, the Israel Balint Society organizes a national group leaders' conference once a year, and local leaders' evening meetings every two months. About 20 Balint groups exist at the present time in various parts of Israel. There is no official procedure for becoming a Balint group leader in Israel. Usually one starts by participating in a group as a member, and after proposing oneself for leadership, one begins to participate regularly in the bi-annual conference of leaders, where training is conducted including using a "fish-bowl format" Balint group. This involves direct observation of the leader and participants sitting in an inner circle by observers sitting in an outer circle. After about two years of observation and discussion of the function of groups, one becomes a co-leader with an experienced leader and finally a group leader.

Experience with a number of different Balint groups (residency training groups and specialists groups) suggests that there are differences between groups, especially regarding the leadership style, attitude and function of the Balint group leader. Little has been published about the leadership of Balint groups for general practitioners. Little is known about the guidelines and goals for leading such groups and how this relates to the way Michael Balint originally led his groups, as described in his book, The doctor, his patient and the illness.[2]

This study was designed to investigate these issues, to explore the goals of Balint groups as they are perceived by the group-leaders and to clarify the tasks of the group leader. These results will be compared with Balint's own idea of the role of the group leader. This will be placed in the context of some biographical details of Michael Balint's life, the context in which his ideas were first elaborated and the current position of the Balint movement in Israel. This study will clarify the role of Balint groups in the professional development of general practice in Israel today.

Methods

For this study, a questionnaire, translated into Hebrew and expanded from a previous one found in the literature[4], was developed to examine the attitudes of Balint group leaders and participants towards the role of the group and the role of the leader. The questionnaire contained two parts. The first part consisted of four open questions about the nature of the Balint group, the role of the leader and the contribution of the group to the participants (Appendix 1). The second part contained a series of ten statements about Balint groups (Appendix 2). Participants were asked to rate their agreement with each statement on a Likert type scale of four items including strongly disagree, disagree, agree and strongly agree. The questionnaire was distributed to 25 Balint group leaders attending a seminar at a national Balint Conference held in Israel in 2006.

Data analysis

Responses to the closed questions were analyzed using simple frequency distributions. The responses 'strongly disagree' and 'disagree' were grouped together, as were the responses 'agree and strongly agree', to make the response to each question dichotomous. The responses to the open questions were analyzed using grounded theory. As responses were collected, they were classified into emerging themes. This process stopped when no new themes emerged from the data and no new statements were found to add to the themes (saturation of the categories

Results

Of the 25 group leaders participating at the conference, 19 agreed to complete and returned the questionnaires.

Description of participants and characteristics of their Balint groups

Half of the participants led groups of

residents in family medicine and half led groups of practicing primary care physicians (specialists in Family Medicine in Israel) and the results were analyzed along these lines. Regarding answers to the open questions relating to the aims of the group (Table 1), the group leaders felt that the groups of family medicine residents and the groups of family medicine specialists had more or less the same aims:

- elaboration of their feelings (emotions) that have occurred in the interaction between patient and doctor,
- gaining insight into the way in which the participants behave,
- development of self-awareness of one's emotions, the perceptions and reactions that arose during the encounter with patients and then looking for alternative reactions, taking into account the personality and character of the patient, making it possible to articulate accumulated feelings,
- sharing feelings with colleagues and finding similarities between the experiences and thus feeling less lonely and anxious,
- receiving alternative points-of-view as result of the exposure to the perceptions and behaviors of colleagues,
- relief and sharing as a source of preventing burnout and receiving social support and empowerment.

In the groups of residents, however, there was more emphasis on the doctor-patient communication and more social support

The analysis of the answers relating to the tasks of the leader (Table 2) shows that there is a similarity between the leaders for the two types of group here as well. The leaders of the two groups see the following as their chief functions:

- the creation of a free, supporting, empathic and secure atmosphere, without a judgmental approach,
- opening and closing the sessions,
- encouraging the members of the group to participate in the discussion,
- clarifying certain points
- reflecting reactions.

Nevertheless, we found that in the groups of residents there was a greater emphasis on the need for preserving rules and boundaries, whereas in the group of specialists there was more emphasis on not giving solutions. With regard to answers to the closed questions (Table 3), the greatest agreement was found in response to statements that reflected the emotionally supportive nature of Balint groups, the need to contain anxious emotions, to explore specific cases as a basis for discussion, and to allow for discussion of staff inter-relationships, as well as patient care.

Group leaders disagreed with statements regarding providing direct answers to GPs, and direct guidance or actively teaching GPs in the Balint groups. Study participants were divided in their answers with regard to questions about the need for Balint groups to focus on the daily work of the doctor, to focus on difficult cases and the need for hierarchies in Balint groups.

Discussion

When Michael and Enid Balint started their first group with social workers, at the Tavistock clinic, they were confronted with the question of how to promote insight and awareness of the unconscious processes that occur during meetings with patients, without the social workers being in personal psychoanalysis, or transforming the groups into psychotherapeutic groups. Balint decided to use a method which concentrates on the group members' countertransference that he had previously used in Hungary, for supervising trainee analysts. The participants were not allowed to use notes and their presentations were more like free associations. From this material and from the reactions of the group, the psychodynamic processes which occurred during the doctor-patient encounter were brought into consciousness.

The method that Michael and Enid Balint continued to use with general practitioners was based on the same ideas. The most important issue in the meetings was the way in which the doctor used his personality, his scientific beliefs and his automatic emotional reactions during his encounter with the patient. The aim of focusing on these issues was to enable the physician to recognize his feelings, his behavior and reactions to his patients, and by understanding their dynamic meaning, and then modifying them. Balint called this process: "a limited though considerable change in the personality of the doctor"[2]. This was, in his opinion, one of the main goals of the group work.

According to Balint, the attitude and behavior of the group leader is the most important factor in the group work. Through his own attitude, the way he listened, his ability to allow everyone to be authentic and express his thoughts in his own way at the appropriate moment, he was able to act as a role-model. Balint thought that the leader should avoid a teacher–student relationship and should interfere only when it was really needed. He should not make judgments but rather open possibilities and help every member to find his own ways to cope with the problems met in their work. Of course, it is difficult to fulfill all these demands, and a leader may make mistakes, hopefully without harming the group, whereby he should be able to accept criticism. But the leader should prevent the Balint group from becoming a psychotherapeutic group and should not put the focus of the group on the relationship between the presenter of the case and the group-leader[5]. He should also be careful, about touching on the presenter's personal and intimate issues, and protect group members from the unwanted intrusions of others.

But a leader is always influenced by his role and a lot of emotions are turned towards him. However, he should not interpret them, but pay

attention mainly to the countertransference between the presenter and the patient presented. Furthermore it is important that the personal attitudes of the presenter relating to his encounter with his patient be compared with the attitudes of other participants. Destructive aggression or over-identification should be discouraged and the leader should withhold expressing his own remarks until the members of the group have given their opinions.

Comparing the role of the leader, in Michael Balint's time to that of leaders in Israel today, a principle difference can be noted: Balint saw as one of the main goals of the group, to bring about a certain change in the personality of the doctor and therefore recommended almost always, avoiding giving support and positive reinforcement. At the same time, he felt it was important to maintain a certain degree of anxiety, which he regarded as the main stimulus for creating change. Contrary to expectations, from the results of our study, it appears that leaders in Israel saw giving support and reducing the amount of anxiety as one of their main goals. They did not regard the purpose of the group as the bringing about of a change in the doctor's personality.

Yet the Israeli group leaders remain true to Michael Balint's ideas and methods in refusing to provide solutions to problems raised in the group or giving detailed advice. In this way, they encourage the doctors to find solutions for themselves and to learn to live with uncertainty.

It should be pointed out that the differences between today's leaders in Israel and Balint as a leader may originate for a number of further reasons. In the Tavistock groups, the two leaders were usually both psychoanalysts (a psychiatrist and a psychiatric social worker) and the participants were all senior professionals. In contrast, the leadership in Israel is usually composed of a combination of a mental health professional (psychiatrist, psychologist or social worker) who may be psychodynamic in thinking (although rarely an analyst) and a psychologically minded family physician. This combination may lead to more relating to emotional problems that arise in the daily work of the doctor, and by so doing giving more encouragement and support.

In Michael Balint's group, the leaders were trained psychoanalysts and the participants were qualified doctors who were ready to invest a number of years in a weekly meeting, doing introspective work, including accepting criticism. These conditions do not exist in many groups at the present time (especially obligatory residence groups). Although in Israel, most of the participants in Balint groups are senior professionals, yet there are also residents and young doctors, who have not yet got enough experience and professional competence. Therefore the character of the groups has changed, as shown in our present study and some previous other studies in the USA[6,7].

Leaders today, at least in Israel, may rely mainly on their intuition, their personal experience and their personality. We suggest that a more structured training should be created, whereby doctors could learn the basic principles of the present theories of group work and psychodynamic theory, preferably in an experiential way. Such training should help the leaders to act in a more sophisticated way, understanding more deeply the personal and inter-personal processes that occur within the group. This will help them to improve group-work, deepen the understanding of processes that occur and foster the personal changes that might take place among the participants.

Appendix 1 – Questionnaire for Balint Group Leaders – Open questions

Please answer the following questions.

1. Describe your Balint group.
2. What are your goals as a Balint group leader?
3. What is your role as leader of the group?
4. What is the contribution of a Balint group to its participants?

Appendix 2 – Study questionnaire for Balint group leaders in Israel – Closed questions

"Please state your degree of agreement with the following statements."

Strongly Agree	Agree	Disagree	Strongly Disagree	Statement
				1. Giving support to the participants is an important task
				2. Giving guidance and advice to the participants is an important task
				3. There should be a hierarchy among the leader and the participants
				4. To reduce tension and to calm down the participants is an important task
				5. Specific cases should be discussed
				6. One should give positive enforcements
				7. The leader should assimilate into the group
				8. The daily work should be dealt with
				9. One has to deliver answers
				10. It is possible to discuss problems that exist between the doctor and other team members
				11. The processes occurring in the group, should be dealt with
				12. Difficult and problematic cases should be presented
				13. One should relate to the personality and psychological problems of the doctor

Table 1: Answers of the group leaders' relating to the role of the leader

Group of specialists	Group of residents
To enable a comfortable, free, supporting, empathic and safe atmosphere	Supporting and legitimating
To avoid judgmental remarks	Avoiding being judgmental or criticism
To protect the presenter	Watching the safety of the presenter
Encouraging the participation of the group members	To encourage the participation of all the group members
Giving boundaries to the group	To determine rules and a frame
To avoid a therapeutic group	Watching boundaries
Summarizing the meeting	Opening and closing of the session
Avoiding personal exposure	Focusing on the subject
Avoiding giving answers (a solution)	Active listening
No teaching	To enlighten blind spots
To enlighten and to reflect	Sharpening the problem
Cooperation with the second leader	
Keeping secrecy	

Table 2: Answers of the group leaders' relating to the goals of the group

Specialists	Residents
Working through of feelings	Working through of feelings
Self awareness	Encouraging (promoting) insight
Giving the possibility to express hard feelings	Giving a possibility for ventilation
	Improving the listening to the patient and to his troubles
	Improving the doctor-patient communication
Sharing troubles, escape from loneliness	Belonging to the group
Prevention of burnout	Prevention of burnout
Liberation from being stuck	Broadening of possibilities
Learning from colleagues	Receiving new points of view
	A source of support

Table 3: Agreement of the group leaders with statements regarding the function of the Balint Group leader (n=19)

Agree and Strongly agree	Strongly Disagree and Disagree	
19	0	1. Giving support the participants is an important task
4	15	2. Giving guidance and advice to the participants is an important task
14	5	3. There should be a distinction between the leader and the participants
18	1	4. Reducing tension and calming down the participants is an important task
16	1	5. Specific cases should be discussed
16	3	6. One should give positive enforcements
4	15	7. The leader should assimilate into the group
13	6	8. One has to deal with the daily work of the doctor
0	19	9. One has to deliver answers
18	1	10. It is possible to discuss problems that exist between the doctor and other team members
16	3	11. The processes that occurs in the group should be dealt with
14	6	12. Difficult and problematic cases should be presented
4	15	13. One should relate to the personality and psychological problems of the doctor

Table 4: A comparison of the opinions on the leaders' role and tasks between Michael Balint and the group leaders in Israel.

Michael Balint's opinion	Group leaders in Israel
Giving minimal support	Giving support is an important task
One has to encourage a certain degree of anxiety	Anxiety and tension should be reduced
There is no hierarchy among the leader and the participants	There exists a distinction between the leader and the participants
The leader should assimilate into the group	The leader should not assimilate into the group
Changes in the doctor's personality are the focus	The doctor's personality should not be touched
One should not give positive enforcements	Positive enforcements should be given
To learn to live with uncertainty	Answers (solutions) should not be given
One should deal with daily work	One should deal with daily work
One should not teach or guide	One should not teach and guide

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What Kind of Doctor?
A Resident's Search for Professional Identity

Alan H. Johnson, PhD
Charleston, South Carolina, USA

Introduction

It is the responsibility of a family medicine residency educational program to heighten the resident's (trainee's) awareness of the many roles he or she plays and how they interact to support or compromise the delivery of patient care. One is free to effectively manage one's behavior only after one becomes more conscious of the explicit and implicit expectations that accompany each of his or her several professional roles. Balint seminar training is often the most effective way of bringing to the resident's attention the roles he or she may be unconsciously acting out with patients. Balint training further raises the resident's awareness as to the roles required to meet more effectively the needs of a variety of patients.

Every individual on the planet experiences himself or herself, at some level of consciousness, as a unique person, different than everyone else. However, in addition to the individual's uniqueness as a person, he or she also has assumed in the course of normal growth and development a number of roles, ways of being and doing with others. That is, in addition to individual awareness of himself or herself, the person has also related as a child to a mother and/or father, brother, sister or cousins and later to a few significant others. At some point a significant other will become a partner in marriage and from that partnership one often moves to assume the role of a parent to a child or to children. The first role we learn and, under excitement or stress, the one we return to most often, is that of a child. We continue to explore and experiment with adult roles throughout life. Our professional role must as well remain a theater of experimentation if the art of medicine is not to devolve into a hollow, technical ritual.

Beyond the roles within the family, one may have established, through schools or employments, several longer or shorter lasting friendships, some of which will begin to solidify through memberships or partnerships in teams, clubs, businesses, unions, fraternities, or professional associations. In an ever expanding social sphere of contacts, one experiences oneself as part of a neighborhood, community or city, as a national citizen, and finally as a participant in the global village, the family of mankind. It is only the aspects of ones many roles that are involved in patient care that will be explored in this paper. Specifically, it is those roles that are played out around the doctor/patient encounter that we must illuminate. However, an awareness of the full range of roles that contributed to the orchestration of one's present personality as practitioner as well as the full range of roles that are configured in the patient is necessary for comprehending fully and empathically the doctor-patient relationship. This very broad social perspective on the evolution of roles in the physician's personality is taken because the breadth of family practice is such as to call upon all of them at some time with some patients. What kind of doctor does the patient need is a question that the physician must always be ready to ask when conventional behaviors, treatment and caring, become frustrated, and not a natural, evolving response.

Historical Reflections on the Physician's Roles

Several historically established roles converge in the behavioral script of the family physician, placing diverse, if not divergent, expectations of the doctor-patient interactions. The *physician technician* role of a doctor is to follow a well outlined protocol of biomedical analysis in directing the interview and outlining the subsequent treatment. The *scientific medical authority* of the doctor is to be demonstrated in the masterful orchestration of case history, laboratory results, and physical examination, leading to clear patient directives, relevant prescriptions, follow-up appointments and/or referral: good "case management." The role of *scientific medicine authority* is to attack, conquer and control disease.

The *physician educator* role calls for the doctor to assess the patient's current understanding of his or her distress and to reframe these same conditions in the context of symptoms of the disease process or normal personal, couple or family "developmental events." Presumably the disease or the developmental crisis is amenable to "medical management." The *physician educator* is as well focused on the preventive aspects of medicine and how one is to behave in order to preserve or improve health. Medical education is treatment for the future. The *physician healer* role of the family doctor first requires his or her physical presence in an immediate, personal relationship. Second, the healing role asks the physician to speak empathically to the patient and the family. Hopefully he or she will lend support, allay fears and inspire confidence. For a portion of the patient population, and the professional community of doctors, there is yet another role expectation: that the physician will explicitly or implicitly point to a spiritual, religious or transpersonal source of inspiration that is available to undergird the medical or healing process: "a higher power."

These roles and certain other random behavioral requests create an enormous theater of

confusion in the consulting room instead of an intimately secure chamber of cleansing and healing: a flurry of interrogating questions, prescription and dietary directives, abbreviated patient, parental or partner admonitions, directions to laboratory and referral sites, ritualized assurances and a paucity of meaningful dialogue. Roles are the cultural scripts that frame dialogue within society and preserve deeply held collective values. They norm expectations and relationships and prescribe what may be verbally offered or elicited in conversation. The roles of *medical technician, scientific medical authority, patient educator, personal healer or* secular advocate of health, all vie for the super ordinate position in directing how the physician and patient should interact. These roles constitute the background chorus shaping the dialogue and the silence in the doctor/patient interaction. By coming to understand the implicit demands of these roles, whether externally imposed or internally prescribed, the family physician takes his or her first step toward understanding the doctor/patient relationship.

The central importance of the doctor-patient relationship is at the heart of the practice, writing and teaching of one of America's foremost founding organizers, residency directors and advocates for the specialty of Family Medicine, G. Gayle Stephens. He is keenly aware of the confluent expectations that flow into the role of the family physician and how they govern the therapeutic effects of the doctor-patient encounter.

> Man has always sought for a healer of his diseases. In the days when all sickness was believed to be due to evil spirits, the medicine man emerge in society as a tribal official who was on good enough terms with the gods to influence them on behalf of his patients. In the course of evolution of society, concepts of disease have changed and the primitive priest-physician has been replaced by a relative newcomer, a scientist-physician. For modern man, issues of life and death still are governed by mysterious and incalculable forces. Man still is, as always, in desperate need of a healer.
>
> There are many forces which threatened to depersonalize the meaning of doctor and patient. Not the least of these forces is the burgeoning increase in scientific knowledge. An exclusive preoccupation with pure science may be an obstacle to the wise practice of medicine. A preoccupation with a disease instead of a person is detrimental to good medicine. Any physician who looks upon a sick patient as an exercise in diagnosis or treatment is not a complete physician.

The physician and internationally recognized existential philosopher, Karl Jaspers, in his essay, "The Ideal of the Physician," points to several historical roles that converge in the behavior of the modern physician:

> The priestly type of the prehistoric physician; the Hippocratic physician administering rational treatment with an open mind for the whole of man and his situation; the physician of the Middle Ages, holding onto authoritarian speculative concepts — all of these have been replaced for centuries by the physician of modern natural science. He is no longer a priest but a humanitarian... And yet all of these past types are still with us, taking effect once again in either sensible or foolish ways.

A leading American sociologist, Talcott Parsons, points to a comparable evolutionary emergence of the modern physician:

> Priests and magicians have thus been the "original" agents of social control everywhere. The roles of physician, lawyer and, if you will, of "administrator" and social worker have only gradually and unevenly differentiated off from the religious roles.

Carl Gustav Jung, the noted Swiss analyst, poignantly characterizes the confounding set of roles, values and expectations into which the contemporary physician is cast in his essay, "Psychotherapists or The Clergy."

> In the course of the nineteenth century medicine shaped its methods and theory in such a way as to become one of the disciplines of natural science, and it also adopted that primary assumption of natural science: material causation. For medicine the psyche did not exist in its own right...
>
> The patient is looking for something that will take possession of him and give meaning and form to the confusion of his neurotic mind.
>
> Is the doctor equal to this task? To begin with, he will probably hand over his patient to the clergyman or the philosopher, or abandon him to that perplexity which is the special note of our day. As a doctor he is not required to have a finished outlook on life, and his professional conscience does not demand it of him. But what will he do when he sees only too clearly why his patient is ill; when he see that it arises from his having no love, but only sexuality; no faith, because he is afraid to grope in the dark; no hope, because he is disillusioned by the world and by life; and no understanding, because he has failed to read the meaning of his own existence?

What is the family physician to say when confronting the illness of his or her patient in the perplexing context of contemporary life and the diverse social expectations, the imperatives of scientific medical training, the clouded and ever shifting professional demands for "responsible management" of patients and the ubiquitous presence of the Professional Staff Review Organization (PSRO)? As Franz Kafka's weary and used country doctor confesses:

> That is what people are like in my district. Always expecting the impossible from the doctor. They have lost their ancient beliefs; the parson sits at home and unravels his vestments, one after another; but the doctor is

supposed to be omnipotent with his merciful surgeon's hands. Well, as it pleases them; I have not thrust my services on them; if they misuse me for sacred ends, I let that happen to me too; what better do I want, old country doctor that I am...

To write prescriptions is easy but to come to an understanding with people is hard.

The focal point of these many doctor roles may be the consulting room, a bedside or perhaps a private office adjoining the examining room. These places, or these events, are the crucible within which the healing encounter occurs. What is the script of the doctor to be in this situation? How are the archetypal roles of scientist, priest, teacher, or technical magician to resolve themselves in the present? Is the family physician fated to be like one of Luigi Pirandello's *Six Characters in Search of an Author?* How is the physician to sit with, interact, talk to, dialogue, manage, interview, educate, counsel or consult with the patient? Who is the physician to be?

Integration of Physician Roles

A supporting educational framework is necessary for young residents within which to review their professional and personal behavior as they begin their educational transition. They are moving from the emotionally constrained classroom, often not yet married or parenting, and over-intellectualized environment to a highly specialized business/factory like operation, conventionally referred to as a hospital, in which they are now addressed as "doctor". Without such a structure, neither student, resident, nor experienced practitioner can sympathetically or critically review and assess his or her practice of family medicine. Family practice is a professional art and no less in need of an intellectual basis than the professional arts of ministry, law, engineering or teaching. Arts are not only practiced, they are also philosophically scrutinized, poetically refracted, amplified in literature, personalized in drama and scientifically analyzed.

Art is a way of perceiving and representing reality and in medicine, the art is the way of knowing as well as of feeling. It is an art for the physician to understand the existential dimensions of life, his own as well as those of his patient; and to communicate effectively at the personal level.

The Balint seminar is that professional educational structure within which the science and art of medicine are thoroughly mixed with the intellectual and emotional reflections of a young physician beginning to examine, in the moment, the human experience of meeting and treating real persons as patients and experiencing their own emotional responses as person and doctor. Text book patients or simulated patients are classroom history as well as the prescribed script of the "ideal doctor." As the single case, focused discussion unfolds it becomes apparent to all, that thoughts and feelings about that one patient can vary significantly as well as the emotional impact of that patient on the various members of the seminar. Over the course of a year or two it will also become apparent to members of the seminar that each participant takes on a different doctor role with patients than his or her colleagues. It will also become apparent to participants that every member of the seminar has his or her unique healing relationship with their patient; everyone is working on their art of practicing medicine and the role they would like to assume as doctor.

The art and science of medicine, as well as the roles of *physician, technician, educator, and healer,* and *scientific medical authority* have blended effectively and powerfully in several contemporary physicians who have compassionately addressed the illness and health care needs of people throughout the world. They are examples of the inspired convergence of several roles in the person of the physician: Michael Balint, Herbert Benson, Deepak Chopra, Dean Ornish, M. Scott Peck, Rachel Naomi Remen, Elizabeth Kubler-Ross, Bernie S. Siegel, Andrew Weil, etc., etc. When you consider these individuals it is difficult not to be impressed by the diversity of their backgrounds and the diversity of their contributions to individuals and to society at large. I mentioned them to make personal, present and palpable concepts and values enfolded in the convergence of very diverse physician roles. Each of these doctors has been significantly shaped by their medical practice and has significantly changed the lives of those people they have treated. Pursuing the question of what kind of doctor one wants to be is irrevocably tied to the pursuit of what kind of person one is choosing to be.

In the USA, residents have tenaciously followed culture's stringent rite of passage for entering the profession of medicine: academic excellence for four years in college, most often with a major in biological sciences, or an identified premed curriculum, four years of medical school, the completion of a residency lasting anywhere from three years to six or more depending on choice of specialty and finally completing the process at great personal expense, or great personal indebtedness, with only minimal income and long hours during residency. What then follows, in the contemporary world, is a search for a more independent, self directed professional practice and the discovery that the establishment of such a site is almost economically unfeasible. So one is likely to join a smaller professional association of doctors or merge with a larger corporate entity that provides all the necessary equipment and administrative support to practice corporate medicine. Whatever the social structure of the practice happens to be, one expects to interact with patients that are respectful and deferential in honoring the doctors medical advice. While some patients will fulfill that expectation, many will diverge slightly or markedly from that idealized role. They will

present only episodically, engage in unhealthy or self-destructive behaviors, not follow medication or dietary prescriptions and not pay their bills. Likewise, regardless of the confidence, competence or personal charm of the physician, patients may judge their physician failing to show a personal concern, not showing compassion or empathy and raising doubts about his or her medical competence. Stanley Reichman in his article, "The Physician-Patient Relationship: Expectations and Reality," very nicely summarizes the situation in these words:

It is this gap between expectations and reality that produces fear, distrust, anxiety and hostility on the part of the patient and worry, discomfort, frustration, and anger on the part of the physician.

It will be this "worry, discomfort, frustration, and anger" that is thoroughly processed and reviewed in the Balint seminar. How each of these emotions is internalized by various group members will be evident in their shared communication. In the various roles assumed by group members in responding to the patient of the day the presenter will have an opportunity to reconsider how he or she may relate differently to this patient on a next visit. A variety of doctor roles will emerge in attempting to treat the patient and his or her illness. As well it will become apparent that the treatment implied in these different roles is not all the same. Herein we begin to see the art of practicing medicine reflects the style of the artist.

The Emanuel Models

Ezekiel and Linda Emanuel in their thoughtful article, "Four Models of the Physician-Patient Relationship," identified the four roles that a physician might play and proceeded to state their preference as to the one they thought superior. They wanted to identify the ideal physician-patient relationship. In attempting to do this they articulate what they consider should be the goals of the physician-patient relationship, the physician's obligations, the role of patient values, and the conception of patient autonomy. The first model they cite is a *paternal or priestly model* in which the physician acts as the patient's guardian. In this model the physician is presenting the patient with selected information that will encourage the patient to consent to the intervention that the physician considers best. The second model they identify is called the *informative model*, sometimes called the scientific, engineering or consumer model. Here the physician provides the patient with all relevant information from which the patient selects the medical intervention that he or she wants. In this model the physician's role is a purveyor of technical expertise. The third model they cite is called an *interpretive model* in which they define the physician's role as a counselor whose goal is to elucidate the patient's values and what he or she actually wants and to help the patients select the available medical interventions that realize their values. The fourth model is called the *deliberative model*. This is their preferred model. Within this model the physician's role resembles that of friend or teacher. Here the aim of the physician-patient relationship is to "...help the patient determined and choose the best health-related values that can be realized in the clinical situation." In their concluding statements they expand further their definition of doctoring and the role of the physician.

> The essence of doctoring is a fabric of knowledge, understanding, teaching, and action, in which the caring physician integrates the patient's medical condition and health related values, makes a recommendation of the appropriate course of action, and tries to persuade the patient of the worth of this approach and the values it realizes.

As of 1992 the Emanuels admitted that "...many physicians currently lacked the training and capacity to articulate the values underlying their recommendations...." They foresaw a need to implement changes in medical financing, medical care and medical education: "we must educate physicians not just to spend more time in physician-patient communication but to elucidate and articulate the values underlying their medical care decisions, including routine ones." The *physician technician, scientific medical authority, physician educator and physician healer* all seem to have been integrated in the four models that the Emanuels have created. Also the concept of value clarification seems strongly to emerge in their articulating the responsibility of a physician: a clarification of physician values as well as patient values.

Physician Role Defined by the Process of Care

Several studies have attempted to define the practice of family medicine in terms of coded, clinical problem treated. However, a more psychologically and sociologically appropriate way to identify family practice, and the role of the family physician, would be to analyze the care provided to patients regardless of the specific clinical problems that are diagnosed. A group of researchers at the University of Wisconsin set out to do that very thing in 1983. Eleven family physicians, all in private practice, all board-certified and three of whom were residency trained, constituted a reference group for the study; they ranged in age from 34 to 54. Each of these physicians was contacted by phone and asked to describe some care that they had provided to a patient or family which they felt typified family practice. The physician was then asked a series of standardized questions to help elaborate their response. Their responses were recorded and transcribed verbatim. The study group then reviewed the transcripts to define what they saw as common elements. In addition, each member of the reference group was sent the vignettes from four other reference group

members with the request that they too identify common elements. A second phone interview to the reference group of physicians posed the question, "If you were going to make up your own list of family practice criteria that you see emerging in these reports could you tell me what they would be?" Responses were reviewed and refined again following the second round of calls. In an effort to further validate their work, the study group contacted four reference group physicians and posed the following question: "If you were going to evaluate your friend's family practice what criteria would you apply?" The study group then came to a consensus and was ready to consolidate its findings into 10 elements that seemed central to family practice. Physicians who had not participated in defining the elements were asked to review the 10 elements for editorial clarification. Faculty and residents following a discussion of the content of family practice training in relation to family practice were asked to rank order the 10 elements. The following list defines the 10 elements central to family practice, and arranges them in the rank order that was created by 15 practicing family physicians of the University of Wisconsin residency program. The ranking by residents was very comparable to that of the faculty and no one element varied by rank more than one point.

1. *Personal Relationship with a Patient:* The ability to develop, across time, a sense of partner-relationship, friendship, and commitment to the patient, characterized by mutual personal investment, sensitivity, honesty, trust, and respect. The key to the relationship is the physician's having a sense of the patient's worth and dignity.
2. *Medical Knowledge and Skills Characteristic of Family Medicine:* Competency to apply skills in all areas of medicine to the problems presented by a representative patient population.
3. *Comprehensiveness of Care:* The ability to recognize and be responsible for the care of a full range of medical problems, chronic and masked as well as acute and obvious.
4. *Anticipation of Problems and Continuity of Care:* Care of the patient over an extended period of time by one physician in such a way that a patient's problems are adequately managed. This involves (1) availability of care, (2) commitment to keeping track of a patient's problems and their resolutions, and (3) anticipating health risks.
5. *Problem Definition and Medical Decision-Making:* The ability to recognize and define the patient's problems from the presenting complaint, past history, and family context, to verify and diagnose those problems, and to select the most appropriate treatment.
6. *Care of the Individual within the Family Context:* Carrying for individuals using the data, resources, and trust gained from looking after other family members at various stages of their lives.
7. *Problem Management and Resource Coordination:* The ability to implement appropriate management plans according to the patient's needs and to use appropriately all resources available to the physician.
8. *Values and Attitudes That Enhance Family Medicine:* Placing highest priority on the patient's needs and interests, recognizing and accepting one's own strengths and limits, and counseling patients in a commonsense, nonjudgmental manner and with a sensitivity to patients' beliefs and values so as to be a positive therapeutic influence.
9. *Attentiveness to Practice Organization:* Improving the efficiency of service and quality of care by monitoring the way the practice functions; this includes (1) accessibility of service, (2) timely patient flow, (3) good medical records, (4) sound business management, (5) good staff morale, and (6) effect if partner interaction.
10. *Involvement with the Community:* Participating actively in the life of the community and utilizing the understanding and relationships that result as resources for patient care.

Elements number one, six and eight clearly establishes the foundation for the role of physician as empathic, respectful, trusting friend who is pledged to develop a mutually committed partnership with the individual patient and his or her family. From such a foundation the physician most certainly could respond in the role of teacher and healer as well as scientific medical authority. Elements number two, three, four, five, seven and nine seems to represent the physician in the role of medical technician: a physician who is an efficient administrator managing all health-related issues. Element number ten places the physician in the community as a kind of "medical scout"; however, one must certainly realize that it is such community involvement that allows the physician to be socially rooted and secure as a whole person. Element number eight explicitly talks about the physician in the roll of counselor who explores in a nonjudgmental and deliberative way the beliefs and values of his or her patients. This element also asks the physician to recognize his or her strengths and limits.

While this study empirically distilled the essential elements or behaviors of family practice, it did not take the next inferential step to further integrate these behavioral elements into discernible physician roles. Personal and professional identity is not experienced as an enumerated list of activities or behaviors; a gestalt must form which brings into being an integrated whole from otherwise fragmented and isolated pieces of behavior, thoughts and feelings. There is a sense of personal awareness and of social recognition that comes with the identification of a role: physician, teacher, minister, mother, father, sister, carpenter, ironworker, foreman, computer programmer, etc. etc. etc. Identifying or clarifying a role(s)

certainly does not encompass all of one's personality; however, it is a necessary and progressive developmental process in cultivating a professional identity. Where but in the Balint group is the resident given time, encouragement and the supporting milieu in which to begin this important integrating step: the individual and socially interactive, developmental process of practically and artistically creating his or her role as physician and person. Creating this role is a lifelong process and the heart of a living profession.

A Summary Discussion

From the perspective of seasoned family physicians, sociologist, philosophers and writers I have attempted to profile the various archetypal roles that may converge in "sensible or foolish ways" in the life of a young resident or a seasoned family physician. Whether in priestly, didactic, scientific, technical or consoling counselor silhouette the form of the physician emerges, and moment by moment with each new patient encounter the silhouette shifts yet again into a slightly new form. Moment by moment it is certainly much easier to identify discrete elements of behavior than to identify the role which shades each of those elements in a deeper and more meaningful way. It is sometimes difficult to make that inductive and/or intuitive step to see the role that is been enacted both by physician and patient. However, it is just that additional step that is necessary if the physician is to appreciate fully the more complete meaning of the values, feelings, thoughts and judgments that are being projected in his or her behavior. What is still more important in being able to identify the physician role(s) is the understanding that role is most often assumed in some complementary way to another role, that of the patient. What is the patient communicating that is leading the physician to assume this particular role at this particular moment? Or should we say, how is the physician interpreting the patient's behavior that causes him or her to see the patient in just that role?

In addition to citing the studies of the Emanuels and researchers at the University of Wisconsin, I made an appeal to you, the reader, to understand a fundamental quality of roles that shapes almost all human communication from our very conception to the day of our death: reflecting on the role transformations that you have witnessed in your own life. We emerge in a social matrix and attempt first to find a complementary role with a mother, or mother surrogate. Other roles begin to emerge as we again attempt to find complementary ways of being with authority figures of the family and negotiating with our siblings. From there I enumerated still other roles with which we experiment throughout our adult life. Often I have seen residents fall into the role of the dutiful daughter or son, the successful daughter or son, and old maid aunt or uncle, a playful sib who would become preoccupied in discussing baseball and avoiding chronic hypertension is his patient, a somewhat critical parent infantilizing a patient and just a friend enjoying a patient while avoiding more relevant health-related issues.

Role is not only the building keystone of personality it is as well the bridge to human, life-sustaining contact. Role is the mirror in which we see ourselves. In the social sea from which we only partially emerge, role defines the character of our swimming to stay afloat and translate from one encounter to another. The importance of understanding role is due to the fact that it is a relation oriented pattern of behavior that both doctor and patient exhibit and experience. One of the first and most telling signs in dealing with someone who is significantly, pathologically disturbed is that one first notices a very uncomfortable sense of relationship or non-relationship. Sometimes, as well, this can be the experience in dealing with genius. In between those extremes, however, there is a great variety of relationships to be experienced and understood and herein lies the work of a Balint seminar in attempting to illuminate the many roles that are enacted, moment by moment, in the doctor-patient relationship.

The deceptive thing about role that should be commented on is that it is not an entirely conscious pattern of behavior. The accommodations that we make early in life in assuming a complementary role, and the accommodations that we continue to make throughout adult life happen at both a conscious and unconscious level. This has been most graphically illustrated by noticing the similar patterns of posturing and gesticulating that are clearly visible when reviewing videotapes of people engaged in conversation. There is a graceful flow of body movements from one to the other so that it is hard to say who is leading and who has followed. Yet, each person may have been mostly unaware of the social dance they were doing. Here is where the Balint group is of invaluable aid in bringing to the presenter's awareness certain profiles in his or her behavior as well as profiles in the patient's behavior. Either may have been assuming a role of which they were unaware. It is also true that the presenter may choose in forthcoming visits to experiment with changing his or her role and this may in turn effect a change in the patient's role. The presenter, in fact, on a later patient encounter, may experience things going more smoothly without noticing what he or she has done differently in relating to the patient. Transformation in roles may be so subtle as to remain unconscious.

The Emanuels hypothesized that many physicians, as of their writing in 1992, "... lack the training and capacity to articulate the values underlying their recommendations..." I would support their hypothesis in 2009, and elaborate on it further. A specific value domain that comes to mind is one of spiritual/religious orientation

which very often plays a confounding role in medical practice. In some cases the religious or spiritual orientation of a patient may support them through crisis events and/or sustain them through long-term chronic, debilitating diseases. Their spiritual or religious orientation allows them to work cooperatively with their family physician and follow his or her recommendations. However, a very strong religious or spiritual orientation can direct patients away from considering certain treatment options, seeking allied health consultation or support and avoiding certain medications. Very similar spiritual or religious orientation on the part of the resident may likewise affect his or her willingness to explore certain treatment options, medications or consultation referrals. As all of the authorities that I have quoted note there is a very long history of the physician taking on by choice or, through projective identification, a certain kind of priestly role. To be unaware of the induction into this priestly role by a patient or their family is to fail to understand the true problem presentation of a patient at that moment. Whatever diagnosis follows from such a presentation is very likely to be somewhat inaccurate and lead to both medical and psychological complications. As Stevens noted, "For modern man, issues of life and death still are governed by mysterious and incalculable forces. Man still is, as always, in desperate need of a healer." The exploration of the role expectations around the healer or priest would seem central in the professional education of a contemporary physician. The discussion of such issues as these often arise in the Balint group as a result of what participants see in the presenter and his or her patient or, because of their own unique, spiritual or religious response to the patient.

The archetypal roles that are likely to emerge at various times in the doctor-patient relationship have been explored as well as the more conventional, social roles that are a part of everyday life. None of these roles taken in isolation direct the resident, or the experienced physician, to assume the full scope of responsibilities that are necessary in the successful, compassionate and effective practice of medicine. These roles have been discussed and presented in such a way as to allow the resident, or the experienced physician, to address more consciously the question, "What kind of doctor do I want to be?" Put in a more existential way, we might say, "What kind of doctor am I being?" I trust that it also has become apparent to the reader that for the resident, or the experienced physician, addressing this question is irrevocably bound to the question, "What kind of person do I want to be?" In so many ways the intimacy and therapeutic potency of the doctor patient relationship depends on who the doctor is as well as what the doctor knows or does. To attempt to practice medicine only "objectively" is in many ways to deny the therapeutic potency of the doctor-patient relationship regardless of the many roles through which it may manifest. To deny the "subjective" dimension of the doctor patient relationship is to denying the physician's ethical responsibility for the values, feelings, and thoughts that comprise his or her communication with the patient. In other words, the resident, or experienced physician, is ethically responsible for the role that he or she has consciously or unconsciously assumed in the doctor-patient relationship. Given these ethical responsibilities leads me to conclude this paper with "A Decalogue for Family Practice Residents Entering Practice." This Decalogue was originally presented as a part of an address by Dr. Gayle Stephens to the Department of Family Practice at the Medical University of South Carolina in June of 1979.

1. Don't give up the reform ethos. Keep on the side of responsible change in education, practice and social justice.
2. Don't lose faith in the power of relationships and the therapeutic use of self. (Or, don't hire anybody to save you from spending time with patients.)
3. Don't turn your practice into a mere business. It may not be less, and it should be a great deal more.
4. Learn to distinguish between uncertainty and ignorance; only the latter is remediable and potentially culpable.
5. Find some way to practice charity; i.e., willingly give a part of your services consistently to those who cannot pay.
6. Try to see that the groups in which you hold membership are at least as moral as you are.
7. Humanize and personalize the Microsystems in which you work.
8. Act at all times as if the patient is fully autonomous; the weaker the patient is, the more vulnerable you are too violating his/her personhood.
9. Reflect on your professional experiences. Within the bounds of protecting patients' privacy, think, talk, and write about your clinical stories.
10. Worry less about patients becoming overly dependent on you than about your becoming undependable.

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Balint Group Architecture: A Response to Sitting In or Sitting Out

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The two discussions in the Journal of the Balint Society about 'Sitting in - or sitting out' (Tyndale and Salinsky, 2010, Elder, 2010) are the tip of an iceberg, and, to me, suggest issues and discussions broader than this limited choice. That is, these reports identify and stimulate thinking about so many additional and related questions for me that I believe it is helpful to more fully consider these issues - both above and below the surface - in order to sufficiently appreciate the impact of 'Sitting in - or Sitting out.' What follows is an articulation of the specific questions that are raised for me, an offer of a broader framework within which to consider these questions, and then an exploration of how this framework can help to consider the issues implicit in these questions.

First, some questions:

In addition to sitting in or sitting out, several additional, related questions that emerged and their implications:

Should the presenter participate in the discussion of the case they present? If so, how do they truly let go of the case?

Should the presenter be allowed to add information they 'forgot' in the initial presentation and then later remembered? If so, doesn't the case change? Can the 'forgotten' material be understood the same way after it is remembered?

Should the presenter be expected to or prevented from responding to the discussion? Responding definitely changes the discussion and the flow!

If the presenter sits out, when and how should s/he be re-integrated into the group? This is potentially very awkward.

If the presenter does not sit out, how might a leader guide the presenter's participation in the group's discussion? Again, the challenge and benefit of truly letting go of the case emerges.

Second, a framework:

I read these two reports while at the 2010 Oxford Balint Weekend of Reflection and Renewal, and, not unrelated, my reading them followed a walking tour of Oxford led by John and Mary Salinsky. The gestalt of this experience is dominated by the richness of the history and architecture of such a setting - a setting where proper debate is so fitting. I offer these observations and this context to share my own musings about the emergence of insights and added perspectives provided by experiences outside one's primary interest or focus.

Having read the two reports of discussions about sitting in or sitting out, and while considering the various pros and cons of these alternate methods, the phrase 'Form follows Function' came to mind. That is the form of the group, including the decision of sitting in or sitting out, has everything to do with the function of this decision. What would be the purpose of considering the presenter's position vis-à-vis the group? I then realized that this principle of 'Form follows Function' is a primary tenet of Louis Sullivan's modernist architectural style (Kaufman, 1969). It is not a big leap to the notion of the architecture of a Balint group, and to the value of using this metaphor to think of the ways each approach might be considered and understood with respect to purpose.

In suggesting an architecture metaphor, I refer to the steps that a group takes as they work on their task – essentially, the group's structure. Typically, for a Balint group, there is the assembly of the group at an appointed time along with the social banter of the moment, followed soon after by a leader's beginning request for a case; a consideration and acceptance of the case or a choice among several offered cases; an opportunity for clarifying questions or questions of fact, a push back (or not), a discussion and speculation about the case; a return of the presenter (as necessary) and an end to the allotted time. As I think about this architecture of a Balint group, I believe that it would be particularly helpful (e.g., anxiety reducing) for group members as well as co-leaders to have clear expectations about the process of the group experience. It becomes a structure that group members can depend on to guide them about their role – a role which differs in each part of the process. There is an understanding of what rules or guidelines to follow, and these rules or guidelines inform the leaders in their efforts to assist group members through each phase and from one phase to the next.

For example,

Stage	Leader role	Group Member role
Who has a case?	Invite a case	Consider potential cases
I do	Recognize offered cases	Offer a case
Clarifying questions?	Invite questions	Consider needed information
Presenter push back	Structure transition	Monitor personal reactions to the case
Group takes the case	Invite speculation	Consider Doctor - Patient experiences or dynamics
Presenter rejoins the group	Invite return to group	Continue case exploration
Time is up	Thank presenter and thank group	

Returning to the original question, to sit in or to push back and sit out, what would be the benefit of staying in or sitting out, or

alternatively, what is the role of the presenter once the case has been presented to the group?

Questions imbedded in the question:

Can or should the presenter let go of the case mentally and psychologically and emotionally by giving this patient temporarily to the group, or does s/he hold onto the case, getting none of the feeling of relief one gets when handing over a troubling situation for someone else to handle?

Should the presenter participate in the discussion, still embroiled in the emotional complexities one holds for the patients we present, or can a presenter better benefit by getting on the outside of the case, only listening and observe others grapple with the drama?

Should a presenter add information they have 'forgotten' - thus changing the case and losing the psychological importance of the unintentionally hidden data, or focus only on listening to the group process their case as presented, without forgotten information and consider the importance of what they forgot to identify?

Based primarily (but not solely) on observations from groups where presenters are asked to sit out and in which they are asked to hold off adding information they may have forgotten in their presentation of the case, I have been impressed by the palpable relief experienced when a presenter can truly let go of the patient they present. This will often be accompanied by comments such as "She's yours!" or "You can have him." In other words, they have truly distanced themselves from this patient. On occasion, there is a noticeable desire to add information when it occurs to the presenter who is sitting out that there is something important that the group does not know. These presenters will sometimes make eye contact with a leader and ask "Can I add something?" or just begin to react to or respond to something the group is grappling with, or ask "Can I rejoin the group?" My response is almost always "Not yet."

My encouragement to stay out would occur whether or not the presenter pushes back, and to me, the request is evidence that the presenter has not yet fully separated from the case. They clearly have owned the patient, but they may be so enmeshed in this patient's situation that they may have compromised their own objectivity. Staying out can encourage listening from the perspective of an outside ear. Finally, the participation of the presenter and the potential to add additional clarifying information make the group's work more of a consultation encouraging a focus on solutions rather than exploring the territory of the relationship.

Returning to the group

Finally, the awkwardness of returning to the group will occur in any group where the presenter is asked to hold off participating while the group explores the case. If the presenter remains in the group but is asked to not participate, there is still the challenge of when they are free to participate, if they so wish. This is important as well, because the return of the presenter to the group can be an interruption of the group process. In other words, can the group continue to process the various aspects of the case in the same way with the presenter free to participate and presumably ready to make corrections or add commentary?

The presenter's return creates an awkward dynamic between presenter and group. The group members often – especially in a 'young' group – look for feedback or confirmation that the work they have done on the presenter's case has been helpful and relevant. The presenter is equally interested in communicating their appreciation and value of the work to the group. Both impulses interfere with processing the dynamics of the case.

A third alternative to Sitting in or Sitting out:

I suggest that one of the unique contributions of Balint groups is to create opportunities for physicians to present a challenging case to colleagues, truly let go of the case and just listen to the ways others understand what is going on in the relationship. In addition, physicians rarely, if ever, have the opportunity to speculate about a colleague's case without concern for accuracy or for resolution. These opportunities are facilitated by the request to the presenter that s/he formally sits out. The challenge of returning a 'sitting out' presenter to the group should not dictate whether or not we opt for this intervention. One solution to the challenge of returning them to the group without disturbing the group process and without putting them on the spot to respond to the group's work is to invite them to return to the group "...when they are ready." This leader intervention tells the group that the presenter is to be considered as part of the group and it tells the presenter they may participate or not as is their inclination. What is ambiguous to the group members is whether the presenter is silent because they are not yet ready to rejoin the group or they have rejoined the group but have nothing to contribute or they wish to remain in their own space. There is no expectation to respond to the group's work, and there is total permission to maintain silence or to add their contribution if and when they desire. The presenter's space and emotional safety is preserved by giving them the option, and the group's process is preserved because there is no automatic focus on the returning group member. No one needs to know how the presenter is managing the choice; they are now like any other group member who chooses to speak or not.

Using this approach, the presenter sits out and his or her return is invited, but their participation and potential engagement with group members is left up to them. It is less interfering of the group's process, is protective of the presenter, and returns the group to wholeness while preserving the roles of listening and speculating. In addition, I believe it is easier for the group to continue to 'work' the case.

Summary:
I have seen sitting in work as well as sitting out as a technique designed to help a presenter truly give a case to the group. However, the leader must be vigilant to keep the presenter from deciding on their own when they wish to enter the discussion. Their presence in the group can also be a temptation for group members to address them directly, thus undermining the purpose of letting go of the case. An alternative view could suggest that this is merely material to interpret as reflecting something about the case. However, this happens on occasion with a push back method as well. Allowing the presenter to return to the group '...when they are ready' may facilitate a smoother transition while preserving the unique opportunities for presenter and for the group. This alternative intervention (Form) may enable the use of a push back method to support listening from the outside as well as speculation for its own sake (Function).

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A very short introduction to Balint groups

John Salinsky

(A guide for newcomers to Balint weekends, originally written 2009)

Balint begins

Balint groups are named after the psychoanalyst Michael Balint (1896-1970). In the late 1950s, Michael and his wife Enid began holding psychological training seminars for GPs in London. This work was first described in the book The Doctor, his Patient and the Illness (1957). There were no lectures and the doctors' education was based on case presentation and discussion in a small group of nine or ten with a psychoanalyst leader. To begin with, Balint encouraged the group members to hold 'long interviews' with their problem patients. This helped the doctors to concentrate on becoming good listeners. Subsequently the focus changed to studying the relationship between doctor and patient in the context of every day ordinary-length consultations. The groups met once a week for a number of years so that patients and their progress could be followed up. The continuity also enabled group members to feel at ease with other. Since those early days, Balint groups have spread across the world and in 20 countries there are national Balint Societies whose aim is to foster and develop the Balint approach.

Balint groups today: what happens?

The group members and the leader sit round in a circle and the leader (or one of the leaders if there are two) asks 'who has a case?' Someone volunteers to talk about a patient who has been on her mind. The problem may be that the patient has been emotionally disturbing or just difficult to understand or to engage in treatment. The group listens to the story without interrupting. When the presenter has finished, the leader invites the group to respond to what they have heard. Responses take various forms. There may be questions, advice to the doctor, emotional reactions induced by the patient's story and speculations ('fantasies') about what else might be going on. Too many questions to the presenter can be counterproductive, as the aim is to get the group members themselves to work on the case. In a variation of the group process which originated in Germany and has become popular in the UK and The USA, the leader first asks if there are any simple questions about facts that need to be clarified (e.g. how old is the patient?). When these are finished, he asks the presenter to 'sit back' i.e. to push his chair back a little and to remain silent for about 20 minutes.

This effectively prevents the group from asking any more questions and throws them back on their own resources. The presenter is allowed to have her say and respond to what she has heard when she is invited to join in again later.

The role of the leaders

The leaders are following what might be called the Balint Agenda. Their first aim is to make the group a safe place, where confidentiality is observed and members feel free to talk about their feelings and their work (including their mistakes). The leaders will discourage unwanted and intrusive questions about the presenting doctor's personal life and history. Personal anecdotes are sometimes volunteered and can be helpful. The leaders will allow this provided there is no pressure. The group is not a therapy group although its effects can be therapeutic.

The leaders' second aim is to keep the discussion focused on the doctor-patient relationship. They may ask how the patient has made everyone feel. Do we feel angry or sad? Do we like the patient and want to help him? Or would we prefer to keep him at a distance? The group may be invited to consider how the patient is feeling or what sort of doctor he wants his doctor to be. A group that dislikes or fears the patient may be unwilling to engage and will try to 'escape' by talking about generalities: 'these patients are always untreatable' or recommending referral to an expert whom somebody knows. In this situation the leaders will try to bring the group back to the work, perhaps by representing the patient ('If I were this patient I would be feeling terribly alone and abandoned right now...')

If there are two leaders, they will be trying to work in sympathy, picking up cues from each other. One may steer the discussion while the other watches for people trying to get a word in (or trying not to cry).

Ending the session

The session ends, like a therapy session, when time has run out. At least one leader will be keeping a discreet eye on the clock. There may be one or two presentations (including follow-ups) in a ninety-minute session. Often the presenting doctor may be invited to have the last word. The leaders may ask for a follow up and thank everyone. They do not attempt to tie the loose ends or give a reassuring summary.

Benefits of Balint

What does participation in a Balint group do for a group member?

The first and most easily obtained benefit is to have a safe place where you can talk about interpersonal aspects of your work with your patients. The group will be sympathetic and they will all have been in similar situations themselves. This is a great relief and usually means that when a dreaded patient turns up again he or she will seem less gruesome. We believe

that the Balint group experience helps to avoid professional 'burnout'. Are older Balint doctors still enjoying their work? Try asking them!

Secondly, the Balint group encourages doctor to see their patients as human beings who have a life and relationships outside the consulting room. They become more interesting to listen to and easier to help.

Thirdly, the group members may gradually reach a deeper level of understanding of their patients' feelings and their own. They may realise that certain patients or emotions may resonate with what is going on in the own inner and outer lives. This may be causing problems which the doctor can learn to avoid or even to turn to therapeutic advantage.

We believe that experience in a Balint group is of immense value in helping doctors (and other who work with people) to reach a better understanding of their patients and themselves and to find their work more enjoyable and fulfilling.

But you have to check it out for yourself by being part of a group!

Balint group leadership: Where are we now?

A short introduction to the First International Balint Group Leadership Conference held in Copenhagen (April 28th-30th 2011)

Andrew Elder

In *The Doctor, his Patient and the Illness*, Michael Balint wrote, when considering the effectiveness of Balint groups, 'perhaps the most important factor is the behaviour of the leader of the group.' Although there has been quite a lot of effort put into attempting to demonstrate effectiveness, it is striking how little has been written about leadership.

Clearly it remains necessary to pursue research into effectiveness. How else are we to persuade our funders, programme directors and faculty to support us? But no one ever joined a group because there was evidence of its effectiveness. It is our experience in a group that convinces us and changes the way we practice. And surely the quality of the group experience has quite a lot to do with the person leading the group and the approach the leader adopts.

In the last ten years or so, there have been very few papers published that concern themselves directly with leadership. I will briefly refer to three of them. In 2004, Alan Johnson, Don Nease and colleagues published a paper entitled 'Essential Characteristics of Effective Balint Group Leadership'[1]. In the opening paragraphs the authors make their concern about this subject clear, 'this lack of research in Balint Leadership...has had unfortunate consequences...ineffective group leadership has sometimes dampened enthusiasm for Balint work.' As a result of their research, they come up with what they describe as essential characteristics: creates climate of safety, acceptance and trust; establishes and maintains group norms (boundaries etc); promotes movement towards the group's task; understands group process; personality and style of leader (modelling behaviour). Few would quibble with that list. The difficulties, however, lie more in the complexity that lies behind each of these characteristics.

Much more recently, André Matalon and his colleagues in Israel[2] have written that 'little has been published about the leadership of Balint groups for general practitioners...and little is known about guidelines and goals for leading such groups.' They then make a comparison between answers given by Israeli Balint leaders to questions about how they perceive their role with Michael Balint's own views about the role of the leader in these groups. I will give one example. The Israeli group leaders placed emphasis on 'giving support' and on 'reducing anxiety and tension'. Michael Balint, in his Appendix on training[3], has a heading 'crises in the group,' most of which he seems to think can be valuable. But he goes on to say 'if such crises occur too often, or leave bitter resentment behind, it is a sign that the pace of training has been too exacting...' But he continues, 'it is an equally ominous sign...if no crises occur; it means that... the group and its leader are in real danger of degenerating into a mutual admiration society in which everything is fine and the whole group consists of nice, clever, and sensible people.' This difference in emphasis would seem to reflect an important parameter to consider – the question of productive levels of anxiety and a necessary degree of conflict within the group.

And lastly, at Brasov in 2009, Dorte Kjeldmand and Karen Glaser read a paper called, 'Gender and other predicaments in Balint groups'[4]. I recall their opening question. 'Where to begin if we are to consider the fundamental question of the Balint group leader's countertransference to the group?' With gentle irony, they outline that the role of the leader is usually suggested to follow a few, very tasteful and humble parameters...and illustrate this by the use of genteel English phrases such as applying a 'touch on the tiller to keep the group on course.' Pertinently, they ask 'what does the group leader bring by way of unconscious biases and countertransference towards the group members and where are these feelings accounted for?' A good question, surely?

Now, there might be many good reasons for there being so few papers concerned with leadership. Group leadership is a practical matter, highly individual and not at all easy to characterise or study. Certainly there are a growing number of workshops and intensives devoted to leadership training internationally. In the UK there has been a marked increase in this activity during the last five years or so. But I would like to suggest another possible reason.

At the beginning of the Balint movement, leadership was the province of psychoanalysts, most of whom were also psychiatrists. Discussions of leadership technique, pitfalls and difficulties were the province of the psychoanalyst leaders and held (in the main) at separate conferences and workshops. Michael Balint himself emphasised this separation very clearly by putting his remarks about leadership in an Appendix of his 1957 book[3]. 'This chapter', he wrote, 'is intended for psychiatrists..... not primarily for general practitioners...its tone is somewhat different from the rest of the book, technical terms being used more freely...' The Tavistock Clinic in London held a regular meeting called the GP and Allied Professionals Workshop, to which a few of us were occasionally invited but in the main this was a meeting attended only by psychoanalysts. A number of valuable papers were written about

leadership by members of that workshop, but they are not part of our literature. In the UK, no psychoanalyst joined the Balint Society when it was founded. The International Balint Federation (IBF) is an affiliation of Balint Societies which were all founded out of the enthusiasm of GPs for a Balint approach to their work. Thus, from the outset, the study of leadership lay outside their main interest and expertise. Later, as GPs took on more of an interest in leading groups they did so largely from within the educational structures in which they already held positions of responsibility.

So, who is leading groups today? In 2009, IBF conducted a simple survey.

IBF Questionnaire Summary
Questionnaires were sent to all (22) member countries affiliated to IBF. Responses were received from 13 countries and Norway and AIPB (Association of International Psychodrama Balint).

Five countries have their own criteria for accrediting leaders. Four said they were in preparation.

Who leads groups?
Mainly GPs: 3
Mainly psychoanalysts: 1
Only doctors: 1 (50:50 psychiatrists/GPs)
Mixed professional leadership: (a clear preference for co-leadership between GPs and mental health professionals): 10

Does your society have a formal leadership training course or programme?
Yes (USA and Austria); Hungary (one day/month for a year); Denmark had a cohort trained (1998-2000) and a further is being planned.

Quite a few (9) countries offer varied programmes of week-ends, conferences, intensives and workshops.

Different Professional Directions to Leadership
Neither Michael Balint nor Enid thought that being a practising psychoanalyst was in itself sufficient to qualify for being a Balint group leader. In 'Lessons of the Masters' (2004)[5], Michael Courtenay says that, 'both analysts and non-analysts must make a journey into a 'Balint space' of special expertise. It is perhaps interesting to think about the nature of that special Balint space. Looking back at my experience of working with Enid Balint, I can say that she never sounded like a psychoanalyst when leading a group, even though she would have fiercely defended the special nature of the analyst's contribution. As a result of Michael Balint's earlier proscription have GP leaders lacked confidence in developing a conceptual framework with which to think about issues associated with leadership? Is this partly where we are now?

Questions
In his 'History of the Theoretical Roots of the Balint Group Movement' (2009)[6], Alan Johnson asks 'precisely, what was, or is, the theoretical foundation of the Balint group method?' Although we might not want to try and give an answer to this question, it's not a bad question to have in mind. How do we navigate whilst leading? To what basic concepts do we refer when considering issues that arise in connection with leadership? What can we observe in a group without some sort of theoretical framework? On the other hand, if we hold to theory too closely, will we see anything other than confirmation of our theory?

What is our view of the group part of a Balint group? Do we take what might be regarded as an analytic view of groups, perhaps derived from Bion or others? Or, do we hold a more benign view in which groups are thought to be somehow self-running and intrinsically developmental? As leaders, do we press the starter, keep the show on the road but basically trust 'the group' to work away, or does our view of groups involve the unconscious, defences and psychic phenomena which require more active intervention? And whatever our views, how do we lead in practice, with what basic assumptions about process? In the UK, when recently we debated the relative merits of the presenting doctor sitting in or sitting out[7,8], it became clear that this couldn't be thought about without an understanding of how such a move might effect group process, and a view about the aims of the group.

How much do we consider the relationship between the aims of different Balint groups and different approaches to leadership? The aims of a group for students, or one for GP registrars, or one for cancer physicians, or an ongoing group for established GPs, will all differ.

Parallel process is often referred to in workshops and discussions about leadership. This usually refers to the process whereby the relationship between patient and presenting doctor becomes enacted in the group process as the group set about trying to help the doctor with his case. How do we use this in practice as leaders? Should we also be bearing in mind a further 'parallel' relationship – that between the group process, including the stance of the leader, and the parallel changes in the consulting room? John Salinsky makes this point in his interesting review of the history of Balint work, *Hanging by a Thread* (2000)[9]. He asks the question whether the reported shifts in emphasis of the doctors' consulting approach through the various Balint books from *Six Minutes*, through *While I'm Here, Doctor, the Doctor, Patient and the Group* to the last such book, *What are you feeling, doctor?* also require a corresponding change in leadership? After all, if the leader is primarily interested in encouraging the group to get behind the presenting complaint, then the doctors are being unconsciously encouraged to become 'detective

inspectors.' If the leader is less concerned with history, more alive to the present work in the 'here and now' of the group – perhaps listening for the way a group might pick up small changes in the doctor-patient relationship – then those attitudes will be more likely to be acquired by the doctors in the group. In the last book written by a research Balint group, *What are you feeling, doctor?*[10] emphasis is placed on doctors becoming more alert to their defensive reactions (red lights) when consulting. In the same way, perhaps, leaders need to develop an ability to notice their leadership 'red lights.' Perhaps when thinking about any aspect of Balint group process, it is helpful to think about the parallel process, in the consulting room. It is, after all, what goes on in the consulting room that is the point of the whole exercise.

This brings us back to the question of the behaviour of the leader and the modelling that this engenders in the group members. Certainly the early leaders, the 'masters', set great store by this, actively modelling in the group process an enquiring, rigorous, attentively listening attitude of mind which they thought doctors needed to develop in the course of their clinical work. They were a confident breed, not afraid to take risks. If doctors are to be encouraged to have the courage of their stupidity, leaders definitely do as well.

Where are we now?

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Balint Society and enrichment – a student's reflection

Josephine Holt

As a 16 year old school student with more than a passing interest in medicine as a career, for my enrichment experience I chose to work one afternoon per week in a local care home. My duties include, among other tasks, befriending guests, and engaging them in conversation. This is sometimes difficult and success can be very limited especially if I start measuring success by the quality as opposed to the quantity of discussions that take place. With that as the challenge I was in need of help and in looking for it I came across the work of Michael Balint.

From this limited beginning therefore I was encouraged to consider more the relationship I have with the guest rather than the topic of conversation. What I have discovered is that with that as my focus it has become easier to step back and let the conversation flow - once it gets started - and to follow it rather than try to direct it. My attention is less on the subject matter of the conversation and more on the process of engagement, the mechanism by which the conversation moves along.

The one technique I use frequently is that of repeating back to the guest what they have just said but in a different way. This is very basic but helps to create opportunities for the guest to build up their own confidence which in turn helps them to have confidence in me. Making notes about my own conversation skills and the path followed by the conversations themselves means that I can take 'difficult cases' away with me and reflect on them outside of the working situation.

Away from the home, I reflect on the direction taken by the discussion and its effect on me, how it made me feel, to what extent was the conversation directed by my expectations, was I an active listener, how do I think the guest felt after the conversation? Family members become my Balint group meeting. Active listening gives way to active reflection and hopefully active learning which can be directed back into the following week's conversations. 'Active listening' is more exciting than worrying about filling up the awkward silence or worse again paying little attention to what is being repeated in a conversation loop. As a consequence I find I am more relaxed and my confidence as a carer has grown.

I have no Balint training and know no Balint-trained GP, but this process of reflection is positive and therapeutic in a way that I assume a Balint meeting might leave me feeling. Geriatric medicine is not something that I would have considered as a specialism but working in the care home has given me the opportunity to look beyond the patient and to study their condition, reflecting upon what I like to call the texture of the relationship within the context of the patient's condition.

It strikes me that Balint has a lot to offer busy GPs. As the rate of inflation rises, unemployment queues lengthen and small businesses find it difficult to obtain credit from banks unwilling to lend, so the incidence of depression and levels of stress in society increase. Therefore, it is fair to assume that GPs' surgeries will be fuller than usual of 'difficult cases' as emotional problems take their toll.

At the same time, practices are electing to work together in consortia replacing the work currently carried out by Primary Care Trusts. This can only increase the responsibility placed on the general practitioner both in terms of clinical judgement and time. Disagreements between hospitals on prices may threaten the doctor-patient relationship if the public feel that GPs do not have the patients' best interests at heart. Was there ever a time when Balint was more needed?

Time is limited and the pressure on time available per doctor interview is likely to be under increased pressure. However at this point one is reminded of a response given by Archbishop Desmond Tutu to a question about how much time he dedicates to prayer – 'The busier I am, the more time I give to prayer'! So might it not be with the doctor-patient relationship. Is this then an opportunity for Balint Society members to put their training to even more effective use? Not only might Balint trained GPs be able to suggest a consortium-based group but also if they are to contract directly with hospitals shouldn't the teaching of the Balint method also include hospital doctors and surgeons? There is nothing to lose and much to gain.

The 2011 Balint Society Prize-winning essay

What is the Role of a Medical Student in the Care of Patients?

Lara Curran, 3rd year student at University College London, School of Medicine

During the time I have spent in Balint, I have found that one particular unifying theme has run throughout the sessions, becoming a frequently recurring topic of discussion amongst our group. I feel this theme has been the group's struggle with the limits and restraints of the patient-medical student relationship. This issue has arisen in case discussions as varied as the interaction with a patient who has expressed suicidal thoughts, to the occasions where we have talked about the relationships that have been forged with the patients during our cancer projects. Being a medical student in clinics enables us for the first time to take an extensive, and often what feels like invasive, look into a patient's illness. This privilege can sometimes feel undeserved as we often have little or no capacity to improve the patient's medical condition. At times I have found it easy to feel as if I am taking something from the patient, whether it's their time or personal information, without being able to give anything useful back in return. It is tempting to feel that the interaction has been more for my benefit than for the patient's, almost exploiting their illness for its educational value. In essence, this ethos contradicts the patient-centred approach that has been instilled in us from the beginning of medical school, leaving many of us unsure as to what our 'role' in hospital can be defined as and how far we are permitted to extend it's boundaries in attempting to improve the care of patients. In the most extreme cases, can our interactions with patients cause them emotional distress that is counterproductive to their recovery?

One particular case that I encountered this year has caused me to consider this issue carefully. In September 2010, I was assigned to the haematological malignancy ward to begin a 6-week placement in oncology. Although I was excited to begin clinical medicine, I was also extremely apprehensive, as this wasn't my first experience of hospital oncology. The previous Christmas I had been diagnosed with Hodgkin's lymphoma and had spent most of the last year undergoing chemotherapy treatment. Although I was lucky enough to make a full recovery, the experience and all the emotions that had accompanied it were still at the forefront of my mind, especially as my remission had only come a few months before term began. To my surprise, the time I spent in the oncology placement was not nearly as harrowing as I had expected it to be. I found I was able to separate my own experiences from those of the very ill, and often elderly, patients I would see on ward rounds.

Creating this wall between them and me, patient and medical student, was the way I was best able to cope. Listening to some of the discussions in Balint group, I have wondered if this could be a tool commonly used by medical professionals to maintain a degree of emotional detachment that we find protective.

The protective wall

This wall that I built up was less easy to maintain when I came into contact with one particular patient. As part of my teaching, an oncology registrar asked me to clerk a patient on the ward. I asked the staff nurse if she knew of any suitable patients who wouldn't mind speaking to me and she directed me to a patient in a side-room. I was warned that this was a patient who was at risk of neutropenic sepsis due to her myelosupressive chemotherapy regime, meaning I would have to wear a mask, gloves and full protective apron. I was told that the patient was very friendly and would have no problem talking to me. This patient turned out to be a 33-year-old lady who had only recently been diagnosed with acute myeloid leukaemia. She had initially presented to hospital with an acute onset of shortness of breath and recurrently bleeding gums but had previously felt completely well.

On entering the room, I instantly felt uncomfortable and awkward, attempting to build a reasonable rapport with the patient whilst half my face was obscured by a mask. Despite this, she was extremely understanding and talkative, which began to make me feel more relaxed. I asked her if it would be OK if I asked a few

questions about how she had come to be in hospital and, as the nurse has predicted, she was very obliging. From talking to her I could gather that she was a well-educated woman with a highly pressured job in the financial sector and that she had three young children, all under the age of six.. She was originally from the United States but had been living in London for five years, where she subsequently met her husband. Her diagnosis and the speed at which her life had been completely transformed had obviously come as a huge shock. The beginning of the conversation had begun with some general questions about her life and these had been well received. The discussion became more difficult as we moved away from these 'safe' topics to begin talking about the reasons for her medical admission. I discovered that she had completed the first cycle of her chemotherapy treatment and was being considered for a bone marrow transplant. She had lost all her hair in the past few days and was starting to feel the full force of her intensive regimen. Whilst she recounted some of the side effects of her treatment, it became obvious that the mood of our conversation was beginning to change. It wasn't only the patient that was starting to feel uncomfortable; for me this had been the first time I had heard someone else talk about their experiences with cancer at length and I found it impossible not to draw parallels between our two stories. In particular I could empathise with the shock that she had felt at diagnosis and the fear of losing her hair. She was obviously tired and had been nauseous throughout the night. She was in a strange medical ward, away from her family and friends and completely removed from the life she had known only a few weeks prior. This was a patient at their most vulnerable and I had been sent to learn from her terrible experience. I tried to steer the patient away from discussing her treatment, but it was an area we found ourselves revisiting. I felt as though our conversation may have provided her with some kind of outlet to discuss her problems and express her frustration at the situation she had found herself in. During my own illness I had found that discussing my own fears with those closest to me was often too difficult and instead, it was the nurses who I had sometimes opened up to the most.

'I know it must be horrible'

At one point during our conversation, the patient mentioned the horrible nausea she would feel a few days after her treatment. As she talked candidly about this, I couldn't help but be reminded of my own treatment and without thinking carefully enough I replied, "I know, it must be horrible for you. I'm sorry." Whilst recounting her experience of chemotherapy, she had gradually become more outwardly emotional. This was my first experience of seeing a distressed patient and I felt at a lost as I tried to think of something helpful to say. At this point, the patient suddenly seemed angry at my response. She countered, "What do you mean you know? You are so young and have no idea what I'm going through."

This kind of conversation is an example of a situation that can arise unexpectedly and test the boundaries of the patient-medical student relationship. I felt that I had caused her distress and my response had unintentionally belittled the ordeal she had been through. Both the patient and I had made assumptions; I imagined that by trying to empathise with her I might be able to comfort her, whilst she had come to the completely reasonable conclusion that I was unlikely to know how terrible chemotherapy can make you feel. In a sense, I think this encounter exposes how patients can feel as though there is a wall separating themselves from doctors. This wall can mean that both patients and doctors identify themselves as being in completely separate groups i.e. doctors treat people who are ill, they don't themselves become ill patients who require treatment. From this perspective, it could be easy for a patient to make an assumption that a medical student has no experience of what they are going through. I think, in this particular case, my age may have also created a barrier in our communication. I think the patient may have misconstrued my response as being patronising, given that I was only 21 years old.

In the instant that the patient challenged my response, I felt torn between maintaining a professional distance by keeping quiet, and the natural instinct to try to explain what I had meant by my comment. I could completely sympathise with the frustration that had caused her to respond in such a way. I think that part of the emotional isolation that can sometimes occur in such an evocative illness as cancer, is the tendency for a patient to feel that other 'healthy' people have no idea of what they are going through. In a strange and frightening environment, faced with the daunting prospect of chemotherapy, I can't blame my patient at all for allowing her fear to express itself in such a way.

Sharing an experience

I decided that it would be better to try to put aside my preconceived idea of what the patient-medical student relationship should be, and attempt to relate to the patient on a more personal level. I explained that I was really sorry if what I had said had come across in the wrong way, but that I could understand some of what she was going through as I had also been through chemotherapy myself. As soon as I said this, I was scared that I may have crossed a boundary, but on a human level it had felt like the best way to confront the situation. Interestingly, this confession transformed the dynamics of the conversation. The patient instantly switched from being defensive and almost adopted an apologetic tone. More than anything else, I noticed her surprise and how interested she was to find out about how well I had tolerated my treatment. In a way, I think it might have given her an emotional boost

to see someone who had been in a similar situation and was now in recovery. I felt for the first time in the conversation that I was able to provide her with some real reassurance about her treatment.

We finished our conversation on excellent terms, and all the frustrations that we had both experienced during our difficult conversation seemed to have been dispelled. Despite this, for some time after, I continued to worry that I had made the wrong decision by discussing my own health with a patient. I have since seen many cancer patients and have never felt any urge to talk about my illness to them. I think that this one case in particular was unique in that the patient challenged me directly. Although this was uncomfortable at the time, the experience has taught me what I consider to be an invaluable lesson. It gave me an insight into how patients might view medical students and of the sensitivity we must have of the emotionally fragile state patients are in whilst they are ill. It has also shown me that the most effective communication comes when we treat them as people, not just as patients. Whilst maintaining professional boundaries is clearly an integral part of medicine, being able to relate to patients as people is paramount to creating a good relationship.

I have also begun to realise that I may have underestimated the impact that being a medical student and talking to patients can have on their care. I hope that in the case of my patient, allowing her to vent her frustrations and attempting to comfort her by breaking down the wall I had built between us may have helped in some way.

On reflection, I think that the role that we have as medical students is constantly changing. With every patient and new experience I have, I feel that my idea of what it means to be a medical student is evolving and will hopefully continue to develop until the end of my clinical career.

Don Quixote, Sancho Panza and the medically unexplained symptoms

by John Salinsky

(A talk given to the Balint Society at the Medical Society of London on 26 October 2010. A shorter version of this paper was presented at the 17th International Balint Congress in Philadelphia in September 2011.)

One of the first things Michael Balint talks about in *The doctor, his patient and the illness* is the way that GPs in the 1950s were perplexed by patients with symptoms for which they could find no diagnosis in the textbooks.

The first case history in the book concerns Mrs C, aged 32, who is married and childless. Her story is told by Dr M. Mrs C has epigastric and chest pains

Her chest X-rays were normal and the physician to the chest clinic could find no evidence of tuberculosis. He thought that the epigastric pain originated in abdominal wall and that 'massage might be tried'. Massage was tried but it didn't work. She was later thought to have chronic appendicitis and also referred to a gynaecologist. She eventually had her appendix removed, but continued to attend the surgery 'with a variety of pains and drove her doctor frantic. She became 'aggressively flirtatious' and said things like 'didn't you miss me?' and 'I hope you won't be cross with me any more'. Eventually, at Dr Balint's suggestion, Dr M offered her a long interview in which she talked about herself for the first time; she told Dr M about the death of a beloved brother at about the time her symptoms started and about her inability to have sex with her husband. After that her attitude was 'much changed' with no more flirtation. But it had taken four years and an appendicectomy.

Balint's ideas had a revolutionary effect on general practice and opened our minds to the possibility of bodily symptoms being due to underlying unhappiness. Being a psychoanalyst, he assumed that a chaotic succession of symptoms must have a psychological explanation, especially when the patient's personality was having a disturbing effect on the doctor's feelings. And indeed when patients were give long interviews, all sorts of problems about their life story and their relationships came out. Sometimes symptoms disappeared or at least became less important. Even when we stopped doing long interviews, we found that we could sometimes make a connection that enabled the patient to be cured of a symptom which had a psychological basis. We believed that anything you couldn't explain must be psychosomatic. And we were encouraged in these beliefs by psychoanalysts, especially those who specialised in psychosomatic disorders. These disorders comprised not just orphan symptoms but whole illnesses complete with organic pathology but no known physical cause such as infection or malignancy.

Psychosomatic medicine

One of the founders of the psychosomatic approach was Georg Groddeck, a friend and slightly distant colleague of Freud. Groddeck believed that every ailment had a psychological cause. He would ask his patients such questions as: Why did you break your arm? Why did you wish to be unable to speak? Why have you infected yourself? I don't know how they responded to this confrontational approach but I would advise anyone to think twice before using it in the surgery today.

Another pioneer was the American analyst, Franz Alexander, director of the Chicago institute of psychoanalysis in 1940s. He thought that stress and emotion could activate either the sympathetic or parasympathetic nervous system depending on whether the patient's pattern of response to stress was active or passive. Active, aggressive people reacted with sympatho-adrenal activity which Alexander said would produce hypertension, rheumatoid arthritis, diabetes or hyperthyroidism. Those who tended to retreat from danger and become dependent would experience parasympathetic activity resulting in duodenal ulcers, colitis or constipation.

Dr Helen Flanders Dunbar, who worked in New York in the same period, thought that each psychosomatic illness was associated with a distinct character type. The stomach ulcer type was, on the surface, ambitious, hard driving and tough, but underneath was more feminine and dependent. Hypertensive patients, on the other hand, were calm and friendly on the surface but full of suppressed unconscious anger.

These ideas had a lasting influence on psychologically inclined physicians and family doctors. Even when I was a student in the 1960s, asthma, ulcerative colitis, rheumatoid arthritis and hypertension were all commonly thought to originate 'in the mind'.

Do any of us still believe that these illnesses are psychosomatic? I think we might agree that there can be a psychological component and the symptoms may well be made worse by adverse life events. But now that effective physical treatments are available we would be very rash to offer psychological treatment alone. Nevertheless, there are still plenty of unexplained symptoms, that is, symptoms which have no known diagnosis and are not part of any syndrome.

Can we still assume they are psychosomatic? There are problems with this approach. First of all, the patient may not accept this formulation. Worse than that, he says: Don't you believe me then? Do you think I'm, making all this up? If that happens, we have lost all our credibility in a flash. It will be a long and hard journey back to regain our patient's trust.

Secondly, it may turn out that the patient *does* have cancer or a kidney stone or whatever it is he fears. In my early days as a GP, I used to try to persuade people that their emotions were causing their physical symptoms. I would ask them about their childhood, often find some traumatic event and try to link it with the symptoms. I clearly remember one young woman who felt faint and breathless whenever she entered a smoke-filled room. In those days most public rooms seemed to be full of smoke. I discovered that her father had been a heavy smoker all his life and had died of lung cancer in his 40s. I triumphantly pointed out this connection. To me it was obvious. But the patient just looked at me scornfully and said, 'that's rubbish!'

I felt this was most unreasonable of her and didn't know what to do next. I was probably suffering from an overdose of Balint and was trying to go too fast. The Balints' early GP disciples were often mocked by their colleagues because they seemed too eager to jump to a psychosomatic conclusion. Especially a sexual one. This was unfair on Michael Balint who always advised his doctors to listen to the patients' concerns rather than jump in with interpretations.

Medically Unexplained Symptoms

On the other hand, there are some patients, known as 'heart sinks' – and a sinking sensation in the breast is itself a psychosomatic condition – who have had their symptoms for years, have had lots of negative investigations, and are clearly anxious or depressed or have the dreaded personality disorder. Surely they must be psychosomatic? And they do make doctors feel very frustrated.

And so, in recent years, new experts, mainly psychiatrists and psychologists have come in to help us. They have developed new ways of helping the patient to bridge the psychosomatic gulf.

First of all, they say, we should listen to the patient with undivided attention, even though we don't agree with his theory of causation. I think we knew that. We should make it clear that *we know* he is suffering from genuine physical symptoms. It is probably better to avoid saying things like 'I know it seems real to *you*'.

Then we should offer an explanation in terms of some sort of neurochemical, physiological pathway. We should explain that anxiety, generated in the limbic system of the brain results in activation of the hypothalamus and then the pituitary- adrenal axis. Autonomic nerve impulses increase and hormones such as adrenaline are released resulting in all sorts of uncomfortable sensations; intercostal muscle tension causes breathlessness, colonic spasm cause abdominal pain and diarrhoea and so on. This is all a bit like Alexander's theory: part science, part imagination.

Our psychosomatic experts then 'reframe' the symptom in these terms, explaining the illness with a story that starts with emotions and ends with physical pain and discomfort. They advocate Cognitive Behavioural Therapy (CBT) methods to tame the symptoms. And they claim good results with patients who are referred to them.

Can these ideas really help us? Well maybe they are worth listening to. But I still think that we GPs are the real experts in medically unexplained illnesses. . We certainly have more experience than anyone else; we deal with them every day. But they can be frustrating and heart sinking. We need to sit back every now and then and give some thought to the problem.

Mind and Body: indivisible?

First of all, what exactly is our relationship with our bodies? Is it true that the body and mind are indivisible?

Carl Edvard Rudebeck, a Swedish GP who has thought and written extensively about the subject uses the phrase 'bodily empathy'. I'm sure he's right that we need a doctor who can empathise with physical symptoms, and know what they feel like and why they are frightening. We are our bodies, he says. I try and remind myself of this every day. Each morning, in the surgery, as I switch on my computer, I say to myself, the mind and the body are indivisible. But sometimes I'm not so sure. Physiologically, yes. Phenomenologically, no. by which I mean, they may be indivisible but that's not the way we experience them.

Most days, I feel that I am a *mind being*, a mental creature, an active, feeling intelligence sitting in the control module of a large machine on which I am dependent for survival and to engage with my fellow mind beings. A bit like a Dalek, perhaps, though less bent on world domination. I need my body-machine to move about, to pick things up and to digest my food. When it is working, it's fine, I hardly notice it. But when it goes wrong it's infuriating and depressing. Like when your car breaks down or your computer crashes. You think, for God's sake? Why did this have to happen? Can't someone fix it? How can I manage with a body that gives me pains or won't walk straight or won't breathe properly? I wish I could just trade it in for a new one.

Now some of these symptoms may turn out to be the first indication of an explicable illness. But many remain mysterious. I have them all the time. I suspect that you have them too, especially if you are growing older. To this extent we are capable of bodily empathy. We belong to the same species as our patients: human beings

with symptoms of unknown origin that may be psychosomatic.

What sort of doctor?
So what sort of doctor do you need if you have one (or more) of these medically unexplained symptoms, which are making you feel ill and making you fear that worse is to come? You need:

- A doctor who will listen and take you seriously.
- A doctor who goes into the details and examines you physically.
- A doctor who realises that you may need to find out what has gone wrong. Even if this turns out to be impossible you may need to keep trying for quite a long time before you give up.
- A doctor who will go with you on a journey,

This is where we come to Don Quixote.

DON QUIXOTE
You may remember the story of Don Quixote and his squire Sancho Panza.

It was written by the Spanish author, Miguel Cervantes, who has a good claim to be the father of the modern novel, and the first part was originally published in 1604. Don Quixote is an elderly nobleman who has read too many tales of romance and chivalry. He has become obsessed with the subject and believes that he is a knight-errant who must go out and fight sorcerers and enchanters and all sorts of evildoers. He recruits as his servant and squire, a man called Sancho Panza who is an ordinary guy from the village. Don Quixote equips himself with a sword and a lance, a suit of rusty army and an ancient broken-down horse called Rocinante. And he sets off on his quest to right wrongs. Sancho agrees to go with him, lured by the promise that Don Quixote will eventually reward him by making him the governor of an island; but, increasingly, Sancho becomes his master's friend and protector as well as his fellow-sufferer. Theirs is one of great Master-Servant partnerships of literature, along with Mr Pickwick and Sam Weller and Bertie Wooster and Jeeves. The image of the two of them is also familiar from numerous illustrations. The Don is tall and emaciated, mounted on his equally decrepit horse; beside him comes the short, fat grumbling squire, mounted on a humble donkey. Don Quixote is a very long book but it is very funny and very wise and well worth reading. Even if you don't want to read it from beginning to end, you can keep it by your bedside and dip into it at random whenever you wish to be entertained and uplifted.

Now I am going to suggest to you that the patient with medically unexplained symptoms is rather like Don Quixote, setting off on a quest which may seem utterly foolish. The Quest of our patient is to track down the demon lurking within him in the form of cancer or liver disease or kidney disease or whatever it he fears his symptoms represent, and defeat it. The Quest may involve him in all sorts of blood tests, scans, X-rays, visits to specialists both conventional and complementary, and, in extreme cases, surgical procedures. Suffering must be endured, but the patient, like the Don, is stoical.

Sancho, of course, is sceptical about his master's beliefs and in this he resembles the doctor. You will remember that, in the book's most famous episode, Don Quixote charges with his lance at a group of windmills believing they are giants – with disastrous results. His lance lodges in one of the windmill's sails and both he and his horse are picked up and thrown through the air, to land on the plain some distance away. After attending to his master's injuries, Sancho says surely, your honour can see that those are not giants but windmills? And the Don says, Sancho you are a very simple fellow. You know nothing about knight errantry. Of course they look like windmills now. That sorcerer who has been against me all the time has turned the giants into windmills just to deprive me of my victory. Sancho sighs wearily, but he is so loyal that he goes along with the quest and is frequently a fellow victim of the violence inflicted by angry people whom the deluded knight has mistaken for his enemies.

From time to time, Sancho tries to get his master to call it all off.

Is it really a good idea (he says on one occasion) to attack two whole armies at the same time, even if you are a great knight? And anyway they look like two flocks of sheep to me. And maybe we should just rest under these trees, or go to an inn or even go home to our village. He even ties Rocinante's legs together to prevent the old horse from moving. But Don Quixote only believes that his horse has been put under a spell.

I think by now you can follow my analogy. The patient is determined to go on his quest for a diagnosis, the doctor thinks he is deluded but can't convince him. But he goes with him on the journey hoping to protect him from the dangerous consequences of over-investigation and the collusion of anonymity.

The patient is Don Quixote. The doctor is Sancho Panza. And the secret, as you already know, is in the relationship.

Jane's letter
I would like now to tell you about some of my own adventures with patients who had medically unexplained symptoms.

The first was a young woman aged 26 whom I shall call Jane. Jane wrote me a letter in which she complained that

You never take me seriously. I have all these things wrong with me, but whatever it is you just tell me it's psychological. The other doctors are the same.

I felt that I should respond to this challenge, so I wrote back, inviting her to come for an appointment. She had many symptoms: nausea and giddiness; headaches; abdominal pains and bloating; irregular and painful periods; low back pain; painful knees. They had begun a year earlier when she had an awkward fall, injuring her neck. When she was taken to hospital by ambulance she heard someone say: 'she'll never walk again'. She had been a keen athlete, specialising in distance running but had now had to give this up.

I decided that I must show Jane that I was prepared to take her seriously. I took detailed note of each symptom. I examined the affected parts. I asked what she thought was wrong. I agreed to some blood tests and X-rays and referrals to a neurologist, an orthopaedic surgeon, a physiotherapist, a gynaecologist and a gastro-enterologist. I am aware that, in the current climate, this outrageous number of referrals seems guaranteed to bring down on my head the wrath of the Commissioning Group, who would name and shame my practice in their next bulletin. But at the time, it seemed the right thing to do.

All this took several appointments and while it was going on, I also asked her about her family background and her current life. Without in any way suggesting that it had anything remotely to do with her illness, I discovered that she had a boyfriend with whom she lived in a small flat and that she was hoping to do teacher training. Meanwhile she was working at the post office. Her family home was in Wales where her mother now lived with her younger sister. Jane's father and her mother had divorced when she was a child but she had kept in touch with him until he died, a few years previously in his early 50s. She had loved him very much and still missed him. She did not get on well with her stepfather which made relations with her mother difficult.

When we knew each other a little better I ventured to ask if any of these family events could possibly be related to her current symptoms. Could these events be relevant? She didn't think so, but would be willing to consider the role of 'stress' if the specialists found nothing else of note.

We had some successes and some failures with the physical side. Jane's periods improved and there was no gynaecological disease. A CT scan of her brain was normal and the headaches and giddiness cleared up. The back pain improved with physiotherapy. She coped with the irritable bowel symptoms with the help of some symptomatic treatment. We had a lot of discussion about her knees. The orthopaedic surgeon suggested arthroscopy but Jane didn't want that. He referred her to another physiotherapist who diagnosed mal-alignment of patella. She had to wear adhesive tape on her knees in order to correct patellar tracking. We were both sceptical about the usefulness of this and soon agreed that she could abandon it.

During this time I continued to see Jane for ordinary-length consultations about every three weeks. She kept me up to date on her personal life and her feelings as well as her symptoms. We became friends. The symptoms gradually became less important. There was no interpretation beyond the occasional suggestion that 'stress' might have been a factor. But the doctor-patient relationship was important. I was listening to her; looking after her; going with her on the journey.

Eventually she got a job with a financial organisation and was soon promoted. She learned to stand up to her rather manipulative mother. Her boyfriend also became my patient. They got married and moved away. They invited me to the wedding but I didn't go. I think I was nervous about meeting her mother. I did send them a present and received a card expressing their appreciation for my help.

The story of Pierre

My second case is a man I shall call Pierre. He was 42 and came originally from Switzerland. I had known him already for some years and I knew that he was prone to outbreaks of 'medically unexplained symptoms'. He also had recurrent problems at work to do with his relationship with his managers. His marriage had broken up and he was having weekly psychotherapy on a private basis. Then, one day, he came to see me saying that he was feeling tired and weak. His appetite had totally gone and he was losing weight. He was afraid that there must be something seriously wrong with him. Everyone noticed that he was much thinner than he used to be. His girl friend was worried about him. She had told him to consult me. Suspecting a psychological cause, I said, what does your therapist think? '

'She says, "Pierre, I think you should go and see your doctor about this weight loss."'

He had no leading symptoms. I examined him and found nothing. We did some blood tests. We checked his weight. It was about the same as the last recorded figure, about three years previously. But Pierre said he had gained weight in that time and was now rapidly losing it. I reassured him but he kept coming once or twice a week. Each time his face looked more hollow. He looked more desperate. No he wasn't afraid of cancer or any specific illness. Just that he was wasting away. I began to feel anxious myself. He really did look emaciated in spite of what the scales said.

Then he missed an appointment which made me really worried. I imagined that he might be lying dead somewhere. Or had been admitted to hospital where even now, doctors where shaking their heads and saying, 'and his GP totally failed to make the diagnosis'. I telephoned him at home, and to my great relief found that he had mistaken the date of the appointment. But he was terribly grateful that I had been sufficiently concerned to phone and find out if he was all right. This proved to be quite therapeutic.

The next thing I decided to do was to refer him to our Elderly Care Physician. No, he wasn't elderly, but this particular consultant is one of the few general physicians left and is always happy to see a younger patient if there is a problem with diagnosis.

The consultant went through his story in even greater detail that I had done. He ordered blood tests that I had forgotten or never hear of. He did some X-rays. He found nothing. But when Pierre came back to see me he was full of praise for the thorough check-up received. He was feeling better. He looked better. And I noted that his weight had remained unchanged since the beginning of the episode. So I felt better. No, we never found any particular reason for his fears. But once again, going on the journey seemed to be effective.

Success and failure

I would count both those cases among my successes. But I have also had failures. And since we learn more from failure that our successes, I would like to tell you about one of them.

A 17-year-old girl came for the results of her blood tests. They had not been ordered by me and I had not seen her before. This story illustrates the perils of lack of continuity. She told me that she had been feeling tired and lacking in energy for a year. There must be something wrong and she couldn't understand why blood tests were normal. I asked about her life and her family: He parents had separated a long time ago. She had been living on her own for the last year. Her diet was bad. But better now. 'This is nothing to do with why I am ill.' It hard been hard work getting even this much out of her, but I pushed on What did she do? She was a student. Who did she live with? She had been in foster care until a year a go when she had left to live on her own; and started to feel unwell. It seemed to me that there was a lot of psychological unfinished business here. But when I made that observation she snapped back: 'this stuff has nothing to do with my body.'

Mind and body are the same. I told her. You can't separate them. She sniffed and looked at me as though I was an idiot. It was as if I wanted to defeat her and prove her wrong instead of trying to help her and be with her. Why did I do this? I don't know. It's more likely to happen if it's towards the end of a surgery when I'm tired and I have already seen too many patients. I couldn't stop myself. I needed a Balint group. I wanted to get her back to have a better shot at helping her.

But she said 'I am going to do some research on the internet and find out what's really wrong with me.'

So what went wrong with us? We didn't tune into each other. We didn't connect. I wasn't able to deal properly with the things she was doing to my feelings. Medically Unexplained Symptom patients can be very disturbing and annoying. It can be difficult or impossible to do the right thing. How can we get it right more often? Here are my suggestions:

1. Cultivate bodily empathy. Know what it might feel like to have a symptom that won't go away and drives you mad. Remember your own medically unexplained symptoms. They were real enough, weren't they?

2. Be a Sancho Panza. Go on the journey and humour your Quixotic patient.
   Get interested in solving the mystery yourself. Try and save him or her from getting into too much trouble.

3. Be prepared to carry on the bodily and the psychological exploration in parallel. Get to know the person while helping on the quest for a solution. Maybe they will come together or maybe they won't. But you and patient will come together.

4. Try to maintain continuity.

5. Join a Balint group!

Renewal through Reflection

Keynote address to the Oxford Weekend 2010

Mike Courtenay

Socrates said that an unexamined life is not worth living. The Stoics encouraged us to know ourselves. But do we know what a self is? I recommend Roy Porter's recent, last, masterpiece: *Flesh in the Age of Reason* for a look at the problem. I have come to believe that my personality in old age is the product of an evolving process throughout my life. Although my present body has a kind of continuous relationship to the physical reality which contains my brain, my mind has undergone a change over time with regard to what I believe about the nature of who I am. I just hope that my geriatric physical being may express a psychological state that is not quite as pathetic as my sarcopenic body! My theme is that mental renewal by reflection is still more productive than my current dietary and exercising regime.

What's this got to do with Balint-work? I will try to explain my thinking. When I began working in general practice in 1952 I did so with a very reductionist stance. My house jobs at the Royal Waterloo Hospital, a satellite of St.Thomas', had involved medicine with surgery every other weekend, a paediatric ward, and weekend duty covering dermatology and psychiatry! Psychiatry there was under William Sargent, a Mephistophelian character who believed all psychiatric illness was somatic. I even assisted him in using carbon dioxide narcosis to achieve abreaction in war-traumatized soldiers. I shudder at the memory! So you can see I had a shaky start.

My problem with trying to apply what I had learned in medical school was that the patients seem to have read the wrong textbooks. While some problems were recognizable: a man with lead poisoning who worked in a car-battery factory, a teenager with TB meningitis, a woman who had a sub-arachnoid haemorrhage, another with rheumatoid arthritis, a man with high-output cardiac failure, etc. (not to mention the Friday-night botched illegal abortions). Though most of the many other cases, such as childhood exanthems or common virus infections were plain, they were not usually testing. What was testing were the patients who came in with mysterious syndromes which seemed to require a diagnosis which I couldn't make, but whose referral to various specialists produced nothing more tangible than a fat folder. And that didn't even cover those who consulted with anxiety or depression.

At the same time, there were a lot of patients to see, due to the vast number of poorer people who came, having previously been unable to pay fees before the advent of the NHS. To illustrate the workload, the money from so-called 'private certificates' at sixpence a time allowed me to buy records of all of Beethoven's piano sonatas during the 1957 flu epidemic. After five years in practice in which diagnosis seemed often beyond reach and the capacity for special investigations virtually non-existent I was admitted to hospital with epididymitis. As investigation and rest put me in bed, I had the opportunity of a recently published book: *The Doctor, his Patient and the Illness!*

After reading it I persuaded my physician, Tony Dornhorst, to let me go home and rest. He had been the only teacher who had really made me think. I immediately wrote to Michael Balint at the Tavistock asking to join a group. After the most searching interview I have ever experienced he said I could join a new group in the autumn. And so it began.

My first Balint group

Meeting at the Balint's house, number seven, Park Square West, in an L-shaped drawing room on the first floor, a new door opened for me. There were eight of us led by Michael and Enid. My ageing memory is full of holes. The doctors I remember clearly are the young woman who irritated me (now a dear friend), the doctor who knew it all (he left general practice soon after the group finished), the doctor from the west country who had two-way radio equipment in his car, the young doctor who I sensed was bullied by his partners (father and son), and the Polish doctor.. The latter never presented a case and left after three months. Michael Balint explained that we were to prepare to speak about a patient with whom we were having difficult every week, though it was unlikely that more than two doctors would talk about their patient in any one meeting. We were not to bring the patient's notes with us. He said that, although he and Enid were psychoanalysts, we were not expected to know anything about it and that the word transference was never to be voiced. He then said "who has got a case?" I think it was the 'doctor who knew it all' who was brave enough to start, but that may be a false memory fed with antipathy! So, week by week, I took the tube from Tooting Bec to Regent's Park every Tuesday afternoon, reported, heard and discussed our difficult cases before returning to start evening surgery at 5 p.m.

My memory delineates a mental fog for many months, from which, eventually things began to make a little sense. Michael often used to interject a little burst of didactic 'teaching' when he thought clarification in the discussion of a case was appropriate, but there was never any over-arching picture of what was going on in his mind. He was often very critical which usually brought Enid in for the defence. But he would admonish any doctor who was over-critical of a

colleague –I well remember being on the receiving end of that admonishment once! Little by little, I became aware that a new form of diagnosis was crystallizing as a result of this Balintian experience, and at the same time I was feeling happier in my work. As I began to understand my patients as people, I also began to change my perception of my colleagues and even my family. After two years of meeting at the Balints' house, the Tavistock Clinic insisted that the group should not meet there as it was not part of their premises, so we moved the meeting in a very Spartan room at the Tavistock Institute. Two new doctors joined the group, one of whom was a colleague working in Battersea. A year later, group musical chairs was introduced so two of us were assigned to a parallel group, while two of them were assigned to the Balints.

A new group and a new leader

What was upsetting was that our new leader was on sabbatical so we had Bob Gosling for one 'term'. At the first meeting I presented an 'impossible' case of the kind we code-named 'the pregnant nun'. Bob challenged me, saying he had heard better things about my work. He was quite right, but I took it as criticism, and was unable to reflect on what he said as a chance for renewal. Because of that failure, years later, I was unable to apply his lesson. I missed the opportunity at one of these Oxford meetings when we had an Italian psychiatrist (whom we called Attila the Hun) as a member of the leadership group who presented just such a pregnant-nun case! I have regretted it ever since. I obviously had a counter-transference in my relationship to Bob, who reminded me of school prefect in my distant past. It remains a reminder that even if there has been a change of personality with the Balint experience, it doesn't always go far enough.

The new group's life came to an at the end of the fourth year, which made me sorry as the new leader, John Wilson, had an interesting approach to leadership, being young and not such a hard task-master as Michael.

The Family Planning Association group

I thought that was that, but the next thing was that Jean Pasmore rang me to say she was supposed to be starting a Marital Difficulties Clinic for the Family Planning Association in Pimlico, where her appointed partner had pulled out at the last minute. Talk about being thrown in at the deep end! There wasn't much literature about sexual medicine in the early nineteen-sixties. In fact Jean and I appear in the bibliography in Masters and Johnson's classic, as we saw the couples on the basis that Jean saw the women and I saw the men. Over five years together, we had some astonishing results, considering we started from scratch, but I am in no doubt that Jean was the mainspring, even though in my case I had beginner's luck. But there was a price to pay as the next thing I knew I was summoned by Michael to join a group to examine psychosexual problems! Jean had been in a group of women doctors for a year, following their approach to Michael, but there were now to be two groups, brought about by several more women doctors and three men. The original Family Planning Association (FPA) group published the book on the subject of non-consummation of marriage under the title of *Virgin Wives* by a co-opted psychoanalyst, J.Friedman. The two new groups, meeting on different days of the week, were invited to try and apply a technique called 'focal therapy' to the field of marital (sexual) difficulties. A group of psychoanalysts associated with Tavistock Clinic had previously developed this idea in a group chaired by Michael to explore the possibility of shortening the duration of psychodynamic psychotherapy, described in a book called *Focal Therapy*, by a new member of the group, David Malan. Looking back, I think Michael's wish to push the boundaries went a little too far for patient safety, even though we had supervisors for our work, mine being Enid and Tom Main, over the two years of the project. I was appointed recorder of the group and wrote the book about our endeavours: *Sexual Discord in Marriage*, with a great deal of help from Michael and David Malan. However, I came to the conclusion that I was not cut out to be a psychotherapist.

Years later, I remember some psychotherapists at a leaders' workshop at the Tavistock Clinic feeling aghast that GPs should have been let loose on patients in a psychotherapeutic setting. I think this experience drove Michael to a more realistic appraisal of the limitations of GPs in their work. That didn't stop him arranging with the FPA that we should become group leaders. I led two groups over the next five years, one in London and then one in Exeter which meant that I had dinner on the train down, stayed overnight at the Station Hotel and caught the seven-fifteen Golden Hind express back to London. I was also in a group at the Cassel Hospital, where the FPA women doctors wanted to study frigidity, a project which ended inconclusively.

Subsequently, I was in a group led by Tom Main, researching how to deal with requests for abortion (this was before David Steel's activity in Parliament led to Abortion Law reform); when Michael called me invite me to join a group researching a new approach to Balint work. I was involved with Surrey University student medical care at the time and felt I couldn't take on any more, but he browbeat me into deserting Tom's group, though I refused to start immediately because of my other commitments.

Six minutes for the patient

So, in the autumn I joined the group which met, would you believe, at the Hospital for Tropical Diseases in St. Pancras. We were a set of old lags: Max Clyne, Aaron Lask, Stephen Pasmore, Cyril Gill, Jimmy Carne, Jack Norell, Philip Hopkins and myself. Enid was co-leader, Mary Hare was

trainee leader, and there were a number of grand foreign visiting Balinteers stretching from Sweden to New Zealand. Latterly a Canadian psychoanalyst joined as a trainee leader.

Michael explained that he wished us to report "run-of-the-mill" cases, not based on long interviews. We struggled for a year before, one day, he vented his frustration with us by settling on poor Aaron Lask's presentation. However, Jack then produced a case which made him smile. We all sighed in relief! As it happened at this time, a psychiatrist in Aberdeen, Colin McCance, invited us all to come for a weekend to Aberdeen and run a demonstration group. (Curiously, I had sat the feet of Colin's father at Cambridge, and his wife had been an assistant in my Battersea practice for three years). Accompanied by our wives, we travelled up on the night sleeper to Aberdeen, lubricated by a bottle of Scotch. We duly gathered and produced a series of cases which were based on just the material of short consultations. This was the beginning of the work which was summed up in *Six Minutes for the Patient*, which included the description of 'The Flash' as a new way of making deeper contact with the patient in a short interview. It may amuse you to know that most of us thought the 'six minutes' was taken from the Royal College of General Practitioners' calculation of the average doctor-patient contact time then current. However, Jimmy Carne still thinks it was related to the minimum time possible between male ejaculations, while the German translators thought it was a British aberration based on our duodecimal currency rather than the superior decimal one and called it *Fünf Minuten pro Patient*.

Michael died more than a year before the group finished under Enid's leadership, during which time we worked to produce the book.

Groups for trainees and young GPs

After that, as Course Organizer of the St Thomas's Vocational Training Scheme, I introduced a pale reflection of a Balint group in the half-day release course, which included other trainees from all over London. Meanwhile, Enid had persuaded Mary Hare and me to form a group which met at University College Hospital (UCH) while she led a group with Cyril Gill as co-leader elsewhere. Enid dared to use GPs as leaders, which I don't think Michael would ever have agreed to. I have very fond memories of that UCH group, two members of which have since become President of the Royal College and two others have become pillars of the Balint Society.

(Another member of the St Thomas's trainee group is now President of the Balint society!)

I feel very privileged to have joined them in such an endeavour. Mary Hare became a close friend as well as a colleague, and her fatal stroke after we had attended a Psychosomatic Congress in Japan left me bereft and the group without a psychoanalyst in a leadership role. I struggled on, greatly supported by the group, but felt we should bring it to a close the following summer.

Research groups

Some years later, during which I was responsible for a sector of an M.Sc course at Guy's, Enid approached me to join a group to review the state of Balint thinking. Marshall Marinker had approached her to lead the group, and it was clear that he was interested in developing a more academic approach to Balint research projects. David Malan once remarked that when Michael came into the room, science flew out of the window! That is rather unjust, as he had sought to get fellow psychoanalysts to assemble 2000 cases they had treated in order to try and bring scientific light on the status of his work. This failed, but though it is my personal view that psychoanalysis has not yet reached the status of a truly scientific discipline, I do not dispute its contribution to medicine, though I do not understand the true ways of its working. But then we don't yet understand the relationship of Einstein's ideas on gravity and Quantum theory.

The group duly convened and while Marshall tried to initiate a research project which could be published in a learned journal, Enid had a different agenda, which was to try and re-establish a renaissance of classical Balint-work. Marshall left the group after a year, probably because of frustration, but continued to provide meeting space for the group. Our work was the basis of the book: *The Doctor, the Patient and the Group*. This took three years of gestation, and although I learned a lot, and enjoyed the gestationary period, with Enid, Andrew Elder, Paul Julian and Sally Hull, It does not seem to have had much appeal. Perhaps there was too much looking back and not enough looking forward. For me it was an exploration of a new kind of doctor-patient relationship in which greater freedom of expression could emerge. This also illuminated the meaning of deep friendship with colleagues who had become friends.

Subsequently, the Balint Society kindly asked me to co-lead a research group with Erica Jones, to examine cases of accidents met with in general practice. The idea had emerged in an Oxford weekend just like this one. We struggled with the task for more than a year but became bogged down, in my opinion, largely because an accident is a single event from which a number of effects emerge and which then take over the discussion. Rather than end the group I offered the suggestion that Tom Main had, during the course of his Balint Memorial Lecture, invited Balinteers to examine their own defences. The idea was accepted. We met for four more years, a whole day every six weeks or so, at various localities, stretching from my home in Adderbury near Oxford, via London, to Paul Sackin's near Cambridge. John Salinsky and Paul then edited our various contributions brilliantly to produce the book: *What are you Feeling, Doctor?*

This work brought me, personally, full

circle, in that Michael, at a meeting with Dutch doctors in a London hotel many years before had made a Freudian slip in declaring that Balint groups were therapeutic! But don't worry, it was only a slip! I think the group displayed amazing courage in reflecting on their own internal state to produce a renewal of Balint work.

So, old friends and new, I urge you to be bold. Reflect on what you experience in the course of your groups, and do not be afraid to introduce changes which seem to you be dictated by the organic need to encourage the evolution of our work. It may well be that the best is yet to come!

Obituary:

Dr Peter Graham 1936-2011

Peter Graham, an active and well-known member of the Balint Society since its earliest years, died on 17 May 2011 after a long illness.

Peter was born in 1936 and educated at Leyton County High School in East London.

He studied medicine at Edinburgh University, gained an Honours BSc in physiology and qualified MB ChB in 1962. He became a member of the Royal College of General Practitioners in 1974 and was awarded his FRCGP in 1994. After house officer and SHO posts in Edinburgh and London he entered general practice as a principal at the Altmore Avenue Practice in East London. He became a partner in 1967 and continued in the practice until his retirement in 2008, by which time the practice had been named after him.

One of his main interests was in postgraduate education for GPs, which became mandatory in 1978. Peter was Course Organiser for the Newham GP vocational training scheme until 1993, inspiring many young doctors by his dedication and enthusiasm. He was also active on the Newham Primary Care Trust, serving on the medical management committee and the clinical governance team and acting as clinical lead for mental health.

His interest in people and their personalities led him to become a member of one of Michael Balint's groups in the late 1960s. He joined the Balint Society shortly after it was formed in 1970 and became a member of Council in 1978. From 1980 till 1988, he served as secretary of the Society In this post, his lasting achievement was the development of the Oxford Weekend. In 1978, Cyril Gill, Peter's predecessor, had organised a weekend on the fringe of Oxford, in the Radcliffe Infirmary, and a day course in Reading University, the following year. Following his lead, Peter inaugurated the first Balint Weekend in an Oxford college, which was open not just to Society members but to any doctor who wanted to have a taste of the Balint group experience. The weekend was a great success and has been repeated every year in one Oxford college or another.

In 1993, Peter was elected as president of the Society. In that year, he also became a member of the research group lead by Michael Courtenay and Erica Jones, which studied 'doctors' defences'. His contributions to the case material and the discussions were crucial, as Michael Courtenay points out below. Peter also recorded all the sessions for us and the transcripts of these were invaluable in the preparation of the book which eventually described the research (What are you Feeling, Doctor, 2000)

Peter enjoyed travelling to the international Balint meetings and was a representative for the British Society on the International Balint Federation Council. He

contributed to Congresses in Budapest, Charleston (South Carolina) Slovenia, Berlin, and Stockholm as well as helping to organise our own International in Oxford in 1998. As a result of these meetings he made many Balint friends in Europe and the USA.

Peter's accounts of the lives of his East Ham patients were characteristically colourful and dramatic. Some of his presentations resembled an exciting episode from East Enders. But there was no doubt that he served his patients devotedly and effectively and their love for their family doctor often came out strongly in what they said and did. He was very interested in psychoanalytic theory and sometimes his speculations about the unconscious motivation of his patients (and ours) could seem a trifle far-fetched. But then, he would come out with a startling insight which was absolutely on target. Peter was a very kind man who always considered the welfare and comfort of other people. He bore his illness patiently, without complaining. He leaves his wife, Raina, three children (Jonathan, Andrew and Rosalind) and four grandchildren. He will be greatly missed by his friends; and the Balint Society will remember him with gratitude and affection.

John Salinsky

Michael Courtenay writes:

I first met Peter, who was then secretary, when I re-joined the Balint Society Council, after a longish pause. Thereafter, the planning of the annual event in Oxford brought us together on a regular basis. I shall always remember his boldness in everything he did. Especially as a member of the research group I co-led with Erica Jones where, after a false start, we were studying doctors' defences. He produced what I consider a pivotal case, in which he was fearless in presenting his own difficulties in the doctor-patient relationship. He gave us all courage in the endeavour to come to terms with ourselves in the pursuit of our professional task.

Secretary's Report 2010-2011

The Balint Society Oxford Weekend, held at Corpus Christi College from 1-3 October 2010 was the largest for many years. This was because an International Balint Federation council meeting was timetabled to happen at Oxford, and because the Icelandic Vocational Training Scheme attended en masse as they did two years ago. This meant more than 80 people, with two group-leadership training groups. The new venue, Corpus Christi College, proved more than satisfactory. They offered the choice of en suite rooms or not, some double rooms, excellent food and a beautiful lecture theatre. I hope all enjoyed the diverse participants as much as I did. We are going to use this college for at least the next two years.

Partly due to the loss of the RCGP Princes Gate site we have curtailed our lecture programme for the moment. We did have two presentations this academic year, both at the Medical Society of London, 11 Chandos Street, a lovely venue that is reasonably priced. The first was given by John Salinsky on 26th October and the paper appears in this journal. The second was the 19th Michael Balint Memorial Lecture, given by Dr Peter Shoenberg on April 12th, preceded by a reception. He spoke on his fantastic project with medical students at University College London Hospital, in which many Balint Society members are involved as group leaders. Attendance was excellent with about 50 members and guests. Without a figure like Peter in a psychotherapy department, involved with a medical school, it seems hard to imagine this scheme taking off elsewhere despite its obvious virtues.

Unfortunately the London Balint day had to be cancelled due to lack of interest. We shall not attempt a repeat next year, though there will be some other London activities. Both regional weekends, at Whalley Abbey, Lancashire in March and at Longhirst near Morpeth, Northumberland, in June were successful, both with over 20 participants and each offering a group leadership group.

The group-leadership workshop had a quiet year with three meetings, but a paucity of groups to be presented, the leaders using the time to debate/discuss leadership issues in a very useful forum. This discussion was continued at the First International Balint Group Leaders meeting in Copenhagen April 28-30. More than 40 leaders from around the world met to participate in groups and discuss issues over a very well organised weekend. It will be repeated next year, the intention being to hold it in alternating years with the International Balint Congress (this year in Philadelphia September 9-11), to keep up an ongoing international forum on leadership issues.

The Annual Dinner took place on June 30th at the Royal Society of Medicine, when Dr Rhona Knight spoke about her work with the RCGP on a new course designed to improve the medical care of doctors by doctors. Twenty-six members and their guests attended. The Balint Society Prize essay was awarded there to Lara Curran, a medical student at University College London Hospital. A UCLH medical student also received the 2011 Ascona Essay prize (to be presented in Philadelphia).

The Council of the Society has been working on updating the constitution to align it with current practice; to think about further improving the group leadership accreditation procedure, and trying to improve links with other likeminded organisations. We have become officially affiliated with the RCGP, the results of which we are yet to realise. We are having joint educational days with the APP (Association of Psychodynamic Psychotherapy in the NHS) and with the IPM (Institute of Psychosexual Medicine) on the 4th and 5th of November, respectively.

The council is also actively seeking a new secretary to take on these duties within the next three years. Please apply or ask for information if you are interested

David Watt

Report from the International Balint Federation (IBF) 2011

www.balintinternational.com

The new Board of the IBF:

- **President:**
  Dr Henry Jablonski (Sweden)
- **Vice Presidents:**
  Prof Donald Nease (USA)
  Dr Kristiina Toivola (Finland)
- **Treasurer:**
  Dr Michel Delbrouck (Belgium)
- **General Secretary:**
  Dr Paul Sackin (UK)

They will take up their office in October 2011.

Membership:

The membership has increased to 23, the Bulgarian Balint Society being the latest society to join the Federation. An application has been received from the Ukraine, but their society does not yet fulfil the criteria for membership. An application from the Chinese Balint Federation is to be considered at the next meeting. There are Individual members in Brazil and Norway and the IBF also has contact with Iceland and Canada where there are individuals who are members of other national societies.

All members of the British Balint Society are automatically members and are welcome to attend any of the international meetings. These are advertised on the website www.balintinternational.com and most of them are conducted in English.

Ascona Prize:

This biennial award for medical students' essays will be awarded at the17th International Balint Congress in Philadelphia, USA in September 2011.Further information about the Prize can be found on the IBF website.

Events 2010-2011:

- **2nd October 2010:**
  a Council meeting of the IBF was held in Oxford, in conjunction with the Oxford Balint week-end
- **7th October 2010:**
  the IBF ran workshops and groups at the Wonca meeting in Malaga
- **7th-9th April 2011:**
  Balint Leaders' Weekend held near the Sea of Galilee, Israel
- **28th-30th April 2011:**
  First Biennial International Balint Leadership Conference (and IBF Council Meeting) held in Copenhagen, Denmark
- **5th -8th May 2011:**
  Balint Leadership Training Intensive held in Melbourne, Australia

Reports on these events may be found on the IBF website.

Future events:

For further information about all future events, including those listed here, please see the IBF website www.balintinternational.com

- **7th - 11th September 2011:**
  17th International Balint Congress, Philadelphia, USA
- **15th October 2011:**
  39th Congrès de la société medicale Balint, Paris, France
- **June 2012:**
  Council meeting of the IBF, Sofia, Bulgaria
- **4th-7th July 2012**
  Wonca meeting, Vienna, Austria (the IBF will run groups / workshops there.)
- **There will be another Council meeting in late 2012, venue and dates to be arranged**
- **September 2013:**
  18th International Balint Congress, Heidelberg, Germany

On a personal note I would like to thank my colleagues in both the British Balint Society and in the International Balint Federation for the exceptional support and encouragement that I have received as General Secretary since I took on the post in September 2003.

I am delighted that Paul Sackin has been elected to take over and feel sure that the IBF will flourish under his administration.

Heather Suckling heathers@doctors.org.uk
General Secretary

Report from the first biennial International Balint group leadership conference, Copenhagen, April 2011

Andrew Elder

The first (IBF) International Balint Group Leadership Conference was held recently in Copenhagen on 28 – 30 April 2011. The event was hosted by the Danish Balint Society. Although some countries within IBF have well-developed leadership training and accreditation programmes, the majority do not. The conference entered new territory by inviting currently affiliated Balint Societies to study Balint group leadership together under the umbrella of IBF. Feedback from participants at the conference itself was positive.

Background

At the IBF meeting in Chicago (April 2009) it was suggested that there was a place for more international co-operation on leadership training and accreditation, and that IBF might consider establishing international conferences for leaders. At Brasov (Sept 2009) a small group - Andre Matalon (Israel), Heide Otten (Germany), Andrew Elder (UK), Michel Delbrouck (Belgium) and Don Nease (USA) - was established to research what individual societies are doing at present and to organise a conference to 'exchange ideas and suggest methods of leadership training'. A 'Questionnaire on Balint Leadership: Accreditation, Supervision and Training' was sent to all (22) member countries affiliated to IBF and the results reported to the IBF council in Gorlitz (May 2010). At this meeting the group recommended that IBF support an international seminar on leadership every two years, alternating with International Congresses. This would be a 2-3 day event, not an IBF sanctioned 'training', but a place to 'explore and exchange ideas about leadership' and would include workshops and seminars as well as Balint groups. This idea was accepted and the Leadership group met again in Oxford (October 2010) with Tove Mathiesen and Jorgen Strobech from the Danish Balint Society to plan the first conference to be held in Copenhagen in April 2011. The conference was to be open to established group leaders or those recommended for further leadership experience by national societies, or individual members of IBF. Two workshop streams were proposed, one in which group leadership remained the same, and the other in which the leadership changed at every session. The conference group and three Danish colleagues (Tove Mathiesen, Jorgen Strobech and Soren Kaltoft) formed the staff team for the conference.

Aims

The aims of the conference were to provide a forum for Balint group leaders from different countries to study leadership together and to learn from each other in a research-cum-training environment; to bring together (under the umbrella of IBF) the different international Balint perspectives; to begin to develop a template for such events which can be adapted for use in different settings (countries). It was not intended to provide an IBF 'correct way' or an approved method of leadership training. In the planning, much debate took place about the role of psychoanalytic theory in such events, and it was decided that in Balint work, theory (if present at all) should follow the experience of working on cases together.

Programme Outline

The conference programme was based on a series of five small group workshops to provide experience of Balint group leadership, observation of group process, and feedback about leadership skills. Participants opted to be part of a workshop (A) in which leaders and observers changed in each session, or to choose workshop B in which a pair of leaders led firstly for two consecutive sessions and a second pair then led for three consecutive sessions. Eighteen participants went into Workshop B (continuous leadership) and nineteen into Workshop A. There were three plenary sessions.

Participants

Forty five people attended from thirteen different countries. Most were experienced leaders but around ten were either less experienced or not yet accredited, and attended with support from their national societies. Twenty eight were GPs or physicians and seventeen were from psyche-professions!

First Plenary

After an initial welcome by Jorgen Strobech on behalf of the Danish Balint Society, and on behalf of IBF by Henry Jablonski, the first plenary consisted of short talks, **'Balint Group Leadership: Where are we Now?'** (Andrew Elder); **The Role of the Conductor in the Group** (Tove Mathiesen); and **'Useful Questions: Generating a Frame for Observation.'** (Michel Delbrouck and Don Nease). Michel introduced Bion's concepts of group behaviour and a framework of questions for observing Balint groups used by the Belgian Balint Society. Don Nease then conducted a large group discussion to elicit the expectations of participants.

Sample of topics raised in this discussion:
Difficulty for leaders in frustrating the group's desire for 'answers'.

The role of leader in helping the group learn how to work; when to 'lead'/when to 'conduct'.

How to pitch interventions when the group has many voices/many levels.

How to learn more about organising leadership training.

Learning more about international differences.

Time pressures/who would have time to be a silent observer for a year.

The impact of relationships outside the group (colleagues/friends/teachers etc) on group process.

What sort of leader does the group want?

Being in need of re-vitalising

Learning about different 'levels' to intervene within the group.

Workshops
There seemed to be a feeling that the introduction of workshops with more continuous leadership was worthwhile. This had been done in order to give some experience of the developing relationship between a group and its leadership, as well as allowing a leadership pair to begin to be more familiar with each other and to get an opportunity to put feedback about their leadership into effect. The process by which each of the 'B' groups chose their leadership pair and then changed to another pair was certainly complex!

Second Plenary
Each of the four workshops was asked to come up with two 'points for debate' to be discussed in the mid-way plenary. These included How to manage initial stages of the group process; How do leaders decide whether to intervene or not, and at what level – intellectual, emotional, unconscious? How to choose between different modes of conducting/facilitating/or leading? Different traditions of leading? Do you need clarifying questions? How to stop parallel stories? What is the role of a co-leader? Communication between co-leaders. Can leaders disagree in front of group? (!) What kinds of cases to be discussed in leadership events – 'ordinary' clinical cases, relationships with group members or whole groups?

Suggestions were also made for other subjects to be discussed at a subsequent conference:

Co-leader discussions, try public debriefing; payment in different countries; how long should groups go on; dealing with a disturbed individual member; differences of leadership in different groups – supervision, cases being presented or groups being presented.

Concluding Plenary
In the last plenary (two hours) the time was divided between inviting feedback; thinking about what people would be 'taking home'; ideas for how future conferences might develop or be different; and a return to some of the theory that Michel Delbrouck had introduced in the first session. Michel returned to a description of Bion's structuring of the mind into alpha (more rational) and beta (more emotional and primitive) elements and described how a Balint group might function as a processor/container in this respect for emotional aspects of the doctor-patient relationship which are too disturbing to be integrated in the clinical setting but can be thought about more easily in the group setting.

During the last plenary, everyone was invited to write a brief response to the following headings: New Ideas to take home; Unresolved Questions; and New Questions.

Evaluation
Evaluation forms were sent out after the conference. Only fifteen (39%) completed forms were received. All were positive and many included useful suggestions for future events.

Summary
It was impressive and encouraging that many very experienced leaders attended, and felt that an event such as this was a valuable IBF development. It felt satisfying (and slightly unexpected) to realise that the conference was able to start to bring the various strands of Balint work together from different countries. Balint work has been taken up and developed differently in all the various affiliated countries – perhaps relying mainly on one professional group (or particular individual) in some countries, more of a partnership in others, more (or less) emphasis on psychoanalytic input in some, more traditionalist in others. To begin bringing these strands together in an exercise of mutual learning felt very positive.

Staff meetings
The importance of structuring regular 'staff' meetings throughout was very helpful. Such a group can think together and support each other, think about themes, and reflect on the process of the conference so that each workshop becomes part of the whole.

Staff team: Michel Delbrouck, Andrew Elder, Soren Kaltoft, Andre Matalon, Tove Mathiesen, Don Nease, Heide Otten, Jorgen Strobech

Report on Balint Society Weekend Workshops at Whalley Abbey, 11-13 March 2011

Caroline Palmer

In March, a slightly smaller number of us met in the tranquil, hallowed and yet comfortable space of Whalley Abbey Conference Centre, to reflect on either our relationship with our patients, or our group-leading skills, and so our relationship with the group.

As the organiser of the weekend, I wondered whether the recent addition of running the NHS to a GP's repertoire of tasks and concern about the anticipated attendant increased workload, might have inhibited people from coming to a weekend concentrating on what they might see as an 'esoteric subject'. To many of us who have experienced the Balint method of case discussion, of course it is far from esoteric, grounded in the real feelings generated in our work with patients, and indeed a crucially practical way of helping us understand what may be going on in either a difficult 'one off' consultation, or during the twists and turns of a developing doctor-patient relationship. Perhaps the current health economy culture and its promotion of a schematic Cognitive Behavioural Therapy type approach, now advocated as an almost universal panacea for all psychological problems presented in primary care, also deters the busy GP from looking deeper into the fundamental core of our apostolic function.

Of those that came, luckily there were equal numbers, keen on the one hand to experience and participate in a Balint group and on the other to learn or improve their leadership skills and it was refreshing to welcome new members to both groups. We were also enriched by the attendance of a good multidisciplinary mix including GPs, psychologists, psychotherapists, psychiatrists, a counsellor, a group analyst, a medical student and a hospice doctor, which helped throw new light and different perspectives on the cases, and may thereby have helped participants to identify or personify different aspects of the patient or therapist in the ensuing discussions.

Themes that emerged from the cases discussed in one group, were of how true or untrue, believable or unbelievable are the stories we are told; how do we know what is fantasy and what is reality? Another predominant theme was the recurrence of a triad often involved in the consultation, i.e. that of the system, as well as doctor and patient, in which we may work or have to operate, which can often distort or derange the consultation, or therapeutic relationship, e.g. with a set number of counselling appointments allowed per patient as per PCT contract, or GP partner views on how long counselling should be for, or what a doctor should or should not be exploring during a patient's appointment.

In the group leaders' workshop, a recurrent theme of labelling cropped up, either of trying to see the patient beyond the label, or on the other hand daring to mention, name and label the 'unmentionable' lurking within the consultation. There were also several cases involving endings, through loss and retirement which may well have reflected the transitions that some group members were facing. The hard but fruitful emotional and mental work within the groups was counter-balanced both by a Saturday afternoon of free time, during which many people enjoyed the physical refreshment of a walk up Whalley Nab or along the River Calder, and also the wholesome bodily comfort of generous satisfying meals, a warm cosy fire in the sitting room grate and the pleasure of quiet relaxing bedrooms, all in beautiful secluded yet accessible surroundings. Whalley Abbey Conference Centre has been booked for next year's weekend workshops, from 9-11 March 2012, and we hope for further interesting cases, brought by perplexed or intrigued participants, having got the running of the NHS neatly under their belts by then!

Balint on the beach: Northumberland 2011

Whalley Abbey weekend 2011

Pictures from the 17th International Balint Congress in Philadelphia

The Balint Society Essay Prize 2012

The Council of the Balint Society awards a prize of £500 each year for the best essay on the Balint Group and the Doctor-patient relationship.

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

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

Length of essay is not critical.

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

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

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

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

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

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

The prize-winner will be announced at the Annual General Meeting.

Entries must be received by 1st May 2012 and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS.

The Balint Society
(Founded 1969)
Council 2010/2011

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(A new council will be elected at the AGM in Oxford on 24 September)

Guidance for Contributors

All manuscripts for publication in the Journal should be submitted to the Editor, Dr Tom McAnea by email as an attached word file. The address is *tomcmc@doctors.org.uk*

We welcome research papers, personal reflections, case studies, book reviews and reports of Balint events and ongoing groups.

References

References may be in the Harvard or Vancouver style. 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.

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