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Hearing Secret Harmonies: Balint and the Re-imagining of Medicine

Opening Address at the 21st International Balint Federation Conference

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'Our great task is to succeed in becoming more human'

Jose Saramago (1922-2010) Nobel Laureate for Literature 1998

I have been invited by the organisers of this our 21st International Balint Conference to give an opening talk on the subject of the conference – Balint: seeing medicine through other eyes.[1] It is a title that takes us to the essence of Balint work. Indeed, the very origin of the Balint project lies in the 1950s with the Balints themselves bringing their 'other' eyes to help explore the work of family doctors. The general practitioners' task in those early groups – as it remains for all professionals joining a Balint group – was to let go of their accustomed way of thinking and begin slowly to integrate into their professional practice a deeper awareness of the emotions involved in the doctor-patient relationship: the practice of medicine and awareness of feelings *woven together* into the fabric of a professional relationship. Doctors emerge from medical school in a somewhat 'one-eyed' state, highly trained technically but with matters of the mind and their emotions rather pushed to one side. Our task is to re-connect *to ourselves* whilst also being able to practice medicine with all that that involves. In short, we must restore binocular vision!

When on the occasion of his seventieth birthday, Freud was greeted as the 'discoverer of the unconscious', he corrected the speaker and disclaimed the title. 'The poets and philosophers before me discovered the unconscious', he said. 'What

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I discovered was the scientific method by which the unconscious can be studied'. [2]

In the same way we might point to the numerous descriptions of the doctor-patient relationship in the literature of the past and say that Michael and Enid Balint were the first to discover a method for the systematic observation and study of individual doctor-patient relationships. We are heirs to a great tradition.

In his masterpiece *The Doctor, His Patient and the Illness*[3] Balint expressed his challenge to doctors with characteristic and imaginative simplicity. What do we know of the pharmacology of that most frequently prescribed drug: the drug 'doctor'? What are its indications? What are its undesirable and unwanted side-effects? These sentences ushered in what must be one of the most sustained ethnographic research projects in medicine. After *The Doctor, His Patient and the Illness*, four further research groups were convened and all published accounts of their work.[4] The last group focussed on doctors' defences and published its findings in 2000 'What are you feeling, doctor?' During the course of the research groups the questions became more refined but continued to look at shifts in the doctors' feelings when consulting with a patient. These were then followed up to evaluate consequent changes in the working relationship between doctor and patient, sometimes for as long as two years.

The approach adopted by the Balints - no teaching, no case notes, mutual exploration within a clear framework to facilitate free association and observation of shifts in feeling – was profoundly psychoanalytic. The aim was that elusive 'limited but considerable' change in personality – no mere addition to our

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[2] This was first quoted by Philip R. Lehrman in 'Freud's Contributions to Science', in the journal *Harofe Haivri* Vol. 1 (1940) and then cited by Lionel Trilling in 'Freud and Literature', in *The Liberal Imagination* [1940]. The remark was made by Freud to Professor Becker in 1928 in Berlin.

[3] Balint, M. (1957). *The Doctor, his Patient and the Illness*. London: Pitman Publishing Ltd.

[4] Balint, E. & Norell, J. (Eds) (1973). *Six Minutes for the Patient: interactions in general practice consultations* London: Tavistock; Elder A, Samuel O. Eds. (1987). *While I'm here, Doctor*. London; Tavistock; Balint, E., Courtenay M., Elder, A., Hull, S. and Julian, P. (1993). *The Doctor, the Patient and the Group. Balint Revisited.* London: Routledge; Salinsky J. & Sackin P. (2000). *What are you feeling, Doctor?* Oxford: Radcliffe.

professional armoury but a *change in the doctor*, leading to A New Kind of Doctor described by Michael Courtenay in the last paper he gave at an international conference (in Lisbon) in the following way' perhaps we are at the dawn of a third phase of Balint work, one in which the doctor can access her emotions and consider the relationship at every consultation'.[5]

In this talk I am going to look at *accessing our emotions through the role of the imagination in Balint work* and I am going to do so through the lens of poetry. But I hope there will be no doubt that my subject is Balint work! I am not advocating the study of poetry as a component of Balint work! But I do hope it augments my talk!

Poem: The Doctor

So, let me start by reading a poem. The poem is called simply 'The Doctor'.[6] It is the first of three short poems, all by Dannie Abse, that I will read during my talk. Abse was a poet, playwright and novelist as well as a practicing chest physician in London. He was the youngest of three brothers, brought up in a Jewish family in Wales, and died in 2014. He said of himself, 'I like to think I'm a Poet and Medicine my serious hobby.' I've always loved his poetry and it is a pleasure to bring him with me to share with you in Porto.

The Doctor[6]

Guilty, he does not always like his patients.
But here, black fur raised, their yellow-eyed dog
mimics Cerberus, barks barks at the invisible,
so this man's politics, how he may crawl
to superiors, do not matter. A doctor must care

[5] Courtenay, M. (2007). The doctor, the genius and his illness. *Proceedings of the 15th International Balint Congress* (Lisbon).
[6] Abse, D. (1989). *White Coat, Purple Coat Collected Poems 1948-1988.* Hutchinson: London.

and the wife's on her knees in useless prayer,
the young daughter's like a waterfall.

Quiet, Cerberus! Soon enough you'll have a bone
or two. Now, coughing, the patient expects
the unjudged lie: 'Your symptoms are familiar
and benign' – someone to be cheerfully sure,
to transform tremblings, gigantic unease,
by naming like a pet some small disease
with a known aetiology, certain cure.

So the doctor will and yes he will prescribe
The usual dew from a banana leaf; poppies and
honey too; ten snowflakes or something whiter
from the bole of a tree; the clearest water
ever, melting ice from a mountain lake;
sunlight from waterfall's edge, rainbow smoke;
tears from eyelashes of the daughter.

So, this our first case: what strikes you as you listen?

For me, the lines that really stand out are the two that describe the doctor's role, *'to transform tremblings, gigantic unease, by naming like a pet some small disease'.* But then I recall that strong first line; so direct that you want to hurry away from it. *Guilty, he does not always like his patients*. But however much he may dislike his patient the doctor must put his feelings to one side and care. At first sight, the poem seems to describe a specific scene, a house-call where the doctor is suddenly in the midst of a family crisis, but we also become aware that there is something universal, almost mythological about the scene as well. The dog barking in this household is

reminiscent of Cerberus, the multi-headed dog of Greek mythology who guards the entrance to the Underworld – to stop people getting out! *Quiet, Cerberus! Soon enough you'll have a bone*. Perhaps we are present at a deathbed scene, or certainly a death-fearing scene: the wife's on her knees in useless prayer. The patient is fearful and seems to expect the unjudged lie from his doctor and certain cure. And then, as in all consultations, there is a prescription: *'so the doctor will prescribe and yes he will* – and the poet (no doubt the doctor too) allows himself the relief of giving a wonderful flowing, timeless prescription of pure beauty and magic, reassurance - *the usual dew from a banana leaf, rainbow smoke* and then that telling, grief-laden, last line, with what musicians call a dying cadence *'tears from eyelashes of the daughter'* – the eye and the mind, body and mind brought together.

The poem invites us to engage with a timeless role of the doctor to be present at the great transitions of life, a midwife to fearful uncertainty, a comforter and witness. Put simply, to have passed this way before.

Oliver Sackswas surely right when he wrote, in his great masterpiece Awakenings [7]: 'There is, of course, an ordinary medicine, an everyday medicine, humdrum, prosaic, a medicine for stubbed toes, quinsies, bunions and boils (protocol-driven medicine perhaps?); but all of us entertain the idea of another sort of medicine of a wholly different kind: something deeper, older, extraordinary, almost sacred, which will restore our lost health and wholeness.' Is the doctor willing to accept this role or not?

A Balint Group

If we're lucky, we are able to bring *our* uncertainties, *our* uneasiness, *our* uncomfortable feelings - even our wildly over-optimistic and reassuring prescriptions - to our colleagues in a Balint group! With the 'courage of our

[7] Sacks, O. (1973). *Awakenings*. London: Gerald Duckworth.

stupidity' we can begin to explore our feelings and mad ideas together within the discipline of a group. Michael Balint's use of the word 'stupidity' perfectly catches that *inner feeling* of risk which so often accompanies releasing an inner hunch, an image, or feeling into a more public place, the *attentive space* of a working group. But a word of caution; this isn't just a release of imaginative ideas for the sake of it, it is a disciplined exercise to begin to listen *to ourselves while we listen to others*, whether in the presence of a patient or whilst listening to colleagues in a group. Imagination is often thought to come mainly from within – the poet walking by herself in search of inspiration - but of course it arises as an inner response to the surrounding world of relationships and sensation.

The poet Robert Frost put it this way: 'a poem begins as a lump in the throat, a homesickness, or a lovesickness. It finds the thought and then the thought finds the words…' (Frost, 1916). Our imaginative response in a group travels upwards from a feeling and is then expressed as a thought. This is truly radical for doctors. Medical culture turned upside down. Our teaching was always to put aside any feelings and then to think.

In Balint groups we learn to listen to a case being presented in a rather similar way to the reading of a poem. In both we are invited to enter a half-lit world where we listen to feelings that lie behind the presenter's (or the poet's) words; to give our free-floating attention to thoughts that are only half expressed, to repeated phrases, rhythms, sudden unexpected moments, pauses or changes of direction; to words that seem symbolic or out of place; to mood and the language of the body. I say we enter a half-lit or easily overlooked world, because the area to which we are giving attention lies between the rational, the accustomed and familiar on the one hand and the truly unconscious on the other. It is so hard to put our highly trained instinct to 'make professional sense' of what we hear into a neutral gear. In just the same way readers often want to 'make sense' of a poem, want to 'understand' it rather than to allow the poem's magic, its music and deeper meaning to work on

them. Although a case has its origin in the reality of the consulting room, when it arrives in the group it is a product of the presenter's mind, divorced from time and place, and open for members of the group to respond through their imaginations.

Imagination

The Oxford English Dictionary defines imagination as 'that faculty of the mind by which we conceive of the absent as if it were present'. The dictionary illustrates its definition with some lines from Shakespeare's A Midsummer Night's Dream[8], spoken by Theseus:

And as imagination bodies forth
The forms of things unknown:
The poet's pen
Turns them to shapes, and gives to airy nothings
A local habitation and a name.

In these few lines Shakespeare tells us that the poet turns his imagination, his airy nothings, into a 'thing' with structure and a rhythm of its own, a poem. If the collective imaginings of a Balint group (their airy nothings), are given shape, they take their form in a changed relationship between doctor and patient: the discussion *may change the angle from which doctor and patient see each other, turn things upside down or fill out the shadows in the doctor's mind.* In short, the doctor may be able to expand her range of movement in response to the patient, feel more sympathetic, more curious, and less disturbed by the strangeness of the patient.

[8] Shakespeare, W. (1911-1962). The Comedies of Shakespeare. *A Midsummer Night's Dream* W. Craig (Ed.). Oxford: Oxford University Press.

In the first two lines Shakespeare reminds us that our imagination gives 'body' to things unknown, to airy nothings. But the words '*imagination bodies forth'* also suggest that imagination arises from the body, perhaps particularly from the physical world of the senses.

Every year, for a week a small group of us help to run a course on reflective practice and Balint for about eighteen doctors from different parts of the world. Two of us are GPs, one is a psychiatrist and one a psychotherapist. But the magic ingredient on the faculty is a poet. On the Wednesday of the course the participants are guided through the various stages of writing a poem. After about three hours, much to their surprise and always to their delight, everyone has successfully written a poem and then agrees to read it to the others. Without fail this is a near-miraculous session. But here's the point. Our poet-tutor always begins the process by getting us to start from our senses; to get in touch with our bodily sensations of sight, smell, hearing, touch, taste and movement – this is always the starting point for what later builds into a poem. And soon we find we've given *form to things unknown*. It is a wonderfully therapeutic and creative outlet for jaded and burnt out feelings. To find your inner poet!

Freud wrote that the ego was first and foremost a body ego.[9] The Balints were certainly interested in bringing practitioners of the body (doctors) and practitioners of the mind (psychoanalysts) together. Doctors touch and examine the body and listen to the language with which people talk about their bodies every day. They are highly trained to think about physiology, but must also *slowly learn to stitch this together* with a feeling for the symbolic language of the body; the significance of touch; and to pay attention to their own bodily feelings when with a patient or when listening to a case in a Balint group. Although not a doctor, Enid Balint was always interested in reports of the doctor's physical examination and

[9] Freud, S. (1923). The Ego and the Id. *Standard Edition*, vol. 19, 7-109.

what the group understood about this, believing that the physical examination of a patient, or its avoidance, carried considerable meaning for both patient and doctor.

Imaginative Perception

Enid Balint's key psychoanalytic concept was 'imaginative perception.' She described it as 'what happens when a patient creates his own *partly imagined, partly perceived world'* (Balint, 1993: 103). Thus, imaginative perception gives reality to the outside world, to the people to whom we relate, and to our own selves. In her view, at the earliest stages of life, the infant cannot perceive reality unless it is perceived mutually alongside someone else, most often the mother. Her thinking is close to Winnicott's often quoted idea that there 'is no such thing as a baby without a mother'. They are an imaginative duo, linked, each creating the other through mirroring and playful interaction based on imaginative perception. Perhaps we can take this further and say that there is no such thing as a Patient without a Doctor. We co-create each other to a larger extent than we easily recognise. Echoes of early relationships come into the doctor-patient relationship all the time and are influenced strongly by the doctor's responses. My impossible patient will not be yours. And your favourite patient will not be mine!

In her essay The Psychoanalyst and Medicine [10], Enid Balint writes that 'by setting physicians free to use and respect their own imaginations in a broader, yet still disciplined way, they can be helped… to tolerate what they see in their patients…particularly those aspects which may seem the most irrational and unacceptable, which once perceived, can show *each man's uniqueness*'.

The study of poetry sets much store by the author's unique 'voice'. Poets spend many years practicing their craft before they have found a voice that is theirs and none other. It is also our task as doctors to find our own authentic way of being

[10] Balint, E. (1975). The Psychoanalyst and Medicine. In Mitchell, J. & Parsons, M. (Eds) *Before I was I Psychoanalysis and the imagination*. London: Free Association Books, 1993.

a doctor. Like no other. The practice of medicine is highly complex. A doctor who is free enough to practice with the full use of themselves is more likely to find satisfaction and pleasure from their work. And benefit their patients too. In family medicine, no part of a patient has to be left behind at the door. Any starting point is valid. The doctor must also be free to respond from a more personal perspective not only through the filter of a mainly medical viewpoint. The healing of the doctor and the healing of the patient go hand in hand. It is not just the 'inner poet' that must be found but the 'inner doctor' too!

It is widely accepted that practitioners need to develop more empathic relationships with their patients. And attachment theory makes it clear that the capacity 'to see oneself from the outside and others from the inside'[11] is the key component of secure and creative relationships. Certainly both require the exercise of imagination. But how possible is this in the course of a busy schedule of clinical work? Just consider for a moment the number and variety of different people a doctor might see during the course of a single day, and the subtlety of their individual needs.

With this in mind, I now want to take us back into the consulting room – not this time through a poem but through a brief clinical fragment from my own GP practice.

Nanny

My next patient this morning comes into my room. She's always jolly, always looking forward to things; she is a nanny, now in her seventies, and quite too good to be true. She was unable to buy, or even look at, a single newspaper during the Gulf War, the Afghan War, Any War. She gives reminiscences of her father, an engineer in the army, and how

[11] Holmes, J. (2010). *Exploring in Security: Towards an Attachment-informed Psychoanalytic Psychotherapy.* Hove: Routledge.

unbelievably good he was; all the furniture in her flat was handmade by him, and the dolls' house too. I think of her as an ageing single nanny still utterly in love with her father. She is looking forward so much to her sea trip around the Norwegian Fjords. She is full of good works and always brings magazines for the waiting room. How suited people are to their occupations sometimes. Or is this just how I see her? She is so much my idea of an old-fashioned nanny. I'm sure she knows every word of Winnie the Pooh and of every children's Nursery Rhyme. The sight of any suffering child upsets her dreadfully. She bustles in, asking for my advice, and says "Oh yes, how silly, why didn't I think of that?" "Of course, how right you are . . ." after more or less whatever I might have said.

Surprisingly though, on this occasion, this morning, after a few enquiries, a rash, a sore eye, she asks if tiredness could be her hormones.

Definitely a different note has been struck. All diagnosis is a musical problem. I don't say much. She tells me how very alone she has felt this winter, deprived of some of her activities through ageing, "It's not like me at all, she says, to feel like this."

She tells me she feels so lonely and alone. And suddenly, I feel her life-long loneliness too. The realization of how she feels hits me with force. Our mood together changes in an instant. She slows down, and talks. I listen. Her only sister, Edith, may die soon. She has less energy to travel around, and is unable to visit her many 'children', her 'babies' as she calls them, and their children too. She remembers all their birthdays. One in midlife is divorcing and she is very upset about the effect on the children whose nanny she was as well, although they are now grown up. She looks lost.

Gently I make a comment about the sadness of people parting. "There can be great sadness," I say, "when people you love are separating from each other."

She recalls the pain of her father's repeated absences from her home when she was a child herself.

Suddenly, the room is full of tears, stillness and time.

The whole emotional texture of our relationship has changed. We are now two people, no longer an all-knowing doctor and an always-obedient nanny.

I have a patient who has become more of a person and less of a caricature.

Tears, Stillness and Time

The patient's childhood self and her ageing self are both in the room together. And in contrast to that lifetime length of time, our professional relationship has changed in only a fraction of time, no more than a moment really. When we speak of highly charged moments, we often say 'Time Stood Still'. And the room was certainly full of tears. My patient had broken down into tears and I felt inwardly tearful as I listened. I had also experienced a lot of separation as a child growing up and had somehow preferred to keep this patient at arm's length as some kind of cartoon nanny.

Professional work is made up of such moments, moments of occasional contact between the feeling worlds of two people. Sudden emotional access produces a change of gear. Nothing is true for long, if ever, and must be freshly re-imagined. When we think we have arrived somewhere, the patient has usually moved on!

It is so often said that GPs have no time. As professionals we are often left feeling that we have too little time as we rush from patient to patient, or from meeting to meeting. But time adds up. Family doctors spend more time with their patients than is often realised.

Time is of the essence when we consult. 'I won't keep you a minute, doctor'. 'I seem to be taking so much of your time these days, doctor.' 'Don't worry, take your time.' With an open-minded unhurried attitude the important point is reached more quickly, time expands; whilst hurrying, anxiously pressing in on the patient, time contracts. The clinic over-runs. *Past trauma continues to seem like yesterday and deep down, in the unconscious, there is no measure of time at all.* And hovering over all our efforts, only just out of sight, just off-stage, is the time limit of all our little lives (Shakespeare). The sound of Cerberus barking can be heard again.

In his recent book, The Order of Time, the Italian physicist, Carlos Rovelli, writes *'We are time. We are this space, this clearing opened by the trace of memory inside the connections between our neurons. We are memory. We are nostalgia. We are longing for a future that will not come.'* [12]

Everything is always present. Time can suddenly expand or collapse in the consulting room as it also can in the course of a group discussion.

'Every moment is a window on all time.' [13]

We speak of holistic or whole-patient medicine. Sometimes this can sound not much more than a curricular requirement to include a psychological and social context for the patient, but it can also refer to a *sudden snapshot*, a glimpse of a more complete person suddenly perceived. What Balint called '*the totality of the person, a human being with his own goals and failures, his joys and sorrows…'* (Balint, 1966). These pictures leave an after-glow, a lasting impression until another moment updates them. Just as it was for my patient and myself, they serve as navigation points, for doctor and patient alike.

In my next poem, the poet gives us just such an imaginative glimpse of himself as a doctor and as a person. The poem is called: X-ray.

X-ray

Some prowl sea-beds, some hurtle to a star
and, mother, some obsessed turn over every stone
or open graves to let that starlight in.
There are men who would open anything.

Harvey, the circulation of the blood,
And Freud, the circulation of our dreams,

[12] Rovelli, C. (2018). *The Order of Time* London: Penguin.
[13] Wolfe, T. (1929). *Look Homeward, Angel: The Story of a Buried Life.* New York: Random House.

pried honourably and honoured are
like all explorers. Men who'd open men.

And those others, mother, with diseases
like great streets named after them: Addison,
Parkinson, Hodgkin – physicians who'd arrive
fast and first on any sour death-bed scene.

I am their slow-coach colleague, half afraid,
incurious. As a boy it was so: you know how
My small hand never teased to pieces
an alarm clock or flensed a perished mouse.

And this larger hand's the same. It stretches now
out from a white sleeve to hold up, mother,
your X-ray to the glowing screen. My eyes look
but don't want to; I still don't want to know.

In this poem Dannie Abse [6] brings his boyhood self alongside a moment in his adult life as he prepares to look at his mother's X-ray on the screen. The poem draws its tension from the poignancy of a particular moment which is both professional and highly personal. The poem is a meditation on the nature of the medical gaze, of medical 'looking'...*'my eyes look, but don't want to…'* and it is a meditation on what the poet feels about himself as a doctor. It takes the form of an inner dialogue with his mother. He contrasts himself, a *slow-coach colleague, half afraid, incurious,* with his medical forbears honoured for their discoveries, *'men who'd open men.'* Freud and Harvey are brought together in a single sentence. The reader is left with the anxiety

of whatever the X-ray will reveal, but also something of the burden of what it means to be a doctor. It ends: 'I still don't want to know.'

How natural not to want to know! Surely, it is healthy to have a limited appetite for pain and suffering? Emotional support is needed in finding a balance between what we can face and what we can't. Although we have to find that balance for ourselves, the surrounding professional and social culture has a big influence. A perfectionist and heroic culture with an unforgiving and critical underbelly can make it very hard to admit vulnerability. A Balint group, on the other hand, can provide a culture of support through fostering individual respect and the development of trust but can also help in recognising what is possible and what is not. Where would we place ourselves on the Dannie Abse self-rating scale between heroic over confidence *'first on any sour death-bed scene'* and his self-description, '*incurious, half-afraid?*' And whatever our individual disposition may be, our 'not wanting to know' will change from patient to patient, illness to illness, year by year and with whatever personal ups and downs we are facing at the time.

Patients are so often mirrors to our selves.

Any exercise of imagination takes energy. To come face to face with a difficult or painful situation takes courage. Outward energy is more available to clinicians if they are feeling secure within themselves and within their professional setting. The burden that most clinicians carry is very great. Feelings cross the desk in next to no time at all. Anxiety and depression, paranoia and anger are all more infectious than a virus. And not only feelings; whole thoughts can move from person to person, embodied pain, unconscious communications; all, in an instant, can appear in the doctor's mind.

A Balint Case

One of the doctors in our group presented a recent contact with a patient he had known for thirty years. He told the group that he had felt profoundly depressed after seeing her. *'It just sat on me all day'*, he said.

Mary, a woman in her mid-fifties had been recently widowed. Her husband had died suddenly in the street while they were out shopping together. Mary had always seen the doctor every few weeks; her husband only rarely. She had a jokey and self-deprecating relationship with her doctor who told us in the group that he felt very warmly towards her. 'She's a northerner', he said 'with a deep voice, a dry sense of humour, sharp, and amusingly dismissive of men. She had been the first female out of 43 pregnancies in her family!' And she always brought a present back for the doctor from her holidays. The doctor, a highly experienced Balint practitioner, had worked closely with her at times of earlier distress. He mentioned that there had been virtually no sexual life in the marriage after the birth of their only child, a daughter, and that he had always felt that she and her husband were not particularly close**.**

The doctor had already seen her twice since her husband's death, but on this occasion, Mary arrived bearing her husband's death certificate. She had seen his body after the post-mortem. 'It was awful', she said, 'they had cut his head open, it was an absolute mess.' She was extremely distressed, no longer concealing her feelings, and the doctor was profoundly affected by her grief. He had suddenly felt that he had *'never known her and had completely misjudged the depth of her emotional life.'*. It was this feeling that he brought to the group.

There were many different voices in the group discussion. Not a poem but a symphony. There were long silences as her *shock and grief* entered the group. Had the doctor suddenly caught Mary's transmitted shock at seeing her husband's mutilated head? Or was her shock a sudden realisation of their damaged relationship? Something similar to what the doctor was later to feel: 'I never really

knew him.' Did the doctor feel guilt? He had not been able to save her the ordeal by issuing a death certificate. Was this a new Mary? Or simply one the doctor had never known? Or that she had never allowed him to know? Had she always loved her husband, despite the difficulties in their marriage, much more deeply than the doctor had ever realised?

The leader commented that the doctor was surprised to find how deeply he felt for this woman.

At our next group meeting, two weeks later, the doctor told us he had arrived with no clear plan when he saw the patient again. He felt open-minded, *without defences*. He told us 'when Mary had sat down…and I asked 'how's things?'… 'she seemed to go back to her old sort of jolly, oh not so bad…her matter of fact way of being'. After a few of these exchanges, the doctor referred back to their last meeting.

'You know, Mary, I've known you for thirty years, and I felt as though I've never known you at all.'

The tears roll down her cheeks. The doctor sits with her. The tears are for herself, her husband, and perhaps for the years of banter which has prevented her from knowing and being known, and which she has used to hide her emotional needs. 'All my life I've had to look after other people', she says. 'And now I want to be looked after myself.' There is no hint of jokiness. Mary makes a clear statement about her needs. It comes after the doctor's utterly unambiguous statement of his own feelings which reach into the heart of their relationship.

With this deeply human moment in a real consultation discussed in a Balint group we are a long way from the mythic encounter we heard in the poem at the beginning of my talk. Through the work of a Balint group, a doctor who has known his patient for over thirty years is able to summon the courage of his professional imagination and in a single consultation transform their relationship together. It is a moment in which doctor and patient face a painful truth: face to face.

Through Balint participation, doctors slowly learn to register feelings, images, sudden hunches; and to observe something of the doctor-patient relationship as well: to listen a little and to ask a little, while also doing whatever needs to be done; breathe in, breathe out, Body and Mind; the two together, hand in hand.

Re-imagining Medicine

If the realities of two-person medicine are taken seriously and the Balint approach sufficiently accepted, it would lead to a re-imagining of medicine itself. Through their discovery of perspective, the great masters of the Italian renaissance moved us away from a flat two-dimensional view of the world. A comparable task for the practice of medicine still lies ahead of us. The challenge is well described by Ian McWhinney, sometimes referred to as 'Canada's Founding Father of Family Medicine', in his lecture given in Oxford at the IBF conference in 1998. [14]

'The implications of Balint's ideas for medical education have not yet been addressed. We speak of adding skills and competencies, but not of teaching a *new way of being a physician*. The difference between these two is fundamental: one is additive, the other transformative; one assumes the status quo is adequate but incomplete, the other that the status quo is *fundamentally flawed*; one sees the solution in terms of additional tasks, the other *in terms of a transformation that will affect everything the physician does'*.[14] Once we have learned to listen more deeply, our clinical responsibility must be to attend to our emotions in every case. We can no longer live with what I earlier called one-eyed medicine. Balint is a call for a radical change in the culture of medicine, to become fully self-reflective. It involves a change to a culture in which doctors take their own emotional and spiritual

[14] McWhinney, I. (1998). The physician as healer: the legacy of Michael Balint. *Proceedings of 11th International Balint Congress* edited by John Salinsky. London: The Balint Society

development seriously and in which medicine becomes a moral as well as a technical education.

What of the Future?

So, what of the future? Just as a consultation is a moment in a much longer story, so also is our conference. Time is on our side. A great future for Balint work still lies ahead. We must have the courage of our imagination. Only when the future is imagined can it be lived.

In recent years the focus of our research efforts has mainly been on establishing the effectiveness of Balint work through the use of measurable outcomes such as psychological mindedness, reduced rates of burnout, increased role satisfaction and enhanced professional self-esteem. But we must not neglect our own history of group-based narrative research. Much of this work has been undertaken by GPs, but accounts are beginning to appear describing how a Balint initiative brought about change in an Intensive Care unit or an Oncology department.

Unexplored areas of potential cross-fertilisation between our experience and other neighbouring disciplines lie at our doorstep. There is a rapidly growing and sophisticated body of knowledge about how attachment relationships, which are strongly echoed in all carer-client relationships, affect many aspects of human development, patterns of mental illness, the language of care-seeking, symptoms and the outcomes of treatment. Advances in attachment-based research, neuroscience and relational aspects of psychoanalysis are influencing each other rapidly at present. All have the potential to furnish us with convincing evidence for the validity of RBM – relationship based medicine! But at present these disciplines are relatively unknown within the field of medicine. Perhaps this is a subject to be pursued at a future Balint Research Congress?

Here is Peter Medawar, a distinguished scientist, writing about the role of the imagination in scientific method: *Every discovery, every enlargement of understanding, begins as an imaginative preconception of what the truth might be - a hunch or hypothesis arises by a process as easy or as difficult to understand as any other creative act of mind; it is a brainwave, an inspired guess, a product of a blaze of insight. It comes anyway from within (Medawar 1975).* [15]

The case of Mary and her doctor, which I described earlier, was taken from the last of our research groups with Enid Balint, the so-called 'surprises' group ( ). In the research aspect of that group, we focussed on our capacity to be surprised when we are consulting with patients. Why are we not surprised more often? Do we habitually screen out discordant observations in order to comfort ourselves with the illusion that we 'know' our patients? We realised that unless we can be surprised by our own responses as well as those of our patients we cannot deepen our understanding. Surprises result from the capacity to register unexpected observations. Contemporary research in neuroscience is now employing a similar concept of 'surprises' in its descriptive models of how the brain functions.

In our present culture Balint work is likely to remain peripheral; often pursued with passion and conviction but a minority pursuit, poised in a fragile position in health care organisations and hospitals, always needing to fight for its space. What was at first an airy nothing, imagined by the Balints in the 1950s, now has a clear structure and form: an international federation with twenty-three different national societies, across many different cultures. Currently there are Balint projects under way in Greece and Iran. In addition to groups on training schemes – for GPs, for psychiatrists, for psychosomatic specialists and for junior hospital doctors - groups are now increasingly being established in departments working with high levels of anxiety and emotional impact – A&E, intensive care,

[15] Medawar, P. (1975). Victims of Psychiatry, *New York Review of Books*. 23 January.

oncology, palliative care and in-patient psychiatry units. In a highly pressurised environment 'good-enough' Balint groups provide a much-needed space for doctors to think and feel. Groups held within healthcare settings can go a long way towards establishing a healthier organisational culture – one in which the emotional needs of professional staff are recognised so that in turn they are more able to respond to the emotional needs of their patients. At a recent international congress a presentation was given entitled: Bringing the World Together through Balint: creating a virtual Balint group for doctors around the world.[16] This paper gave a live demonstration of the work of a group of young doctors from different countries (indeed different continents) who meet regularly in an internet-based Balint group with leaders from the international federation. In both the USA and in Australia, internet-connected groups are becoming increasingly common. In a few days time we shall hear the winning essays written by medical students from all over the world who enter for the Ascona Student Essay Prize – always a high point in any international conference. Balint groups for medical students during their training are on the increase. And in Scotland now, all graduating medical students are given a slim pocket-sized volume of poems, most of them written by doctors and students, called Tools of the Trade, to carry with them into their new career.[17] Perhaps there will be a growing impact from all these various sources of Balint reflection that will slowly affect the mainstream culture. Or perhaps their appearance is an early sign that a cultural shift is already underway.

I have tried to *weave* some strands together – poems, moments from the consulting room and reflections on Balint work – in the hope of stimulating us to

[16] Hoedebecke, K., de Pino Costa, L., Lichtenstein, A. & Nease, D. Jnr. (2015). *Bringing the world together through Balint: creating a virtual Balint group for doctors around the world.* Proceedings: 19thg International Balint Congress (Metz).

[17] Morrison, L. (Ed.) (2014, 2016, 2018). *Tools of the Trade: Poems for new doctors.* Scottish Poetry Library.

think more about the role of the imagination in our clinical practice. Our task is no less than the re-imagining of medicine itself.

I began with a poem. I will finish with a poem. It is the last poem in Danny Abse's volume of Collected Poems: White Coat, Purple Coat. I will leave it uncommented on, floating in the space that we will inhabit together for the next three days in what will no doubt be a very stimulating 21st International Balint Conference.

Song for Pythagoras

White coat and purple coat
a sleeve from both he sews.
That white is always stained with blood,
That purple by the rose.

And phantom rose and blood most real
compose a hybrid style;
white coat and purple coat
few men can reconcile

White coat and purple coat
can each be worn in turn
but in the white a man will freeze
and in the purple burn.

References

Abse, D. (1989). *White Coat, Purple Coat Collected Poems 1948-1988.* Hutchinson: London.

Balint, E. (1975). The Psychoanalyst and Medicine. In Mitchell, J. & Parsons, M. (Eds) *Before I was I Psychoanalysis and the imagination*. London: Free Association Books, 1993.

Balint, E. (1989). Creative Life. In Mitchell, J. & Parsons, M. (Eds) *Before I was I Psychoanalysis and the imagination*. London: Free Association Books, 1993.

Balint, E. & Norell, J. (Eds) (1973). *Six Minutes for the Patient: interactions in general practice consultations* London: Tavistock.

Balint, E., Courtenay, M., Elder, A., Hull, S. and Julian, P. (1993). *The Doctor, the Patient and the Group. Balint Revisited.* London: Routledge.

Balint, M. (1957). *The Doctor, his Patient and the Illness*. London: Pitman Publishing Ltd.

Courtenay, M. (2007). The doctor, the genius and his illness. *Proceedings of the 15thInternational Balint Congress* (Lisbon).

Daly, M. (2019). www.dalypoetry.com

Elder A, Samuel O. Eds. (1987). *While I'm here, Doctor*. London; Tavistock.

Freud, S. (1923). The Ego and the Id. *Standard Edition*, vol. 19, 7-109**.**

Heaney, S. (1980). *Preoccupations: Selected Prose 1968-1978*. London: Faber.

Hoedebecke, K., de Pino Costa, L., Lichtenstein, A. & Nease, D. Jnr. (2015). *Bringing the world together through Balint: creating a virtual Balint group for doctors around the world.* Proceedings: 19thg International Balint Congress (Metz).

Holmes, J. (2010). *Exploring in Security: Towards an Attachment-informed Psychoanalytic Psychotherapy.* Hove: Routledge.

Holmes, J. & Nolte, T. (2019). 'Surprise' and the Bayesian Brain: Implications for Psychotherapy and Practice. *Frontiers in Psychology*, Vol 10. Article 592.

Jones, E. (1964). *The Life and Work of Sigmund Freud*. London: Penguin Books.

McWhinney, I. (1998). The physician as healer: the legacy of Michael Balint. *Proceedings of 11th International Balint Congress* edited by John Salinsky. London: The Balint Society

Medawar, P. (1975). Victims of Psychiatry, *New York Review of Books*. 23 January.

Morrison, L. (Ed.) (2014, 2016, 2018). *Tools of the Trade: Poems for new doctors.* Scottish Poetry Library.

Rovelli, C. (2018). *The Order of Time* London: Penguin.

Sacks, O. (1973). *Awakenings*. London: Gerald Duckworth.

Salinsky J. & Sackin P. (2000). *What are you feeling, Doctor?* Oxford: Radcliffe.

Shakespeare, W. (1911-1962). The Comedies of Shakespeare. *A Midsummer Night's Dream* W. Craig (Ed.). Oxford: Oxford University Press.

Winnicott, D. (1964). *The child, the family and the outside world*. London: Penguin Books.

Wolfe, T. (1929). *Look Homeward, Angel: The Story of a Buried Life.* New York: Random House.