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The Doctor, Her Patients and the Gifts: On the Meaning of Gifts as Reflected in Balint Group Work as Training-with-Research

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Introduction

Discussing *the gift in clinical praxis* brings the expression of Michael Balint *'the patient´s offer'* to my mind. I believe it is fruitful – as a way of reflecting on the relationship – to see the patient as consciously and unconsciously offering his troubled body and soul to the doctor as a gift. The patient hopes or/and fears some kind of response, in exchange to what he is offering.

The patient´s offer – that´s his gift!

A basic uncomplicated exchange could look like this, interpreted by me as the doctor: 'You offer me a severe sore throat, fever and a deteriorating general condition. This gives me the opportunity to feel useful and competent (and thus to earn my living in a decent way), and I give you a diagnosis, a cure and assurance in return'. A gift during treatment can be seen as some kind of interference or intervention in this basic relational exchange. As a clinical doctor you will have to relate to a gift from a patient whether you want it or not.

The daughter of an experienced GP said: 'Mom, you ought to make an exhibition of all the strange gifts that you have received over the years from your patients. It would be amazing.' The idea of such a Doctor´s Museum of Gifts – real or imaginary – is challenging. Just think about the size of it!

Such a museum should – apart from the exhibited gifts themselves – contain:

- the story of the patient;
- the story of the doctor-patient relationship;
- the reflective story 'What were you actually feeling about the gift, Doctor? That is, if you would allow yourself to feel!';
- the meaning of the gift in a deeper sense, reflecting its symbolic significance for the doctor-patient relationship.

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The meaning of gifts is from time to time brought up in Balint group work. It came to my mind that it would be worthwhile to investigate this theme specifically.

Design

I suggested to a Balint group of very experienced GPs working in areas with a large immigrant population – in our 8th and final semester of cooperation – that we all should write down a story or two about gifts and that we should look at them along our usual way of working. Some members sighed. I could sense their unspoken objection: 'Don´t you think we have enough many things to do already in our offices, but to write you stories?'.

I insisted reminding them of a couple of stories about gifts told in the group over the years. They agreed, after all, this is indeed a meaningful theme. For two and a half sessions we discussed eight reports on gifts – seven from the GPs and one from me, a psychoanalytically orientated psychiatrist.

The reports have been modified to prevent any identification of the patients. I will one day report on this work more extensively.

A model for assessing the meaning of the gift?

I suppose I share with many of you the impulse to systematise when you look into a clinical material. Often this should be done explicitly beforehand to merit the name of scientific inquiry.

Thus, scientifically, in the conventional logico-empiricist sense, this is a pre-study. You could look for parameters judging the meaning of the gift in the Doctor-Patient–matrix. It would be multi-dimensional since the gift and its relational context is often complex. From these cases and from others I could go on and try to develop a more systematic view.

But, if you see (as I do myself) this study as a narrative and hermeneutically based exploration, you are justified to let systems crystallise gradually, discovering and mapping the variety of patterns of exchange of gifts along the way. This cannot be done in a vacuum though. You must account for the frame of reference including your values and the theories that you are applying to your study. Remember Michael Balint´s expression 'training cum research'! It points at the possibility of designing the group work itself as a research project. The British Balinters have demonstrated this beautifully (see collections such as *What are you feeling, doctor?* and *Six Minutes for the Patient*). So accordingly, both ways – the logico-empiristic and the hermeneutic –merit to be labelled scientific enquiries.

A small but significant etymological remark

The Swedish noun *gåva* has the same etymological origins as the English *gift* and the German *Gabe*, deriving from *to give, zu geben, att giva*. But it is fascinating that the Swedish noun *gift* also means *poison* – indicating the universal ambiguity of a gift. It can be both a blessing and a curse. But in either case, it can be felt as 'an offer that you cannot refuse'. Often this will constitute the starting point of Balint case work – the doctor vaguely feels that he is trapped. (In Swedish *gift* also means *married*. Maybe this also could be linked to the ambiguities in too many human relationships.)

Cultural and professional attitudes towards gifts in Sweden

There is something appealing and nice about receiving gifts. The code of conduct towards gifts in a Swedish born and Swedish medically trained doctor –whether he became a GP or went somewhat astray and became a psychoanalyst – is governed by the fact that Sweden culturally and legally is a non-bribing society. There are very strict rules – so strict that they are difficult to abide to even for a very conscientious doctor. As a public servant you are not supposed to receive gifts. Gifts are un-Swedish and looked upon with a certain reserve. Doctors are aware of this and many have overly conscientious fears of being suspected of bribery by receiving even small gifts.

The national health system pays the publicly employed doctor well enough so that he, as opposed to doctors in some other countries, does not have to think about money when meeting with his patients. They do not have to give us gifts nor pay us extra money to get the state of art medical treatment. When I try to look at this from the outside, I see a culture both of puritanism, and good intention, decency and a preserved innocence. The latter I like very much.

The difference in attitude towards gifts between a psychoanalyst and a GP derives, I believe, mainly from the significant differences of our working situations. The GP has to improvise during the consultations, scan over and swing between a wide range of tasks and considerations. She often does not know what the next meeting will have in store. She knows that she is short of time and that there are a lot of things she needs to address in the spare minutes she has – or does not have – between her patients. She tries to focus on, negotiate and define the very essentials of the meeting with her patient. Consequently, she treats gifts – unless they are exceptional – as marginal phenomena and, so as not to waste too much time and staying friendly, would say: 'Thank you so much', meaning more OR less: 'OK, I really do not know what to make out of this right now, but let us go on with our business'.

The gift will both literally and mentally be shoved into one of the drawers of the desk of our busy GP. Hopefully she will not be too distracted by this concrete gesture of the patient. So, forgetting rapidly about the gift is a frequent emergency exit (defence mechanism) for the GP. At least on a conscious level. Still, I hold a strong belief that the GP–patient relationship is affected by gifts, much more than my experienced GP colleagues would prefer to recognise. And they sometimes find me annoying (mostly in a constructive way, I would hope).

The psychoanalyst, in contradistinction to the GP, works within a quite rigid framework. He knows more or less by a few minutes (and so does his patient) when to start and when to end a consultation. Regardless if the gift can be expected or come as a surprise, he would look at it as part of the mental exchange between the doctor and his patient, an integrated part of their relationship, and always think of the symbolical significance and the messages embodied in the gift.

As a psychoanalyst/psychotherapist I have a range of inner questions when a gift is offered to me. (I do not always have to ask my patients for the answers). I suppose as a GP you relate to some of these inner questions, to others not.

- What does my patient feel and desire by giving me this gift at this moment?
- How is my patient affected by the way I am receiving his gift? How is he reading my reactions?
- What are my feelings about this gift from this patient at this moment?
- Should I just accept it wrapped up or open it?
- Should I just let the gift lie there between us for a while until we have talked it over, and then make up my mind?
- When should I comment, i.e. make an interpretation of the significance of the gift, for the patient, for our relationship, in relation to very important circumstances in the life of the patient?
- Should I accept it or should I reject it? How should I tell why I cannot accept it?
- How much of my spontaneous feelings and thoughts should I share with my patient? (I have to face reality – I have a bad 'poker face', so absolute neutrality does not exist in my consulting room anyway.)

A remark on the cases

The two cases that I am going to discuss cannot reflect the full complexity and the wide range of issues presented in these two and a half sessions during which we discussed all the gift cases. But to my mind they are representative for a difficulty that all these experienced female GPs were struggling with. One of them concluded: 'I think we are all struggling with our *Eager-to-please-syndrome*. And we do not like to confront ourselves with situations which are contrary to that. That is what we are working on so much here in our Balint group.'

It is important to note that five out of the seven GP cases presented could be labelled as 'poisoned' gifts, with a main (conscious and unconscious) purpose to corrupt the doctor by enticing, seducing, openly bribing, belittling her, etc. Only two cases were expressions of 'love and appreciation' – the most moving one (and

very complicated) I will *not* present to you today. This bias might not be quite that heavy in clinical daily life. After all, cases brought to a Balint group do not reflect the total composition of the doctor-patient relationships at a doctor´s surgery. *But the overall estimate of these doctors was that the 'poisoned' gifts dominated their practices.* This is a good enough reason to discuss this issue from the *aspects of mental health and prevention of burn-out in doctors*. It may be indicative of a general problem in the Swedish national health system which is not only confined to gifts.

I also have a premonition that some of you, reading these examples that I am going to present, might think that the doctor is naive. I do not. I am quite convinced that each and every one of us have such examples in our 'mental clinical archives'. The offers by the patients and how they are received by the doctors will much depend on the personalities and hidden agendas. A by-stander usually thinks more clearly because of lack of involvement. If we were the intelligent, back-seat-driver of our own private and professional lives, we would seldom get trapped. And when we do we would get out of the trap very fast and never be caught again. Life would be efficient and we would be spared a lot of frustrations, surprises and … a good part of life itself. And we would not need any Balint group either. Since such a reliable inner agent is lacking, the Balint group gives us an option to learn from experience and mistakes. 'Little by, little by, little' as Dusty Springfield sings.

Case 1: The doctor as an emotional alchemist

'This is a man in his 60s who came the other day for control of his diabetes and some other ailments. I have known him for years. He is from Lebanon originally and speaks Swedish perfectly. Yet, on this occasion his younger wife came along. When his wife comes along – that is when I get the gifts. I think this is the reason why she is there. On previous occasions I have received strange small cheap-looking souvenirs from Lebanon, or chocolate Santas and Easter hares. One of their sons is the owner of a candy store.

Occasionally, a transitory thought passes through my head: 'What do they want in return?'

When I saw them last time this autumn a medical student was sitting in with me. The wife picked up four knitted tablets from an ordinary plastic bag from a cheap chain of stores. And a small knitted cloth. She said it was a delayed summer present. I thought it was a cheap and good present and thanked them. And they went home.

The medical student did not look concerned or surprised. He said his mother is working at the Migration Authority and she also often gets gifts.

I brought the pieces home. My youngest daughter suggested that I could get rid of them by bringing them to the Midsummer flea market of our community of country house owners. So, I brought the stuff to the country house. As I was cleaning I noticed a small table. The knitted cloth fitted perfectly and now it is on the table. I felt good about that.'

Discussion in the group

The presenter clarified that she is also the doctor of the wife of the patient. She emphasised that she got along well with the husband patient and actually therefore found it quite difficult to understand what the wife was doing there. The group was wondering why the woman would have to bring the gifts for her husband. Was it something cultural? Was the man too shy to bring them himself? There were also some speculations that the wife might be worried about the health of her husband. Maybe she needed to control that he was given proper attention by his doctor. But these viewpoints faded away.

Then followed questions about *when* these items were given and *how* they were handed over by the wife. It seemed they were given arbitrarily over the seasons – a chocolate Santa Claus for summer, an Easter Hare for the autumn call. Never wrapped up as gifts but rather handed over in a small plastic bag or picked up from one, just as had been done with these knitted items. It was clear they could

not have been purchased from the same store that the plastic bag came from – a low price hobby and tool store.

I asked the group: 'I wonder – from which one of these two patients does the gift come?' The group seemed to agree that it was the woman. The presenter then recalled that the woman actually had an appointment in the week to come. Thinking more about it she wondered whether this might be the pattern – that gifts were given *in advance* before the appointments of the wife patient. What would her appointments usually be about? It seemed they were connected with prescriptions and the certificate for the sick list – her being partially or fully unable to work from time to time. The woman was fairly healthy though, the doctor commented.

The discussions swung to the contents of the gifts again. Could it be that the woman brought candy and chocolates from the store of her son that were too old to be sold. The presenting doctor commented that such a thought had indeed crossed her mind because the chocolate tasted really awful (she actually said 'shit', which was not part of her ordinary vocabulary). She often threw it away.

The tone of the discussions had so far been tentative and low pitched – a kind of beating around the bush. Now, there was some more energy in the discussions and the reactions of the presenter.

Were these really gifts as a token of appreciation and gratitude? Could one really explain the junk quality of what was given to the doctor as a cultural idiosyncrasy? Would she have brought such stuff to a Lebanese doctor during her stays in her native country?

The presenter found the discussion interesting. She became aware of her wondering what would be the reason for the call of the wife in the week to come. 'At any rate – it was nice that the cloth fitted the table in my summer house,' she concluded.

Comments

It seemed to me that the doctor unconsciously/automatically had disregarded these junk presents, as they had an embarrassingly depreciating quality, which became evident in the group discussions. Even worse, one could suspect the purpose of the gift was to prepare for the visit of the woman herself in the following week. This was a pattern that the presenting doctor had avoided to become aware of. The low-pitched atmosphere in the group when discussing the case seemed to reflect our wish to mitigate the pretentiousness and the concealed manipulative attitude of the donor towards her doctor. The quiet satisfaction of the doctor about the cloth touched me. It seemed to be an expression of relief. She has a sort of humble kindness inherent in her personality. At least and at last, with this cloth, she had finally managed to convert the pile of 'shit and junk' heaped on her over the years into something plain and useful to herself. That seemed to be a way subconsciously to recover her self-esteem and to stand the patient.

The group discussions were a painful re-interpretation a re-evaluation of gifts and relations which I felt that the presenting doctor could not absorb to its full extent immediately. But as she always does, she would have to digest these matters for a while. But she became immediately alerted that one intention by this fairly successful, healthy and well-to-do woman patient probably was to buy her off cheaply. And she recognised at that moment that it is not compatible with common sense for a doctor to give authorised support to the kind of social benefits this patient used to ask for. But as she and many GPs know, once you get on that road with a patient, you can get stuck in a track, from which is difficult to move. Handling becomes a routine without much thought about whether it is realistic or not. Thinking about it, though, makes the doctor aware of the bad ('shit') taste in the mouth.

Case 2: Doctor or daughter?

The presenting doctor is Balkan-born, speaking excellent Swedish with a slight accent:

'This is a woman from my native country that I have known for many, many years. She is in her mid-70s and very frightened and obsessed by the thought of dying in a cerebral haemorrhage. One of her sisters did. She came to me very often in very anxious states, and she called me by phone. We always speak in our mother tongue. She was frequenting other doctors and hospitals very extensively too. It is very hard to find a good medication against her elevated blood pressure. She always complains and reads about side effects. She checks her pressure at home. At the slightest elevation she increases her medication on her own.

I discussed this patient in our Balint group more than a year ago. You remember, the consultations dragged on, often for more than double the time that I had allocated. There was always something more, though I always take that into account beforehand. But it was never enough, always more questions and worries. I often had to interrupt her to end the session. After discussing it in the group and thinking of her as an abandoned child who was anxious, that there would never be another meeting again with her caretaker, I started seeing her on a more regular and scheduled basis, once a month, once every two months. Overall, I do not think that I have spent more time with her than before. But my patient seemed to calm down and she is not going to the hospitals and to other doctors as much as she used to before.

My patient thinks that a brand-new medication will work a miracle. But then again when she reads about the side effects she does not dare to try them. She experiences herself as very sick. But she looks very agile and takes long walks daily for at least two hours.

Over the years she used to bring me some typical cakes from our home country, a few in a little bag.

On one occasion she brought me at least 60 of them! She had baked them herself, she confided. She told me sternly I should not share these breads with my colleagues or with the staff at our centre. They were for me only! I could put them in the freezer at home.

I felt uncomfortable, yes, uncanny. The enormous amount and the forced intimacy in the prohibition to share all these breads with others. I told the patient this was far too much, but I accepted them. I gave some of the bread to the staff members. Since then my patient has not given me any bread at all. When she visits me, she complains that she no longer has the strength to bake.

I have been thinking quite a lot about these cakes and the uncanny feeling. It just became too much!'

Discussion in the group

The group discussed the exclusive demands of this patient towards her doctor and the doctor´s feeling of 'too much-ness'. The group recognised that the doctor felt much sympathy and concern for her patient. She really felt sorry for this woman in exile. The discussion in the group a year before had helped the doctor to structure the treatment and it had helped. The patient seemed calmer and her overall use/abuse of medical care had diminished. But it also seemed to have stirred up a stronger transference in the patient onto her doctor, a mother-daughter-relation. The presenting doctor nodded affirmingly. Indeed, the patient liked her doctor. She was grateful but also demanding and possessive. The presenting doctor – I was about to write 'daughter' – felt trapped. Though she cared a lot, it seemed she had a need for a certain distance to her patient. There was nothing wrong with the cakes. They were most homely (German: *heimlich*) to the doctor as opposed to her uncanny (German: *unheimlich*) feelings. She recognised being emotionally locked up in a conflict between her strong feelings for her patient and her guilt for not allowing the patient to be too close. This was strongly reinforced by the controlling, anxious

and 'never-be-pleased' attitude of the patient met by the contrary impulse of her doctor – a wish for a certain degree of distance/independence in her way of caring.

Comments

In short, this case illustrates the complications of a loving relationship. The bread-baking had increased after the patient had been given regular visits. Now it seemed the patient felt rejected on a personal level (stopped baking). She must have sensed as she gave the cakes to the doctor, that she would *not* keep them all to herself and her family. But still the doctor-patient relationship survived this disappointment. The considerable improvement in the past year in handling the hypertension and the severe anxiety of the patient was *not* affected. In fact, the patient could continue to make good use of her caring doctor. The doctor could cope better with her daughter-feelings (transference and countertransference). It should be added, though we did not discuss in the group in connection with this case, that in the past year, the doctor had returned to her native country to tend for and bury her own mother. I think that might have made it more difficult for her to handle the strong emotional impact that this particular patient had on her.

Concluding remarks

I thought it was an interesting project in the course of regular Balint work to make a thematic study, in this case on gifts. I would also strongly argue that this kind of specialised study/research can highlight important issues in daily GP practice and function as a pre-study for research on a larger scale or be combined as a multicentre thematic study, involving several Balint groups.

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