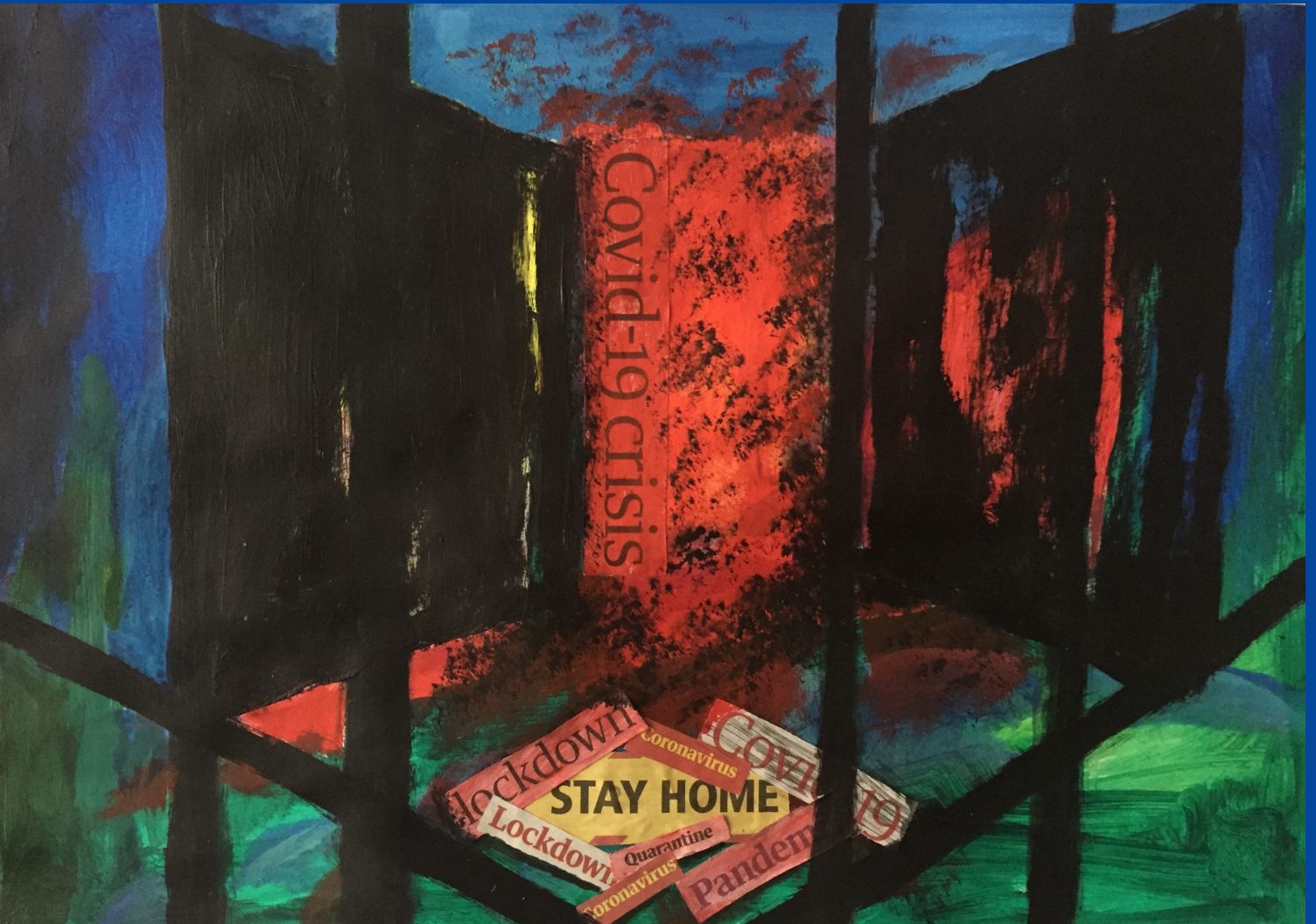


VOLUME 48 | ISSUE 1

# JOURNAL OF THE BALINT SOCIETY



COVID-19 and the Virtual Group

FEBRUARY 2021

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

## **Editorial: COVID-19 and the Virtual Group**

Raluca Soreanu<sup>1</sup>, Shameel Khan<sup>2</sup>, Andrew Elder<sup>3</sup>, Jane Dammers<sup>4</sup>, and Anne Patterson<sup>5</sup>

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**Raluca Soreanu, Editor<sup>1</sup>**

The first issue of volume 48 of the *Journal of the Balint Society* is published at a time of profound societal change, when the meaning and practice of caring for one another, within and without national health systems, is being reshaped by the COVID-19 pandemic. As the content of our social bonds is shifting, what holds us together in Balint groups is also being reconfigured. The Balint community, with its vibrant thinkers and practitioners, is giving its own account of what it means to move to the frame of a virtual Balint group, what it means to see one's patients, group members, leaders and co-leaders on a screen.

At this time of transformation, the *Journal of the Balint Society* is itself changing by moving online, gaining a new space on the website of the Balint Society and taking steps toward becoming a peer-reviewed publication. We will be initiating new sections of the Journal, thinking about special issues and inviting guest editorship from other disciplines. The *Journal of the Balint Society* was first published in June 1971 and thus we are celebrating the fiftieth anniversary of the Journal with this edition. It is a testament of the commitment of Balint practitioners that there have only been three editors since 1971: Philip Hopkins (1971–2001); John Salinsky (2001–2011) and Tom McAnea (2011–2021). As the new editor, I extend my gratitude for the hard work and dedication of all the former editors and offer particular thanks to Tom McAnea who took over the editorship ten years ago, and oversaw its transformation to A4 size with a pictorial cover in 2014.

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<sup>1</sup> Raluca Soreanu, PhD, is a psychoanalyst, effective member of *Círculo Psicanalítico do Rio de Janeiro*, and Reader in Psychoanalytic Studies at the Department of Psychosocial and Psychoanalytic Studies, University of Essex. She is the author of *Working-through Collective Wounds: Trauma, Denial, Recognition in the Brazilian Uprising* (Palgrave, 2018). In the past five years, she has studied the Michael Balint Archive, found at the British Psychoanalytical Society. She is an Academic Associate of the Freud Museum and the Editor of the *Journal of the Balint Society*.

Volume 48(1) is a special issue on the theme *COVID-19 and the Virtual Group*. The first section, 'COVID-19: The Doctor, the Group and the Screen' brings together student voices (including authors who won the Essay Prize in the Balint Society competition of 2020) and experienced Balint practitioners. Our authors are Hosam Elhamoui, Catarina Rodrigues dos Santos, Adam Jaffa, Deberah Davis, and Suni Perera. The second section of the Journal comprises winning essays of the 2020 essay competition, authored by Jenny Jack, Resha Jazrawi and Vikram Kohli. In the conference papers section, Andrew Elder writes on the theme of imagination, bringing us his Opening Address at the 21st International Balint Federation Conference (Porto, 2019), entitled 'Hearing Secret Harmonies: Balint and the Re-imagining of Medicine'.

We aim to maintain the new section 'Voices from around the World' in future volumes of the Journal, and capture experiences across various Balint cultures. In this issue, Homa Rezaee gives an account of a Balint group practice in Iran. In the section 'State of the Field: Commentaries', Monika Gorny, Toby Stevens, Lawrence Congdon, Amy Jebreel co-author a study on doctor burnout. We will maintain the new section 'From the Archive' in future issues, as we aim to explore archival materials and lesser known conversations and exchanges that impact the Balint tradition, and to investigate the intersection between psychoanalysis and medicine. In the current issue, I bring a commentary on a set of letters from psychoanalyst Otto Fenichel to Michael Balint, written in 1940 and 1941, at a time of struggle, displacement and efforts to create a new home. The issue also includes three poems, by Christopher Bu, Rosalie Cattermole and Kai R. Scott-Bridge. Artist Penny Elder has gifted us with four paintings (including the cover image) capturing in a forceful manner the atmosphere of the COVID-19 times.

The creative work done in the pages of this special issue amount to a re-imagining of the 'frontline'. In the past year, this has been one of the words we have

uttered, heard and written hundreds of times: 'frontline'. In a global redistribution of stillness and movement, some spaces that were characterised by flow and circulation (including – or perhaps especially – capitalist circulation) have decelerated or turned still, while other spaces, such as the hospital or the emergency room, have known a powerful movement, of an intensity and with patterns not felt or experienced in recent times. The 'frontline', with its doctors, and nurses, and other kinds of carers, swells up. It is not so much a straight 'line', a linear demarcation, a rim, a clear boundary between those who are suffering and in need of care, and those who are offering the treatment. It is instead, a *mesh*, a tangle of crossings, assemblies, and forms of being alongside.

What is it like to be on the 'frontline', if the frontline is not a line, but a kind of meshwork? In his book *Lines: A Brief History*, anthropologist Tim Ingold (2007) evokes the Inuit's image of movement and travel over land and sea ice, drawing on Rudy Wiebe's (1989) contemplation of the Arctic, *Playing Dead*. For the Inuit, when a person moves, she becomes a line. To encounter another human or animal is a kind of crossing of lines. The entire country is thus perceived as a mesh of interweaving lines, rather than a surface or an area. In Balint groups, the 'frontline' crises of the pandemic are approached as a meshwork and not as an issue of securing or resourcing the definitive rim of the offer of care. The 'frontline mesh' includes unconscious material, the 'stuff' of fantasy, and the doctor-patient relationship. Balint groups make visible some of the threads of the mesh, without pulling it apart. On both 'sides' of the 'frontline' there is suffering, fragmented threads, exhaustion, breathlessness, screen-work, and vulnerability.

In what follows, the Deputy Editor of the Journal, Shameel Khan, and the members of the Editorial Committee, Andrew Elder, Jane Dammers and Anne Patterson, write their reflections on COVID-19 and the virtual group.

**Shameel Khan, Deputy Editor<sup>2</sup>**

COVID-19 has had a paralysing impact on our social togetherness by inoculating fear, uncertainty and alienation into the nucleus of our day to day life. When closeness becomes contagious and threatens the existence of a species, then how does a race evolve in such paranoid-schizoid times? When confinement begins to mutate into sensory malnourishment then how does one resuscitate warmth and hope in isolation? A doctor-patient relationship thrives on a sense of 'being together' with each other in a journey that is undertaken in the pursuit of healing. The pandemic has challenged our ways of undertaking this journey with our patients by bringing technology in between as a transitional object.

Virtual connection offers a safe and effective alternative during the pandemic for continuity of essential treatment for our patients. A remote connection whether over phone or online introduces a whole new dynamic between the doctor and patient. Although it helps in maintaining a sense of 'being together' with our patients, delivering care, holding and containment cybernetically is a relatively new paradigm. Unfamiliarity to technology itself can be a huge source of anxiety in some of our patients. Adjusting to the loss of a physical space i.e. that of a consulting room can be both challenging as well as quite surreal for both doctor and patient. Balint groups can help us make sense of relational, affective or even technological variables that can interplay between the doctor and patient at times of compromised connectedness. Dealing with the burden of the pandemic can potentially lead to burnout and exhaustion within the

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<sup>2</sup> Dr Muhammad Shameel Khan is a consultant general adult psychiatrist with an interest in group work and physician wellbeing. He has a Masters from University of Essex in Foundations of Psychoanalytic Psychotherapy (Tavistock and Portman NHS foundation Trust) and a Postgraduate Diploma in group work from Institute of Group Analysis. He is currently involved in supporting and developing the practice of Balint groups within the contextual healthcare systems of Pakistan. He has also previously worked as a faculty and postgraduate training programme director for psychiatry at Aga Khan University Hospital, Pakistan.

healthcare workforce. Balint groups can help healthcare professionals in processing the burden of providing care especially at a time when public expectations are high. Although online Balint groups had been operating for a long time, these groups acquired a primary role following the pandemic. How can technology influence methodology, group dynamics and leadership variables in online Balint groups? How can we protect the nature and ethos of Balint groups when transitioning into the virtual space? The current issue of the journal begins to address some of these questions in a creative and critical manner.

**Andrew Elder, Editorial Committee Member<sup>3</sup>**

It seems such a long time ago that talk was of clear skies, empty streets, and the clarity of birdsong. My feelings then were of unreality, not grasping the severity of our collective situation. And now my feelings are of weariness, vulnerability, isolation, and loss. When will it ever end? Living in my comparatively safeguarded Zoom Room I feel a sense of guilt and disconnection from the trauma and exhaustion of so many colleagues and my family who work in the Health Service.

Of course, all medical consultations occur in a cultural context. As a result of the COVID-19 pandemic the matrix of all our interactions has changed fundamentally. Underlying the Covid culture is a reversal of our normal patterns of attachment in which proximity brings security as opposed to risk and danger. 'You know, doctor, isn't it funny but I just seem to feel better whenever I see you.' Now, patients and doctors have become a potential threat to each other. Doctors normally have a feeling of confidence that they can be close to a patient when needed, to touch the patient and perform examinations without fear. For both parties, there has been a traumatic rupture in the security usually derived from

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<sup>3</sup> Andrew Elder was an Inner London GP (1972-2008). Honorary Academic Staff Tavistock and Portman NHS Foundation Trust. Balint Group leader. Past President Balint Society (UK) and Co-ordinator of International Balint Federation (IBF) Leadership Taskforce for its first six years. Awarded Honorary Doctorate (2017) for work in primary care and mental health.

their interactions together. And even when restrictions finally end, and the so-called 'new normal' arrives, the physical, mental, and personal after-effects of the pandemic will continue to roll in for many years and will fall mainly on the front-line doctors and nurses of the Health Service.

Can Balint groups help us to observe and think about the doctor-patient relationship in such troubled times? Fortunately, Balint Groups on Zoom have become well established worldwide in the last ten years – pioneered between the American Balint Society and Young Professionals in WONCA as well as in Australia and New Zealand. Just in time! How different are Balint groups on-line? How is leadership and participation affected? This edition of the Journal of the Balint Society examines these important questions.

#### **Jane Dammers, Editorial Committee Member<sup>4</sup>**

In 2020 we advertised two Prizes for the Balint Society Essay Prize, one for undergraduate students and one for everyone else. We had a very good response with 28 entries split more or less evenly between the two categories. I had the pleasure of reading all the submissions – some essays, some poems, some stories, and it was difficult to choose the winners. In the end we, the three readers decided to allocate the prizes equally to two contributions in each category. Hosam Elhamoui and Catarina dos Santos in 'Zeroes and Heroes' give a very thoughtful account of co-leading a Balint group online, raising many issues which will resonate with other leaders, while Jenny Jack tells the story of 'The Junk Lady and the Golden Chain', set in a closely observed Balint group session. In the undergraduate section, Vikram Kohli writes about a difficult consultation accompanying a GP on a home visit exploring his own reactions, sympathies and

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<sup>4</sup> Dr Jane Dammers retired GP, Medical Educator and Appraiser in Newcastle and Gateshead. Past President of the Balint Society UK and currently co-ordinator of the Training and Education Committee.

prejudices towards the patient, and Resha Jazwari describes being entirely new to Balint and how the Balint group came to be an interesting and useful experience. Many of the submissions were influenced by the COVID-19 pandemic and we are pleased to have been able to include some of these in this issue, alongside the prize winners.

**Anne Patterson, Editorial Committee Member<sup>5</sup>**

To paraphrase Winnicott's (1960) famous phrase: 'there is no such thing as an infant,' only an infant within the context of maternal care, one might say that 'there is no such thing as a patient', only a patient within the context of the doctor-patient relationship. The ethics of the doctor-patient relationship is defined within the Hippocratic Oath: 'first, do no harm.' Psychoanalysts following Freud and Klein have understood, however, that, in the unconscious, phantasies of damage and harm abound for both parties. One of the tragedies of the pandemic for the doctor-patient relationship has been the collapse between these unconscious phantasies and the terrifying reality of COVID-19: doctors and patients in close proximity can actually kill each other, in reality, rupturing assumptions of trust and benevolence. Balint groups offer the opportunity to explore the underlying dynamics of this relationship and perhaps it is no surprise that in the early days of the pandemic the groups I led with junior doctors were full of images of trench warfare such as: 'going over the top.' The patient, implicitly, even explicitly, became the enemy and any relationship of trust between juniors and seniors was also felt to have broken down with the seniors experienced as distant field generals, callously sending the young soldiers to their deaths.

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<sup>5</sup> Anne Patterson is accredited Balint group leader and co Vice President of the Balint Society, Psychoanalyst, Fellow of British Psycho-Analytical Society, Consultant Psychiatrist in Psychotherapy in NW London, Editor of the New Library of Psychoanalysis and co-director of next European Psychoanalytic Film Festival.

From another perspective, it is also well recognised that both doctors and patients can succumb to the collusive phantasy that the doctor is both omnipotent and omniscient. Further, doctors can project their own mortality and vulnerability into their patients thus bolstering omnipotence with immortality. The COVID-19 pandemic has challenged these illusions and suddenly, brutally, doctors have had to face their own all too human fragility. Linked to this is the shattering of our collective narcissistic illusion/delusion of having 21st century mastery over our individual and collective destinies.

Overwhelmingly, the pandemic has faced us with loss: the loss of loved ones, colleagues and friends and also the loss of our protective illusion, all of which necessitate the long and painful work of mourning. I think it is crucial to follow Freud in his distinction between mourning and melancholia to avoid an over medicalisation of grief and loss: most people in mourning are not ill, it is a universal, healthy response to loss. It is perhaps no coincidence that Freud wrote 'Mourning and Melancholia' in 1917 during the First World War. Balint groups offer an important opportunity to think about and understand these ordinary human emotions and to avoid pathologising either the doctor, the patient or their relationship both during and after the pandemic.

### **Authors Note**

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

## **‘Zeroes & Heroes’: The Experience of Balint Leaders during COVID-19 Pandemic Lockdown**

Balint Society Essay Prize 2020 joint winner

Catarina Rodrigues dos Santos<sup>1</sup> and Hosam Elhamoui<sup>2</sup>

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## Introduction<sup>1</sup>

As Michael Balint was developing his group for the benefit of general practitioners;<sup>2</sup> it almost certainly did not occur to him, or his wife and collaborator Enid, that there would ever be a time when neither the group members nor the leaders were in the same room! Neither did it occur to us, as relatively new leaders of Balint group, before COVID-19.

Four sessions into the new Balint group with junior psychiatry trainees, we felt forced to set aside our initial dismissal of virtual Balint as lockdown took place. We were tense, had never done this before, but we gave it a go.

There was psychotherapeutic literature that explored remote therapy and virtual Balint groups, for which we were thankful.<sup>3</sup> Nevertheless, we sensed that we were stepping into new, undiscovered land, and we kept a joint record of our group's journey, which continued remotely until the easing of lockdown in the summer. Our desire to write about our experience arises from the shared reflection we had throughout this process.

In this essay, we explore the importance of maintaining our Balint structure, which has been adapted locally to suit the psychiatry trainees' needs, and how through this, the group was able to explore the doctor-patient relationship in light of a pandemic. We also reflect on apparent links between the external reality of the pandemic and recurrent themes in the doctor-patient relationship, as well as its

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<sup>1</sup> Dr Catarina Rodrigues dos Santos is a Specialist Registrar in Forensic Psychiatry with a special interest in Medical Psychotherapy and Medical Education. She currently works in the Edenfield Unit, Prestwich Hospital in Greater Manchester Mental Health, and undertakes an IGA Foundation Course in Groupwork with Group Analysis North. She emigrated from Portugal in 2009, studying Medicine in the United Kingdom.

Dr Hosam Elhamoui, MD, MRCPsych, London, is a Higher Speciality Trainee in General Adult Psychiatry and Medical Psychotherapy Year 8, Manchester, UK.

<sup>2</sup> Balint M. (1954). Training general practitioners in psychotherapy. *British Medical Journal*, 1:115–20.

<sup>3</sup> Lemma A. (2017). *The digital age on the couch: Psychoanalytic practice and new media*. London: Routledge; Nease Jr DE, Lichtenstein A, Pinho-Costa L, Hoedebecke K. (2018). Balint 2.0: A Virtual Balint group for doctors around the world. *The International Journal of Psychiatry in Medicine*, 53(3): 115-25.

possible effect upon the group. Towards the end, we could not resist reflecting on the gifts (welcome and unwelcome) that technology brought our Balint group in a time when we question if this particular breakdown may lead to any breakthroughs.

### **Why Was It Important to Maintain the Original Structure of Balint Group Despite Pressures to Hold an Informal Peer Support Group?**

While a Balint group is a supportive structure for doctors and its effects can be therapeutic, it is not designed to be a 'peer support group' and indeed not a 'group therapy'.<sup>4</sup> Instead, it insists on making the doctor-patient dyad the centre focus.<sup>5</sup> The burden that medical staff (all health staff but doctors in relation to our discussion) are being subjected to as a result of the COVID-19 crisis may have imposed an apparent pressure to change the focus and therefore, the structure of the Balint group in its entirety, rather than subtly modulate the process.

Traditionally, the Balint format we typically adhered to included one presentation followed by a phase of enquiry, a 'push back' phase and later, a discussion divided into the patient's and doctor's perspective. The doctor would then return and continue the discussion until the hour was up. We had historically adapted the original Balint structure to suit the psychiatric trainees in their first year of training. As such, we make an explicit division of the discussion time between exploring the patient's perspective and the doctor's perspective. This division is designed so trainees can attend to the patient amidst their enthusiasm to support and think about their colleague's experience -often an identified-with view.

In the face of lockdown restrictions and almost overnight, our Balint group moved from real to virtual space. With this, we felt invited as group leaders to

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<sup>4</sup> Salinski, J. (2009). A Very Short Introduction to Balint Groups, The Balint Society, <https://Balint.co.uk/about/introduction/> [accessed 28 August 2020].

<sup>5</sup> Sklar J. (2018). *Balint Matters: Psychosomatics and the Art of Assessment*. London: Routledge.

change the group structure, externally by participants and internally by our felt pressure to respond. There was hope that the format could include direct support for doctors, with space to discuss their own worries about the virus.

It was tempting to do so, and it even felt depriving to deny our trainees an opportunity for support. Nevertheless, we felt there were significant risks in changing the Balint structure, and instead, listened to the implicit request for flexibility.

But what could the group be risking? We hypothesised that unstructured Balint would encourage a predilection for the doctor's perspective in the doctor-patient dyad. Watchful of the socio-political climate, we felt there were external and internal pressures for the doctor to be idealised; the reticent soldier who braves great danger and hears clapping feels they cannot protest. Changing the format as an informal source of support would likely deepen this state of idealisation. This could shield the doctor from recognising their negative counter-transference, a vital source to their patients' own challenging experience.

### **How We Proceeded as Group Leaders**

The situation was complicated, and the function of the Balint group became more important than ever, reflected in the consistently high attendance of participants to the group. This made it necessary that we, as group leaders, questioned our rationale for what we were doing and, more importantly, reflected on the group's performance and the trainee responses. To this end, we held near-weekly post-group leaders' debriefings to discuss the constant evolution of the process, its impact on the doctors, and how we both felt about it. We used our debriefing sessions to track the evolving themes of the group and contemplated how the external reality bore resonance with group themes illustrated later in the essay.

By tolerating our own guilt about not creating a peer support group, we may have actually *supported* our doctors to stay with feelings of guilt, shame and helplessness,

enabling them to be more receptive and empathic to similar difficulties faced by their own patients. As such, ongoing consideration of the parallel process was paramount. Instead, we responded to requests for flexibility by making nuanced changes of the Balint experience. We endured the rise of the informality of initial virtual Balint sessions, made concessions for more generalising comments, and after sessions spent a few minutes to reflect on aspects of technology and check-in with trainees. This preservation of the structure with out-of-session modulation allowed for space to consider the doctor-patient relationship without neglecting the increasing needs of trainees under pressure. We encouraged a meta-emotional position, gently encouraging doctors to connect with how difficult thinking about their patients can be, in a pandemic that threatens the doctors arguably more than their patients. We hoped to reduce the likelihood of acting out, such as becoming frustrated with patients, or striving to provide idealised care that could be unsustainable and risky to the doctor.

By adhering to a predictable structure, we were able to tease out difficulties in the doctor-patient relationship during the COVID crisis. Challenges were observed in the ways doctors approached a structured Balint session, the flow of discussion as well as the content of the discussion.

### **Themes in our Balint Group during a Pandemic Lockdown**

'Balint groups themselves can be influenced not only by individual stories told in the group but also by agents from the outside, such as external traumas'.<sup>6</sup> Attentive to this, we tracked themes of discussion during COVID-19, linking possible associations between difficulties brought by doctors, with those encountered by the nation. In other words, the intertwining of internal and external reality being played out in the doctor-patient relationship. While this cannot be proven, the

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<sup>6</sup> Rabin. S, Maoz. B, Elata-Alster. G. (1999). Doctors' Narratives in Balint Groups. *British Journal of Medical Psychology*, 72: 121-125

reproducibility and structure in the Balint sessions helped disentangle some central dilemmas, and comparisons were made with contemporary articles, to help with tentative links.

### **Difficulty Keeping the Patient in Mind When the Doctor Feels Threatened**

An initial theme was the difficulty of keeping the patient in mind when the doctor felt physically under threat. This took place in the initial phase of the lockdown, as deaths from coronavirus were counted daily, and the physically vulnerable were asked to isolate. It coincided with the initial requests for a change in the Balint format to become more unstructured and alike to a peer support group. Examples of this theme included cases in which the patient's family member, and not the patient, became central in the discussion or cases when minimal history was known, and the focus was more on the doctor's own state of mind.

#### *Feeling Trapped: The Hero Doctor Needs Rescuing*

Another theme that emerged and was sustained during the pandemic was the perception that doctors felt trapped, basking in idealisation but then trying to maintain this position at the expense of their own health and anxiety, as well as their loved ones. Links could be made to external realities such as the idealised weekly 'clap for our carers', running in parallel with worries about vulnerability and uncertainty, such as the lack of personal protective equipment (PPE), changes to psychiatric training progression and medical redeployment. An example of this theme was a case when a therapeutic boundary (such as clinic time) was breached with a patient who maintained a praising position of the doctor.

#### *Closeness at a Distance: The Neglectful and Infective Doctor*

Further to this, themes of doctors juggling closeness and distance from patients to maintain idealisation became prominent. Being an 'ideal' doctor was difficult to

define because the quality of the disease was seen to *infect* the quality of the dyad relationship. On the one hand, the doctor could risk killing patients by transmitting COVID-19 in attempts to care for them. Conversely, keeping a distance from patients (physical distance and wearing masks) equally threatened the idealised doctor position, with doctors worrying about being 'neglectful'. Both stances brought about feelings of guilt and helplessness. Around this time, while the death toll continued to rise, there were significant anxieties about vulnerable doctors and patients. Namely, anxiety about lack of testing & PPE with reports of healthcare staff dying of COVID-19, concerns about making difficult end of life decisions and advice not to engage in a patient's resuscitation without PPE.

#### *The Despair of the Psychiatric Doctor in a Pandemic*

The height of hopelessness and sense of futility peaked shortly after the Prime Minister was admitted to intensive care. During this time, doctors in our Balint group discussed cases featuring the futile role of a doctor in a time of an incurable illness, specifically the sense of uselessness of psychiatrists in a time of physical disorder and limited ability to use their skills of communication, as physical barriers such as masks and distance impeded this. This was a time of introspection in the group, questioning the role of a 'doctor' in society and coming to terms that the doctor has limitations, and can only try to be 'good enough' with the patient.

#### *The Guilty and Criminal Doctor*

Another recurring topic included the doctor testing boundaries of reasonable force and interference in the patient's life. There was anxiety about becoming a coercive agent by ill-judged use of the Mental Health Act while at the same time worries about breaking the rules and becoming guilty of a crime. For example, considering legal measures to stop infected patients from leaving wards. This frozen state of confusion coincided with public confusion over the present and future with regard

to COVID-19. There were concerns about the public breaking the law and interpretation of lockdown practices could vary. Arguably, there was a national atmosphere of paranoia that one could be caught by the police and charged with a crime. Tentative plans about lifting the lockdown were uncertain and, with it, a sense of 'bated breath'. If the lockdown was lifted, was there hope at the end of the tunnel or was the country risking a 'second relapse'?

### *The Doctor Tends to Injuries*

As the 'NHS Clap' was gradually discontinued, themes relating to the collapse of idealisation emerged. There was some focus on doctors experiencing racism or xenophobia, which paralleled the general perception that the virus was a 'foreign disease' not belonging to the West. Cases towards the end of this period also featured the doctor's guilt at 'overlooking' the psychiatric care of their patient as their attention had been directed towards COVID-19. Indeed, there was a concern about a growing 'silent pandemic' in the mind of the public. As the hope for an easing of the lockdown into the so-called 'new normal' grew, so did the anxiety about the 'indirect' costs of the virus on health and society as a whole.

### **Anxiety and Resistance Within the Group**

As anxiety rose about the role of the doctor in the pandemic, we noticed a rise in tendencies to avoid denigration. Within the group, this could become a difficulty in selecting cases to present, difficulty in thinking about patients' perspectives and non-attendance. Resistance in the group was felt in the more informal and dismissive approach towards Balint, which became prominent during the time of highest anxiety about COVID-19.

There were also instances of the group wanting to discuss more than one case, reflecting the unmanageability of intense emotions evoked in the doctor. In

these cases, the leaders had to empathically encourage the doctor to stick to one case.

Lastly, anxieties about being viewed as an actively 'infective' or 'neglectful' doctor led to descriptive styles that were heavy in medical terminology and lacked warmth possibly masking, thereby, the underlying anxiety. At times, doctor-patient interactions were stripped down and focussed on sole clinical decisions, with language becoming technical, blunt and with little nuance. In these cases, doctors agonised over their guilt about actively harming and conversely, neglecting patients in their attempts to be helpful doctors.

In turn, we responded to the group's dismissive style and observed our own counter-transference. One of us wished to thank participants for joining the Balint group despite everything, in the desire to demonstrate that Balint was helpful and a wish that doctors would continue to attend. The other fought feelings of irritation at periods of informality in the group, and tried to bear a more flexible structure in view of the changing circumstances. During sessions in which a blunted affect predominated, we could feel emotionally cut off, and occasionally boredom crept in.

Over time, the group became more contained as all members grappled with the evolving circumstances and the new format. We noticed it became more 'alive', with language moving from the more distant technical and classificatory to the more metaphorical and emotionally laden. This helped engender honest discussions and with this, more tolerance of a 'less than ideal' doctor and patients with limitations and struggles themselves.

### **Virtual Balint: What Was Missing?**

Moving to a virtual space was a new experience for everyone, and we were curious about its potential impact on the Balint experience. There were technical features

that helped to emulate Balint, such as 'hiding self-view', having a 'virtual' waiting room or turning off the doctor's camera in the 'push back' phase.

It is hard to pinpoint exactly why the virtual Balint felt different, but it did! We were left wondering about what is lost when there is no physical copresence, and instead, the group meets as disembodied entities. Gillian Russel, in her elaborate study of screen psychotherapy, invited us to consider the impact on learning and memory when she pointed out that "the embodied experience of acting and moving in space is connected to learning, mental processing, and memory. Movement and the three-dimensional qualities of physical co-presence may make a greater and more lasting impact on memories".<sup>7</sup>

We ended the group with a sense of personal satisfaction, having managed to carry on the group through a difficult time. Our trainees valued the group and provided positive feedback, nevertheless, we were left feeling that something was lost when togetherness was shielded by the screen. Did the absence of essential external security impinge on the internal security of the group?<sup>8</sup> Has the temperament of our digital medium and its occasional tantrums limited our ability to provide a holding function as group leaders?<sup>9</sup> The latter factor, we wondered, forced communication to be much more explicit at the expense of implicit less cognitive interaction<sup>2</sup> and we found that it was harder for the group to be natural and spontaneous. The free-associative flow in the group became rather constrained.

Despite the physical distance and difficulty in free association, there was a curious contrast of greater intimacy, at times bordering on intrusiveness.

One experienced faces as closer, and by seeing into members' homes, there was access to mundane yet intimate details. At times, the personal sphere encroached on the group flow, with external noises such as the local bin collection, or the

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<sup>7</sup> Russel, G. I. (2015). *Screen relations: The limits of computer-mediated psychoanalysis and psychotherapy*. London: Karnac Books.

<sup>8</sup> Parsons, M. (2014). *Living Psychoanalysis*. East Sussex: Routledge.

<sup>9</sup> Balint, M. (1979). *The Basic Fault*. London: Tavistock.

accidental flip of the camera focussing on the foot of the - at least consciously-unaware trainee... The group experimented with muting themselves to limit background noise, but the unnatural silence was soon felt to hamper spontaneity and free flow of discussion even further.

It is possible that the lack of our physical presence impacted on how safe members felt, and how vulnerable they allowed themselves to be. Although small shifts were noted over time, the quality of containment in a challenging time may have fallen short, or taken longer to establish.

### **Togetherness Lost in Silence**

Silence experienced in virtual Balint felt different. As if we no longer shared space of contained meanings, yet to be expressed.<sup>10</sup> In an embodied group, the silence does not have a world of its own, but it can feel like a shared experience for group members. Each member floats in their internal associative process but has an awareness of togetherness and takes on unconscious responsibility for silences, by the physical presence of other members.

In virtual Balint, it felt as if there was little pressure to break silences. There were moments of unity in the group, but we learned they were held by a fragile thread, susceptible to rupture once silence crept into our virtual space. Speaking up did not seem to originate from an unconscious wish to relieve the anxiety in the group. Instead, it often reflected a conscious decision to be responsible for the interruption in the group and say something 'typically' appropriate and fitting to the moment.

As group leaders, we often wondered aloud to the group about the significance of silences for the patient and the doctor, but these searches for unspoken meaning were rarely fruitful. Instead, it felt like we were hitting a tough membrane<sup>7</sup> enclosed around each group member, too dense to penetrate or to allow

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<sup>10</sup> Sabbadini A. (2004). Listening to silence. *British Journal of Psychotherapy*, 21(2):229-40.

a free flow of ideas. Reflecting on the situation in our debriefing sessions, we sensed a parallel process happening with us. Just as the group struggled with disconnection, we were perhaps, excessively curious about the silences.

Maybe we were anxious to keep the group alive, far from the deadening and detaching quality of these silences. Our inability to fully connect through the (virtual) spaces was something we felt as a moment of mourning, which we could not make up. Something had been lost by the absence of bodies in shared spaces, and it could not be retrieved!

### **Concluding Remarks**

Safely tucked in rear headquarters, it can be easier to spot how the *external* reality of the doctor's working conditions and public sentiment during the COVID-19 pandemic intertwined with their *inner* reality. We hope that our account reflects the interweaving that took place and the impact it had on the doctor-patient experience. In a time of compulsory heroism, encouraging doctors to tolerate feelings of guilt, shame and helplessness, may have helped them in becoming more receptive and empathic towards similar difficulties faced by their own patients, in the present and future to come. As for technology's role, the jury is still out; surprise and gratitude that it allowed us to help doctors think about their patients, tempered with – dare we say it – a feeling of a *less than full* experience of being in a Balint group. Even though this particular journey has ended, we hope this account, alongside many others, can map out further understanding in this era of virtual exploration. For now, we long for a time of embodied spaces, perhaps also in a wish to ward off death and call for life.

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

## **Balint Work Using a Shed, a Cat and an App**

Balint Society Essay Prize Submission 2020

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I am part of a Balint Group in a leafy university area of a biggish city<sup>1</sup>. I have been involved with this, my first group for a couple of years now. About a week ago we met virtually for the first time using an app because we couldn't meet safely face to face due to the COVID-19 risk. Lockdown is well established at the time of writing. This essay is about that meeting and how the context, circumstances and format of the meeting affected me, the Group and our ability to communicate and connect with each other and our patients.

The meeting took place at our usual time. There was a series of emails and group chat messages about using an app and how that might work. Our group comprises GPs, therapists, psychiatrists and myself. I am a manager in a healthcare practice. Although I feel very at home in our group I do feel slightly "other" as I am the only man and also (I think) one of two people who work mainly outside of the NHS system. Also, my particular field of healthcare is small compared to say medicine. As such I sometimes feel a bit of an imposter in the group who seem to me to have in some ways more legitimate credentials. We had to exchange emails in order to facilitate the meeting. That was a new step. In our group chat there were a series of messages about the format and there was a possibility the app we would use would limit us to a 40-minute session and then we would have to immediately start a 2<sup>nd</sup> meeting to make up the time to the expected number of minutes. So there would be a hiatus. I didn't like the idea of that as it could interrupt the flow, but I accepted it as hard to work around. This was agreed by all and shortly before the meeting started, a digital invite to the meeting was circularised. There was another round of chat about acknowledging receiving this. When the meeting finally started there was a period of a number of minutes when we each logged into the meeting, our faces popping up on screen, getting the audio working

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<sup>1</sup> Adam Jaffa manages and co-owns Gentle Dental Care, a dental practice in Belfast which he has worked at for over 25 years. He came across Balint 4 years ago and has really enjoyed working with professionals from other disciplines which he finds insightful and supportive. He is working towards co-leading a group.

and saying hello. The prep and check in period was much more bitty and disjointed than our normal face to face meetings which have been very smooth. Some of us were familiar with the app and could use it easily. For others including me it was a new experience.

Prior to the meeting I was a bit hesitant about one aspect of it. In my home there is one room that would guarantee me the privacy to do a meeting such as this, my bedroom. I live in a shared house. I knew I would want to be comfortable for the meeting and therefore would be sitting on my bed. I thought about how that would look to the group and it felt a bit weird to have colleagues seeing me in that very private, intimate part of my home. I anticipated that each member of the group would likewise be displaying some of their home by using the app. I sat up on my bed, leant against the headboard and put cushions behind my head. When I checked how this would look on screen, I saw that one cushion which had a picture of a winking face on it was behind my head. The winking eye was peeking out from beside my head! This was not the right image for the meeting, and I laughed to myself about it and was glad I had spotted this before going live. It could have looked provocative and been a distraction.

Also prior to the meeting there had been discussion throughout my profession (online) and within our practice about using video consults for patients. I was wondering if this would be from the practice or sometimes from my home because with the COVID-19 lockdown we can only come to the practice for some kinds of emergency cases. While face-to-face treatment in our practice has stopped now, of course patients still have the need to be able to reach us.

The other aspect of the lockdown was about protection. This means protection for patients possibly contracting the virus from us and vice versa. I thought about the emotionally protective factor of distance. I was wondering how the apps would work for us and for patients and how they would feel about the communication. Would they feel they could be understood? How comfortable

would they be with the new format? There was the benefit of ease of connectivity, but would there be new emotional or practical barriers with apps? What about patients who didn't have the apps? They would be limited to phone calls with more focus on tone of voice and lack the benefit of facial expression and body language. I thought about my cushion and possible inadvertent messages to and from patients and professionals using apps. Would patients start to interpret things they could see in my home to form a different opinion of me and vice versa. Would fantasies and new ideas start to develop? Would people be grateful for the opportunity to communicate or shy to reveal a little of their homes and themselves in this way?

As the virtual meeting started, I noticed how glitchy the technology was at the start when using my phone. You can only see a few of us on screen at any time and who you see changes from time to time dictated by the functionality of the app and who is speaking at any moment. I knew the other participants were present, but I couldn't see all of them at any one time and I couldn't tell who could see me at any moment. This worked ok but was slightly disconcerting and I stopped using eye contact really (because I didn't know exactly who I was looking at) and started just listening to the voices of the group. This might have been weird for the people seeing my face as my expression could have been relatively fixed as I listened. I wasn't sure what they would make of that. There was also a challenge in terms of taking turns speaking as we were lacking some of the visual cues that any group relies on when they are together physically.

Once the group was settled and present, people immediately started commenting on our broadcasting locations. This was quite a subject and one person complimented another on their decor. One person had a screen behind them -was this deliberate and metaphorical I wondered? Someone else sat in front of a wall where a number of pictures were displayed. You could not make out the subject of the pictures, but each was framed identically. The pictures were uniform in size

and hung in a perfectly ordered sequence. Someone else broadcast from what could have been a Study. On one shelf a model aeroplane was mounted as if in mid-flight. This drew my attention for some reason, and I wanted to ask about that plane but held back out of politeness. One person was broadcasting from their garden shed and you could clearly see the wooden walls and eaves. I acknowledged I was in my bedroom and made apologies about my cat who was likely to make an appearance. I love my cat (who happens to be quite beautiful) and was actually keen to show her off for some reason. She is an important part of my life and helps keep me emotionally calm after the intensity of work. I guess I wanted people to see and understand something of that. Indeed, she did come in and lay on my lap as we talked. That was lovely for me.

My immediate impression of some of the faces is that some people looked slightly tired and I wondered had they been overworked because of the COVID-19 pressure in the NHS system? I felt humbled. My efforts have been focused on our patients who have in some cases less serious needs by comparison. I felt empathy for the various clinicians in our group and wondered would patients notice the same thing? The Leader and Co-Leader checked in with the group and we discussed the new set up. We planned to stop the meeting after 30 minutes to Clap for the NHS effort for the pandemic. Then we would explore one case instead of the normal two. I was of split mind on this point. On one hand I have a lot of respect and admiration for the NHS effort and risks the workers are taking in caring for people. It is to me quite wonderful that the public show their support in this way across the nation. More selfishly I regard the Balint Meetings as precious and thought the Clap would interrupt any flow or connection in our meeting. Would it hinder the effectiveness of our group dynamic? I felt a bit of a heel having this thought especially being someone who works in private healthcare and not subject to NHS pressures and risks. The Group agreed to the Clap Intermission and at this stage I was just rolling with all the changes. The familiar comfort of the structure

and simplicity of the Balint Group format was out the window today. I thought about this as I looked out my bedroom window. Also about how we are adapting to the times we live in and how that might be for patients as well. Would they be proud and supportive of their healthcare professionals operating under pressure or would they be frustrated at not being able to access services and have their needs understood and met as they might normally expect. Would they be clapping or not? The next section of the meeting morphed into a pure check-in and discussion of how we are all doing, how COVID-19 has affected us professionally and how we are coping. The discussion was free flowing and there was a lot of energy and a good bit of humour. A wide range of topics were covered including changes in setting, systems and staff levels. Some people were operating with a massive amount of change and with an expectation there would be more to come. There was also an understanding that the uncertain situation would last for a long but indeterminate period of time. I thought that a lot of adaptability, resilience and determination were being displayed. I did not sense any panic within the group although there was a sense of newness, pressure and stress. I was asked about the situation in my field and explained that we were basically locked down and may be redeployed into the NHS effort. Also that to me, patients had been largely very understanding about the changes and I was surprised I had not had more patients in distress or hysterical with worry. It seemed to me that perhaps my patients can cope quite well without me! I added that there were financial issues because we were largely unsupported by government measures.

I asked the others had they had lots of very anxious patients and they said yes to an extent but that it was manageable. There was some comment on this, and the discussion took off rapidly. Overall, it was unusual for our group to have this kind of long, in depth check in period. Normally this would occupy a few minutes of our time (if that). We would spend most of the time on cases. But this session was different. I felt there was a need for the group to nurture itself. It was important

to share understanding of the bigger picture in society and across the NHS system. To see if we really were ok? This seemed to be more important to the group than the relatively micro aspects of communication with individual patients. I noticed this and about the need for the group to in some way push the patient narratives out and to focus on our own needs, a kind of self-care. I wondered about this and now reflect will this need to be a regular part of our group sessions? I wonder how patients would think of their healthcare professionals given the Mega level threat of the COVID-19 virus and would this affect how and if they communicated with us. Would they stand off more because they think we are busy with bigger things or would they approach more readily, anxious to maintain the relationship?

*Would their schema of healthcare workers' need alter and reform?*

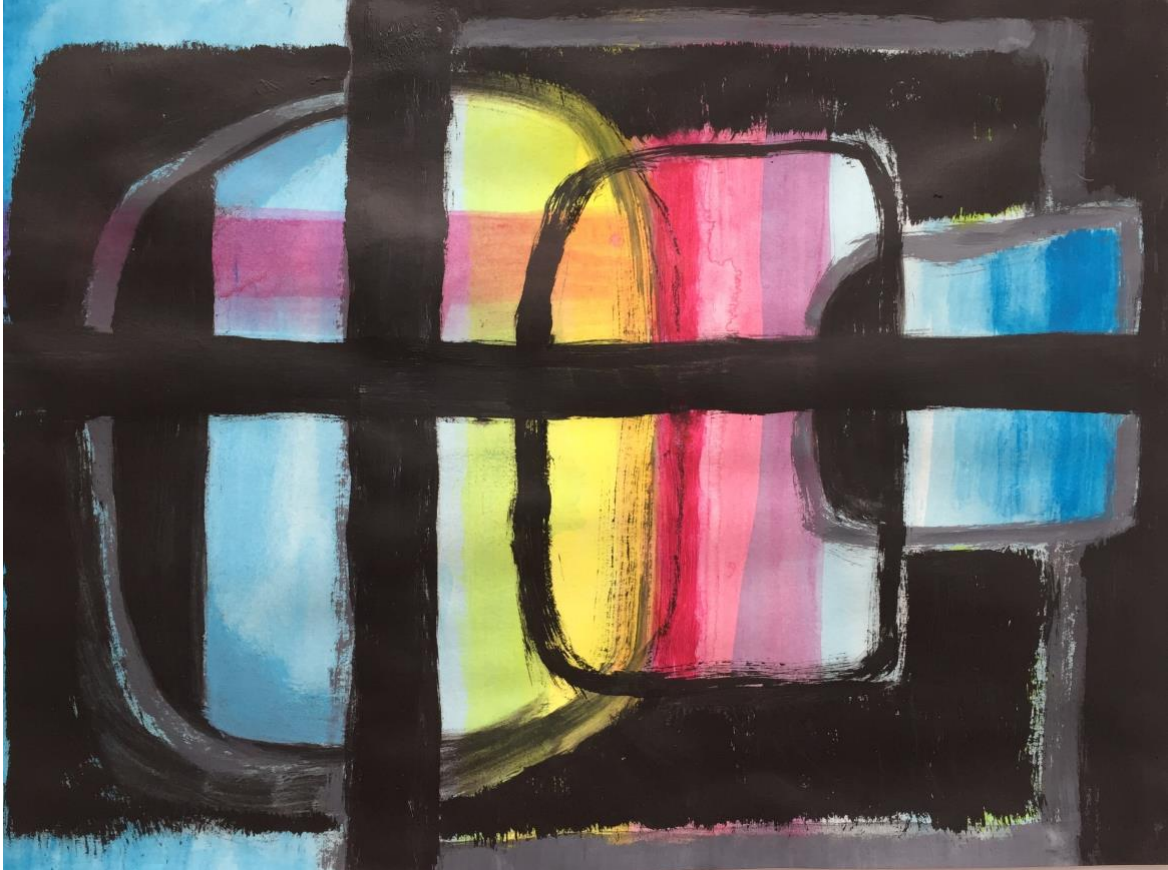
The Clap for the NHS break arrived and most of us took off our headsets and earphones to express ourselves on our doorsteps. It was interesting for me to be standing outside my house clapping along with many neighbours (who were anonymous to me) while inside my house I was in communication with the very NHS workers who were being applauded. People I trust and know intimately. The applause was powerful but there was a curious element of it that was depersonalised, the message was simply "Thank you NHS workers". Inside my house I was hearing specific accounts of individual experiences of what that effort was actually like. I felt like an observer and participant in both groups. It was a stretch for me to connect from the very broad community expression of the clapping into the private environment of the group again. We all did the headset shuffle and got back into our group setting. This was disjointed as we didn't all reconnect at the same moment. Admiration was expressed for the shed but the person there had to change location due to problems with connection or power supply. Patience was required. The shed seemed to me to be an ideal haven. With a gentle nudge we were encouraged to choose and begin our one Patient Case. This

turned out to be revisiting a patient who had been presented in the group before. The case was discussed according to our normal Balint method. There was some bemusement when it came to metaphorically pushing the chair back. This was perhaps because we were all aware that we were already physically separated much more than in normal circumstances. Again, the issues of working with space had surfaced. This patient is not my own case. Therefore, I am not going to go into the details of the case itself except to say I asked the question: "Did the presenter feel the patient would have been anxious to know that the presenter was ok in the midst of the virus?". The answer came back a clear "no". The patient was using the presenter functionally to meet their needs and did not display any anxiety of that kind. Overall, the work on the patient case was carried out in a slightly more perfunctory way than in other sessions. It seemed to me that the first part of our work, before the Clap, had been the more important and meaningful. I felt that we had done something new and that relationships within and across the group had changed and deepened. There was a different kind of solidarity, care and respect between us. I was really glad we had met and was quite proud because there was a sense of progress in difficult circumstances. The group had been resilient and adaptable. I wondered what patients would have made of this if they could have witnessed this? We agreed to meet again, and cross checked our diaries as normal. Our sense of day and date had been slightly affected by the COVID-19 situation and it was important not to accidentally lose track of the next meeting. Afterwards I realised that we had not had the 40-minute hiatus that was expected due to the functionality of the app. The group's Leader and Co- Leader must have paid for a subscription to the app to avoid a break and to maintain the integrity of the group. Nobody had commented on this or maybe I had missed it if they did. The day after the session someone posted a link to alternative software designed for secure and effective patient communication. I checked it out. It looked good to me, but I cannot

utilise it as it is only for NHS workers. My lasting feeling is that our group is perhaps under more pressure and also stronger than ever.

**Author Note**

This essay was discussed within the author's Balint Group, who agreed to publication.



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Artwork by Penny Elder. Retired psychoanalytical psychotherapist and member of British Psychotherapy Foundation. Training therapist and supervisor, Chair of Professional Practice Committee and member of training committees for London Centre for Psychotherapy and Lincoln Centre. Individual and Couples therapist. Trainer and supervisor for Bereavement counsellors. Accredited Balint Group leader. Member of East Finchley and Collage Arts.

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

## **A Safe Place for Caregivers**

Balint Society Essay Submission 2020

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I was waiting to enter our second Zoom Balint group. We had already been in lockdown for one month due to the Coronavirus pandemic which had considerably affected our personal and working lives.

Our Balint group is somewhat unique in that it consists of members who are all mature caregivers, a few already partially retired and some of the others approaching the age of retirement. Many are over the age of 65 or have some chronic condition which makes them more at risk where Coronavirus is concerned. So I was expectant to know how people were managing in the new treatment setting. But perhaps in contrast to our more physical fragility compared to our younger colleagues in the profession, we are a group of hardened experienced doctors who are well versed in the trials, hardships and tragedies of medical practice and who have managed to surface from setbacks and trauma which we have encountered over the years without being burnt out, while still maintaining a love for our profession. All of us agree that Balint groups have done much to protect us in this respect.

Our first Balint group by Zoom three weeks previously had been experimental for most of us and we had all been in high spirits at the easy ability to meet online and continue our group meetings face-to-face. We had been at the beginning of lockdown, some of us assigned to working from home by telephone consultations and those that remained in clinics receiving fewer patients face-to-face. We were managing and there was almost a slight mood of euphoria in the Zoom room.

Three weeks on was a different story. The strict lockdown was working in that the wave of Coronavirus infection was already declining and we had had

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relatively few deaths. General practitioners in my sick fund had set up a nationwide monitoring of all our patients who had tested positive for Coronavirus. Each would be contacted immediately by a GP who would assess if the patient needed hospitalization or was well enough to be treated at home. If hospitalization wasn't needed an assessment was made if the home conditions and family set up were amenable to quarantine at home or in a hostel taking into account patient preference. All were supplied with Coronavirus kits consisting of pulse oximeter, thermometer and facemasks and were monitored daily in case of change of health status until their quarantine period ended. We were doing novel challenging work and our calling to be doctors was strong.

But before our second Zoom began there were some hints in our Balint WhatsApp group that not all was plain sailing and that a feeling of dysphoria was setting in. Mary, a social worker spelt it out: "Maybe before we meet each of us should think of the internal and external resources which are available to him/her in a world which has changed and is still changing and share it with us. It may strengthen and help us". Questions arose whether this should replace a formal Balint group setting. Another group member sent a link for mindfulness meetings on Zoom for those in need.

And there we were. Fran our host had opened the door and one by one we entered the Zoom room. It was lovely to meet in days that many of us had become detached from people outside our immediate families. Did everyone look well? I think my first impression was yes and indeed no one had yet caught Coronavirus or had needed to be in quarantine. Mary again asked if there was a need for a more diverse and flexible meeting outside the normal Balint setting and a short discussion ensued in which most members expressed a feeling that allowances should be made due to the exceptional circumstances in which we found ourselves and we agreed this wasn't going to be a traditional Balint group.

Julie volunteered to present what was pressing on her. Julie is an independent family doctor who works in a single-handed practice. She related how Coronavirus had struck her. Her husband who has had a kidney transplant and is receiving immunosuppressant treatment is highly at risk of complications on catching COVID-19 and she had been advised by his doctors not to work face to face with patients. So she had closed her clinic and was working by means of telephone appointments and digital online patient communication. Most patients understood and were themselves reluctant to go to a doctor, but Julie presented a patient who was angry and upset that she was unable to examine him and found it necessary to refer him to a young doctor who was receiving patients face to face. He felt betrayed by his doctor and was especially upset that she couldn't give him a date as to when she would return to normal clinical practice. The situation had made Julie feel guilty, frustrated and upset. She knew that she couldn't afford to risk her husband's health but here she was, denying her patients comprehensive care without knowing how long the situation would last.

In the discussion that followed a number of doctors brought up associated dilemmas. Sue who had also been sent to work from home due to a chronic condition was almost in tears when she described how frustrated she had become contacting and diagnosing patients by telephone only. "I can't see the patient, feel the patient or place a caring hand on him, never mind examine him. I could return to the clinic, but I am frightened of contracting the disease". Here was a new dilemma for us. For the first time in our working lives the doctor had become fearful of his patient. The patient posed a danger to us and could at his worse cause us to become ill or even die. We were in the early days of Coronavirus and no one knew for sure if PPE could protect doctors from the disease. Where did our allegiance lie? With the patient who in the past we would have done everything for, staying up all night in the hospital setting to save a life; or to ourselves and our families. We were the baby boom generation of doctors who had entered medicine

as a calling and believed in work ethic above all. Should we be discovering somewhat late in our careers the more sensible attitude of the Y-generation whereby work needs to be fun and flexible and part of the enjoyment and quality of life as a whole? There is more to life than just work.

Nancy who had been one of the GPs working with diagnosed Coronavirus patients chose to place herself in the patient's distressed position which she felt was powered by a feeling of dependency on his doctor and fear of losing her. But what I remember most of Nancy's participation was her description of how emotionally draining she found it to deal with patients diagnosed with Coronavirus or placed in isolation due to contact with a diagnosed patient, many of whom felt guilty at contracting the disease as if it were a sexually transmitted infection that they were suffering from. But fear and anxiety were the main prevailing emotions in these patients. Fear of illness, suffering and dying. Fear of infecting family and other people and most of all fear of the unknown. This very much paralleled Sue's emotions as a doctor.

Nancy felt that treatment by telephone from a distance and without eye contact compounded in certain patients a sense of neglect and abandonment, and wondered if doctors needed to increase their contact with such patients to a maximum or to introduce video calls.

Kate also described her situation and associations with Julie's predicament. Kate was due to retire in two months' time. She described how she had worked closely with her patients for many years and had planned how to take leave from them before her impending retirement. All her plans and considerations had been laid aside due to the Coronavirus pandemic and instead she had been sent to work from home with telephone consultations only. Worse than that she had noticed that some of her longstanding patients had already been designated a new doctor without her having said goodbye. This was upsetting and hurtful. I recalled in my mind how I had retired six months previously from my practice where I had

worked full time for 25 years and how during the final 2 months it had been very important for me to transfer my chronically ill and home bound patients over to their new doctor in order that there would be the minimal disturbance in the continuity of care. I also recalled that patients made appointments just to part and say goodbye to me, many of them bringing small gifts and flowers or personal gifts which they had made by hand. And on my last day when I was about to close the clinic they had arranged a surprise party for me in the waiting room. I had been very touched. Kate was to be denied this transition in the care of her patients and a farewell which I knew she deserved.

But on this sombre note suddenly Sean decided to speak. Sean is one of the younger doctors in our group, in his late fifties. He has specialized in family medicine and in geriatric medicine and has recently taken up a position of consultant geriatrician at our local university hospital working fully in the hospital setting. He reminded us that fear is the emotion felt when we enter unknown, unfamiliar, and unpredictable territory. We have been trained as doctors to treat patients based on knowledge and experience accrued over the years and we were unused to dealing with situations of which there is little information. But doctors have in the past learnt to adapt to different modes of practice. Just as with AIDS we had learnt to wear gloves when handling body fluids we could learn how to treat Coronavirus patients. As an example, he cited himself who had been called to do numerous consultations on elderly Coronavirus patients in the hospital. He had learnt to gown himself adequately and to wear a mask, goggles, a visor and gloves and approach, examine and talk to the patient without fear. He hadn't become infected and truly very few medical personnel working with Coronavirus patients in our country had become infected. For doctors reaching out for a ray of light here was indeed an uplifting account.

Paul, another of our younger doctors, added to this new optimistic note. He works in a small townstead in the desert, about 90 minutes' drive from the nearest

town. He often works single handed and has dealt with many an emergency situation by himself. He described doing a lot of home visits dressed appropriately and keeping a distance for elderly patients in the community who had not seen a soul during the lockdown period. Those that lived as a couple seemed to fare better and even minor quarrels seemed to preserve their general wellbeing. But those who were single seemed to lapse into a depressed state with tears and somatic complaints prevailing. If the family was caring, telephone conversations and “window visits” from outside the apartment helped. Here was another doctor who had learnt to treat without fear of being infected or infecting others.

We had all felt much moved by this Balint group and everyone agreed that it had been very supportive. We decided unanimously to meet online more frequently to allow ourselves as doctors an outlet for our emotional needs.

### **Where we are today**

It is now more than 4 months since that memorable online Balint group and we have continued to meet on Zoom but have reverted back to our original schedule. Coronavirus is still very much around and affecting our lives. It became impossible to maintain a strict lockdown for a prolonged period of time and so we have learnt to live and treat in the presence of the virus. All of us except for Julie have gone back to working face to face with our patients but have also adapted to telephone consultations and the new technology of video and digital medicine. We had been struggling under the psychological weight of the crisis, had decided that this psychological pressure needed to be addressed and had used our Balint group to relieve our feelings of stress, fear and anxiety. During work I have learnt to focus on taking care of my patients without being reckless, since it is only rarely a patient with fever enters the clinic.

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

## **'Group': Poem by Christopher Bu<sup>1</sup>**

Balint Society Essay Submission Entry 2020

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## Group

13:57

Logging on, adjusting my camera. The anticipation of awaiting others.  
This hour, each week, I meet with colleagues – but not as doctors, friends or  
therapists. Not as individual listeners, but as a listening body together.  
The resilience of the strongest, the compassion of the most sensitive.

I know my colleagues, and they know me too. But there is an undiscovered aspect  
of ourselves, reserved for deep discourse and difficult conversations.

We may flirt at conceiving of ourselves as 'listeners',  
But in Balint is where we find out.

Greetings and pleasantries, but something deeper approaches. A wealth of tacit  
matter to stumble into. To forage its thickets, to hack through its thorny rows.  
And who is it that ventures, in us? Fixer, Solver or Holder of the correct answer?

Perhaps, just a *stiller* facet of ourselves.

14:22

An urge to speak. An urge to offer. Scanning the faces of quiet expression as we  
shift from presenter to audience, from individual to group.

What's that I suddenly notice? An urge to pause - Someone might speak at the  
same time!

Or maybe no one speaks at all.

**14:23**

The DEAFENING ROAR of implosive silence.

Why does this unfamiliarity feel so familiar? Universal stillness – going unheard.

Omnipresent but shunned.

Tense posture, forward leaning. Crossed legs and furrowed brows.

My breath sits high up and shallow in my throat.

Thoughts in flight.

**14:41**

Group chatter now birthed as matter, but still ethereal in form. Ideas now slightly denser - almost in the realm of conceived things.

Worn, digested and metabolised – we now sit in our communal bathwater.

Ceremoniously we offer this back to our presenter.

Inhabiting all standpoints, all in one time? We glimpse at this very possibility.

Making tangible the unsaid, unheard and unclear relation of things.

Allowing this understanding to wash over us like a just-forgotten dream.

An urge to grasp at it.

**15:00**

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This poem was written by Dr Christopher Bu, Psychiatry Core Trainee (Mersey Care NHS Foundation Trust) - Undertaking Balint group virtually as part of psychotherapy training during the COVID-19 pandemic.

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

## **Being a General Practitioner in the First Months of the COVID Pandemic**

Suni Perera<sup>1</sup>

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In *The Doctor, His Patient and the Illness*, Michael Balint described key phenomena that we now take for granted, that arise from GPs observing their responses in listening to stories of patient care. A Balint training-cum-research group was convened made up of eight to ten GPs who listened to the narration of a story or “case” (no notes allowed) of a patient encounter. The presenter and group both paid attention to the telling of this “case” as well as the evoked feelings in the doctor and the group.

I got a chance to attend a weekly Balint group as part of my three-year vocational training scheme<sup>1</sup>. These Balint groups gave me my first insights into the importance of the setting, the interaction, the feelings and language. How when these are observed in a consultation, they can unlock key aspects of the story – most importantly improving the diagnostic capability of the GP. A major difference to a story telling exercise was understanding the power of the unconscious. Something I was never taught in medical school.

When I ask medical students, who come and sit in with me, about their impressions of General Practice, it is usually that we are interested in patients first and foremost as human beings, not as vessels for discrete illnesses. And that is what makes the job satisfying for most of us is our continuing relationship with our patients, colleagues and teams.

Michael Balint recognised that “the essence of general practice is the continuing relationship binding together the doctor and his clientele. The more they know about each other the better the prospects will be of a mutually satisfactory relationship in health and in illness.”<sup>2</sup> I think it’s these healthy relationships that form the oil that enables the professional machinery to run

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<sup>1</sup> Dr Suni Perera is a GP in London. Her Balint journey began as a GP Trainee and then as Programme director for the Northwick Park GP training scheme. Suni led an award winning project that pioneered Balint groups for care home staff, LAS, Pharmacists, OTs , GPs, palliative care workers. She has recently been appointed a Council Member for the UK Balint Society.

<sup>2</sup> All quotations are from *Psychotherapeutic Techniques in Medicine*, by Michael Balint and Enid Balint (London: Tavistock, 1961).

smoothly without friction or damage to its key components. So how has the COVID-19 pandemic impacted my relationships with patients, my colleagues and my identity as a GP?

Within the first few weeks of the peak of the pandemic, I experienced a heightened sense of uncertainty and disbelief watching world events unfold, sensing the gradual erosion of what was a recognisable form of working as a GP. I work in a practice serving a very multi-ethnic population with variable health, literacy and socio-economic status. Our practice decided that the ethical way forward was to accommodate as many ways of patients connecting with us as possible - phone, letter, walking in. This brought on much debate - what would happen? Would the patients stream in? Would we cope? Was it safe? But in reality, for the first weeks of the pandemic, this approach worked well mainly because the majority of our patients were terrified, and kept well away.

What is the source of this terror? The invitation to meet face to face in a consultation during COVID-19 times is distorted by our sense of risk and danger. For the first time, the consultation, which for me is the source and summit of my craft as a GP, becomes a possible source of contagion, an overt threat leaving the doctor and/or the patient vulnerable to an unknown, possibly fatal disease.

I faced my mortality in every consultation. Even the previous benign gift of exploring the symptom of a sore throat, with a simple look at the tonsils, was now considered a treacherous manoeuvre. I recall the distress within our team. How could we do our job of seeing patients? NHS England's advice was impossible to follow at that time, with a dearth of PPE and outdated premises. Our GPs were angry that they did not have the tools to see their patients or to keep their staff safe. Michael Balint suggested that doctors have feelings and that these feelings can have an important influence on the consultation. These can be identified and used in the consultation. This means that a doctor can have a powerful ability to influence the

patient's thinking and ultimately their total health, without necessarily writing a prescription.

I found, in the height of a pandemic, that seeing a patient face to face was a soothing return to normality. I felt I was a GP again. The first time I used my stethoscope on a patient during the COVID crisis was on someone I hadn't met before. I was all protected, clad in a mask and flimsy plastic apron. I very deliberately took out the stethoscope, feeling its coolness, I purposefully, placed the earpieces in my ears and then the diaphragm on the man's chest. I observed myself savouring the silence, counting his breathing, my head connecting with his heart. In this case I heard a murmur as well as some breathlessness. When I put down my stethoscope, I admired a beaded bracelet on his wrist. He proudly told me that it was his favourite granddaughter's handiwork. It was then that I heard another murmur, a murmur of quiet grief as he now missed her terribly. We decided that this breathlessness needed an investigation, and it was bringing up the thought of being well enough to see this granddaughter that convinced the patient to attend the hospital. Perhaps this was an artful consultation, using my deep listening and connection. But now, thanks to COVID, I observed arising within me, a new irritating, gritty and gnawing doubt. Was I right to say that the hospital was safe in a COVID pandemic? And how had I held the balance of power of my Doctor Drug?

This power came up in another lockdown encounter when I was not feeling much connection between head and heart. I was working doggedly through a long list of telephone call requests. A relentlessly growing list of calls as it felt to me. The message was "Pt (patient) needs dressings again wants Dr Perera to call". I telephoned the patient, portraying outward calm, whilst inwardly dismissive and irritated as he told me he needed a repeat prescription.

I half listened to his enthusiastic hello flicking through his notes: An Egyptian gentleman in his 80's with whom I had only one encounter in the last

year. Why was this coming to me? I looked through my notes of that brief meeting a year ago. I had noted that he is the carer for his elderly disabled wife, and he had developed a small wound in his umbilicus. At that time, my records showed that I had been asked to do a prescription and he was healed with some antibiotics and a dressing that had been recommended by our nurse. And I was curious why he felt he needed to speak to me now, especially when a click of a button by a pharmacist would have magicked the dressings to him.

“Yes Mr XX”, I interrupted, “the prescription, it’s done. “

“Oh, but Dr, I wanted to talk to you let you know what has happened.”  
Chastened I listened with a little more grace.

“You see, I went to my brother’s funeral in Egypt. I got sick and when I went to the hospital, they said I had COVID-19, very bad. I will die and I must go to intensive care. He then re-enacted for me his determination to get home to his wife with dementia, how the carer would only be there for another week, how he nagged, cajoled and begged the doctors to avoid intubation and send him home. And then I heard him say, “Dr remember when I saw you, I told you I was old, I was no good. And you smiled and said, well the oldest trees have the deepest roots, you have deep roots, strong and steady? Well, I remembered this and I said to them in Egypt, I cannot die, I have deep roots. I will live and go home!”.

I hadn’t until then realised the representation those words given to him, a year ago, that fell out of me as I simply responded to soothe a wounded umbilicus, those words formed an invisible cord of attachment between us.

Two of Balint’s concepts are very germane to the topic of how we influence our patients. He coined the term, "doctor as drug" to highlight the huge impact that the doctor's relationship to the patient has in shaping the course and outcome for their illnesses. A second concept, he called "the apostolic" function of the doctor also impacts our patient relationships. In Balint's words, "It was almost as if every doctor had revealed knowledge of what was right and what wrong for patients to

expect and to endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients." Balint noted that the doctor brings to every encounter his personal values and morality, his own notions of his role, and elicits, whether implicitly or explicitly, the kind of response that is most compatible with his own views.

If I, an established GP with experience, now felt unsettled about my apostolic role or doubted my efficacy in these times, I wondered how this was for others, newly qualified or only just forming theirs.

What is it that contains and maintains the scaffolding that supports your growing professional esteem, especially now when you may be working from home as a GP, with little distinction between the different roles you play as mother, wife or home-schooler? What happens when you are now asked to navigate difficult choices, at a laptop on the kitchen table, at home, with a baby in the background? What about those only starting their first year of being a GP or returning after maternity leave, or a locum in an unfamiliar place, all having to cope with being in a place of "not knowing"?

My own pre-conceived notions of illness and suffering, my values surrounding the GP role and the role of the patient, my own emotional response to different types of patients can only be shared in a safe psychological space. Without such space, we are unable to explore the force of such beliefs in our role of doctoring. As a young doctor taking up my professional role, it was the many opportunities for me to practise performing with patients and discuss my performance in a kind and supportive space that helped me grow in skill and confidence. The Balint / reflective group behind me, together with the props of the name badge, the stethoscope around my neck, the greeting of the patient, the setting of the consultation room - it was with these all combined that I felt cheered on by a solid tradition which was mostly strong enough to hold my doubts and fears. New ones have emerged.

Consulting by screen can mean energy-sapping efforts to get the camera angle right, or teach an older person how to connect with the camera in their home. Whilst video consultations are not the same as sharing breath in the same room as a patient, I have found them a strangely intimate affair. We have to sometimes go to extraordinary gymnastics, mental and physical, to achieve that connection. But it can yield joy.

A young mum who didn't want to come near the practice with her new-born baby was simply delighted when I agreed to tend to her by video. I recall the father holding the webcam at an angle so that his wife could show me her healing scar. I caught his image tilting the computer, in their bedroom mirrors, and so I could see beyond what the camera would normally show me. When the consultation ended, I thanked the camera man, and his wife, not aware that I could see her husband, applauded his skill and he gave her a very loving bow.

And now to the e-consultation. What might Enid and Michael say of this encounter?

Balint wrote, "Perhaps the most instructive periods in the history of an illness is the time before the patient and doctor agree what the illness is about and then settle down to treat it. During the unsettled and unorganised periods, it is not difficult to follow the various "offers" by the patient and the corresponding "responses" by the doctor. This interplay goes on until eventually an agreement can be reached."

The COVID pandemic has hurtled us into this new world of electronic triage systems. I now read a consultation, frozen in time, between the patient and who? Is it me they relate to or the computer screen as their benevolent GP asking the questions "what do you want to talk about" or "what do you think the problem is"? Are patients just as happy with electronic interactions with no visuals on the doctor? Some seem to be able to express themselves very clearly.

I wonder what was in their mind when they typed out their answers. Would it be the same if I call them now?

I want antibiotics

I want to see Dr X again

I want you to sort my son out....

I don't want to feel like this for much longer

It feels like we have got to their ideas concerns and expectations (ICE) in a jiffy. But how tempted will I be when tired, jaded or not keen on confrontation to challenge this offer? To be curious and to ask around the problem presented? And where does learning about the unconscious apply in this new domain of remote consultations?

Michael Balint speaks of a mutual investment fund, the small deposits of good will that come from the GP, or their team, interacting in small ways during the course of their lifetime building up trust. We all have patients with whom we have built up a deposit of banked knowledge engendering loyalty. These patients have built a sense of trust and intimacy with us. Are we now cashing in on the past years of banked deposits of face-to-face relationships? Will e-consults allow the same value of connection to be deposited? And how can we maintain a healthy balance, building more trust in this new normal? A trust fund that can be cashed in when needed.

For a healthy trust fund, both parties have a duty of care, and self-care. Michael Balint was not shy of talking about the cost of being a GP. In the last chapter he makes it clear that there is a price to pay for being a GP. Caroline Palmer the past president of the Balint society describes her experience of a Balint group "as the uninterrupted presentation of a problem, and then the 'handing over' of the burden to the group, to see what they can make of it, as you get to be a fellow observer, sitting in, or sometimes out, while hearing the others' thoughts and feelings and then ultimately reintegrating back into the group."

Perhaps that is why as a GP we so need each other, the group, to carry this burden with us. Professional isolation has a great cost to healthcare workers, and during this pandemic. I ask myself, have I been deliberate and intentional in seeking to be even more connected to my colleagues, and in making sure I do take breaks, in an act of caring for them, through caring for myself.

Being a GP is not easy work.

In the words of Balint “All the general Practitioners who took part in our research accepted this hard fact after some remonstrance...What they resented most was that their work and their responsibility had not been made easier by their new experience and their newly won skill. All of them without exception complained about this but all of them without exception found their work incomparably more interesting and more rewarding.”

### **Author Note**

This text combines two talks. The first was given with Dr Andrew Elder at a webinar in October 2020 for the RCGP NWL Faculty ‘COVID and the doctor-patient relationship: consulting in the new normal. A Balint perspective.’ The second was an introductory talk for the Belfast Balint Society Online Weekend Conference.

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Artwork by Penny Elder.

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

## **The Junk Lady and the Golden Chain**

Balint Society Essay Prize 2020 joint winner

Jenny Jack<sup>1</sup>

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*'So say whatever goes through your mind. Act as though, for instance, you were a traveller sitting next to a window of a railway carriage and describing to someone inside the carriage the changing views you see outside.'*

Sigmund Freud. *On Beginning the Treatment* (1913).

The story begins when Asha is twelve. Like a girl in a fairy tale she does not have a name, though in her mind, this is the name that Nina gives her.

Nina picks the tomato out of her sandwich, lays it on the grease-stained cardboard packaging on her lap. She needs to eat. She can feel the acid building beneath her ribcage, knows if she does not it will erupt in an embarrassing gurgle. It is, after all, lunchtime. Protected time. In the group, they are protected for one hour each week from the demands of the day - the medication charts which need writing, the phone calls to relatives, the patients waiting for their dark moods to lift, for the tormenting voices to be gone. Nina knows that, strictly, they are not supposed to eat. Jo, the facilitator turns a blind eye, although she never eats herself.

Sometimes, if the patient presented has an eating disorder, or the story is particularly tragic, Nina will lay her sandwich aside. She chews quickly now, as Rachel talks. Rachel's hands fidget in her lap, and she twists a slim golden chain around her wrist. Rachel is twenty-six, pale and nervous. She is five years older than Asha, the girl in the story, though Asha had a husband back in Iran. This seems too young, to Nina. Nina is twenty-eight, older than both of them, wider than Rachel. Nina is getting married in the Autumn, her mind full of burnished flowers, of ivory silk shoes crunching through fallen leaves.

She is hoping in the next few months to lose some weight. She slots the corner of soggy bread into her mouth now, thinking that Asha's story is about to get worse,

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<sup>1</sup> Jenny Jack is a Consultant Psychiatrist working in a Recovery Mental Health Team in Sheffield and have been leading Balint groups for Foundation, Core and GPVTS trainees for the past 4 years.

that she is about to stop being a carefree twelve-year old running through the compound belonging to her wealthy parents. Nina imagines the baking sun casting shadows of mango trees on to a courtyard. Do they have mangoes in Iran? Some kind of orange fruit anyway, the juice running down Asha's chin, her slim hand wiping it away.

The nurse in the Crisis team wanted Asha to see a female doctor. Rachel is the only female doctor they have. She has been in the team four months. Rachel pauses. She is feeling her way along the thread of the story. Opposite her, Nina watches Gavin spoon pasta quickly from a Tupperware container, his cycling helmet laid casually by his chair.

Asha's father did not like her running like a boy in the compound. He worried about where she was going, what she was doing. He worried about the family's reputation. He worried she was not pure. He arranged a medical examination, then married her off as soon as he could.

Rachel stares straight ahead as she talks. Her fingers, twisting the gold chain, move faster, and Nina worries that it might snap. Asha's teenage years spool forwards. Darkness. They are indoors now, and the courtyard is gone, yet in the shady rooms there are glimpses of sunshine through the windows, the shadow-patterns of leaves. Asha's husband beats her. Rachel swallows. Sometimes, even though she is far away in Rotherham now, Asha still glimpses shadows at the window. That is why she keeps the curtains shut. But she can't keep out her husband's voice.

Nina returns the half-eaten sandwich to its packaging, balances it on the arm of her chair. Gavin keeps eating, methodically. Beside him, Shola, who has worked as a psychiatrist in Nigeria but must retrain in the UK, is motionless, his face impassive. Jo sneaks a glance at the clock, pouchy white hands folded in her comfortable lap. Her dangly earrings catch the light. *Free Association*, she had instructed them at their first meeting as a group. She spread her arms as she spoke, smiling around at their nervous faces. Her lips, pillar-box red, echoed her nail-polish. *Say whatever comes to mind. There is no right or wrong.*

'When we got out of the car,' says Rachel, 'there was all this rubbish piled up outside the house.'

It seems to pain her, the rubbish. Nina imagines a kind of scaffolding. Looking beyond Gavin, she sees the desks they pushed together against the wall earlier, left over from a board meeting, to make space for their intimate circle of chairs. The expanse of wooden surface. She imagines these desks stacked, higgledy-piggledy outside Asha's house as Rachel and the Crisis nurse step from the car, imagines the muddy, puddled ground tainting the toes of Rachel's ballet flats.

Had Rachel mentioned a rat? Nina gives a slight jerk, knocking her sandwich to the floor with her elbow. 'Sorry.'

She bends to pick it up, with a glance at Jake, next to her. He flushes, mumbling, pulling his legs out of the way. Nina sits back, brushing crumbs from her fingers. She cannot be sure if the rat was in the story or her imagination. On the corporate blue carpet at her feet, there are no rats. Still, she feels her toes curl.

In the two-up two-down terrace, Asha lives with her mother, her younger sister. The family live together in one room. Upstairs. The room furthest from the front door. The sister goes to school. A ray of sun lights the murky puddles as she steps outside. She is small enough to slip through the scaffold, her satchel across her chest, to skip from the story, appearing only as a snatched glimpse later when Gavin, blinking, says, 'I'm wondering about the sister...' Nobody else wonders. Perhaps, says Jo, Gavin is holding the hope for the group. Somebody needs to hold it. It is breakable.

In the doorway, through which hope has recently departed, Rachel ducks her head. She is drawn across the threshold by an older woman, tiny, nervous in her movements, beckoning her up the stairs. This is Asha's mother, who may or may not be tiny, though in Nina's mind the stairs are narrow, rickety, the lower rooms in darkness. As in all good fairy tales, the characters expand or shrink obligingly to fit their circumstances.

Upstairs, in a room bare of carpets, of pictures, of possessions, the mother retreats to the corner. She has brought her daughter across the sea, and although Nina

knows that they have flown, in a noisy plane full of chattering people, in her mind she sees a boat. She sees Asha curled inside the boat's ribs as her mother stands at the prow. Her mother summons her strength, she summons the power of waves and wind. She steers them, through the force of her will alone, and she hauls Asha, shipwrecked up the beach. Now, she has delivered her to Rachel, and her strength is spent. She sits back. She waits for this shining girl with her hair like corn and skin like milk to work her magic.

But Rachel is slipping from the story, along with the nurse, who left some time ago. 'We will ask the doctor to sit out now,' says Jo.

Rachel is no longer Rachel. She is the doctor, cast adrift from the group. As she pushes back her chair, they turn from her to the bundle of rags in the corner.

In the bundle of rags is a girl. Her name is not Asha, but this is the name Nina gives her. She is the most powerful person in the room. She is the most helpless. She lies on a mattress, and above her the closed curtains are murky, caked with dust. Her mind is a blaze of light, of images. It is full of screaming. She is the focal point in the darkness.

The clouds outside must have shifted. Through a flaw in the vertical blinds, a spar of light comes to rest on Nina's face. She shunts her chair a little to her left to escape it, and beside her Jake flushes again. His is the type of mottled skin that flushes easily. Along his jawline sprout tufts of mousy beard. He moves his chair in turn, though Shola, beside him, remains still. Through the blinds, Nina can see the well-kempt lawn, trees, and, beyond, fields rolling into the distance. They are on the edge of the city, where it meets the countryside. The leafy suburbs. Yet like a palimpsest, in grainy black and white she sees the view through Asha's curtains. The stacked rubbish. The terraced house opposite. The grids of terraces all around.

'I was wondering where the rubbish came from.' Jake flushes again, at his own audacity in speaking.

Jo swivels to look at him.

'What is your phantasy about that?'

Jake's ears, catching the word 'fantasy', turn pink. He shrugs, mumbles.

'Maybe neighbours put it there?'

And now, Nina can see them. Skin heads in tracksuits, bearing the flag of St George, but also pitchforks. They prod at the rubbish, and the rats run out. Inside, Asha and her mother cower, listening. In Asha's head, the voices mingle with her husband's.

Shola clears his throat. 'I was wondering,' he says slowly, carefully, 'if they put the rubbish there themselves. To keep people away from them.'

The group regard Shola, who never flaunts his superior experience, whose daughter is doing her GCSEs. Other than Jo, he is the only one with children. In Nina's head now, the neighbours melt into the background. The lone figure of the mother stands on the scaffold. At night, she sneaks out in the moonlight, to tend her barrier, to drop scraps of food to the rats.

Jake is staring at Shola, his mouth opened slightly, and Nina sees that he finds this preposterous. The idea that someone would pile detritus around themselves, so as not to be seen. Shola shrugs benignly. He has dropped his idea into the pool of the group and now he will let it be. The ripples may spread, or they may fade. But in Nina's mind something is waking, lumbering from a sea of rubbish beneath a twilight sky. The face emerges of a wizened old woman, bent beneath her carapace of discarded belongings.

'Like in *Labyrinth*. The junk lady, in the rubbish dump. It's a film,' she adds, seeing Jake's incomprehension, but Gavin is nodding. He clips the lid back on his Tupperware.

'I remember that. David Bowie in tight trousers playing the Goblin King.' They laugh, and even Jo smiles, indulgently. Perhaps it is Gavin who is holding the humour, as well as the hope. He taps the lid of his box with his fingers, his expression thoughtful.

'The weirdest bit of that film was when all the creatures came into the girl's bedroom at the end. I mean she opened her bedroom door, and the rubbish dump was still there. Like opposing worlds colliding.'

Nina has an image, suddenly, of her teenage self, on the sofa at home. She is in the den, her feet on a beanbag, and she has covered herself with a knitted throw. The thick, lined curtains are closed on the darkness outside, and *Labyrinth* flickers on the TV screen. Her Mother is upstairs, working. Her father is working late. She is alone. She has a bag of Doritos, and she moves them mechanically to her mouth as she watches, orange dust coating her fingers. This is how her father finds her, just as the rubbish dump on the screen comes alive, as the junk lady heaves herself into view.

He stands in the doorway, in his dark winter coat, a striped scarf around his neck. He stands for a moment, then he turns away.

*Eating again*, he says.

'Opposing worlds, like the world inside Asha's house, and the world outside.' Gavin continues enthusiastically. 'Or the contrast of where she is living now with where she came from in Iran.'

Her memory is composite. Nina knows this. As the others talk, she sees her father in the doorway, herself on the sofa. She cannot say for certain which film she is watching, which scene would be showing if someone, right at that moment, could pause the TV. None of this matters, because this is what she remembers. On the sofa, she makes herself small, beneath the throw, beneath her baggy layers of jumpers. She covers her face with her hair, curls into herself. Less is more. The junk lady, crouched beneath her shell.

'I wonder,' Jo is saying, 'If we can also see the rubbish as a metaphor for something inside as well as out?'

The empty bag of Dorito's rolls to the carpet at Nina's feet. Her father's footsteps climb the stairs, and she sidles to the door, her jumper sleeves pulled over her hands. From the kitchen, she will add to her pile, the scarlet wrapper of a pack of

Kit-Kats, the cellophane of some dried-up madeleines found at the back of a cupboard, a strawberry yoghurt carton.

'Perhaps she feels dirty. The patient. Because of what's happened to her.' She glances towards Jo. 'Maybe contaminated.'

'Maybe it's easier if the rubbish stays outside,' says Gavin. 'Where she can't see it.'

Later, the sight of the pink yoghurt in the toilet bowl will tell Nina that her stomach is empty.

'But what is the feeling?' Jo's gaze sweeps around the group. 'She feels dirty, but what is the emotion she can't acknowledge?'

There is a silence. Nina's cheeks feel hot. *Fat slag*. She sees herself hugging the wall of the school corridor, unable to hide her bulk. Hears the *phut* of projectile spit, feels someone else's chewing gum hit the side of her head.

Smoothing her blouse over the bulge of her skirt's waistband, she lowers her gaze to the spotless blue carpet. She is Dr Nina Carr. She is successful. She is getting married. It is almost eight years since she last searched for the yoghurt in the toilet bowl. The black straps of her shoes dig into her ankles. She sees herself in the wedding dress shop a few days before, on a scalloped, satin chair watching the bubbles rise in her champagne glass. The dresses she has discarded heaped on the facing sofa.

*At least, her mother says, we can buy some shoes.*

'Shame?' She looks towards Jo, hesitates. 'Maybe anger.'

The girl on the mattress raises her head. Her fingers, birdlike, clutch at the neck of her hijab. Her eyes are mistrustful, her jaw clenched. In Iran, she went to university until her husband stopped her. She studied maths. Somewhere in the film reel of her mind, beyond the harsh words, the lightning bursts of pain, is a quiet room, a blackboard, a scroll of algebraic symbols.

'She might feel resentful,' Nina continues. 'Of the doctor. Being close in age, but in a privileged position.'

'Ah, the doctor,' prompts Jo. 'We seem to have lost her.'

'The doctor has been buried in the rubbish,' blurts Jake, then falls silent, looking down at his lap.

Turning, Jo bestows on him a lipsticked smile, as in the room with the bare floorboards, Rachel crouches by the mattress. She stretches a hand towards Asha, but she does not touch her. Her hand hovers, uncertainly, as she waits, balanced there until the backs of her calves begin to ache.

'And what might she be feeling?' Jo keeps her eyes on Jake until his creeping flush matches her lipstick.

'Frustrated?' He offers, glancing around him for moral support. 'Guilty?'

Asha lifts her gaze to the level of Rachel's outstretched wrist. The golden chain, the single bright object in the room. In another life, she had worn jewellery. Perhaps, she will wear jewellery again.

'I think that she would feel guilty.' Shola's voice, as he steps in to rescue Jake, is deep and assured. 'Like the mother. She wants to help, but she can't.'

Although Rachel's chair is pushed back from the group, Nina sees, in the periphery of her vision, her feet cross and then uncross. The anxiety of being both in and out of the discussion. Present, but silent. Nina can empathise with this, from the times when she has been the doctor, when she has brought her own patient, her own self to be held up, turned this way and that, subjected to the group's scrutiny. Rachel's hands are folded in her lap, the gold chain snaking finely across her wrist.

Jo glances towards the clock. It is time to bring the doctor back in, but as Rachel talks, Nina hears only the thread of her voice, reflecting on what has been said, holding on to it as she allows herself to retrace her footsteps back down the stairs, through the front door, beneath the scaffolding. Nina sees the bracelet around her wrist, its quicksilver flash, as she negotiates the puddles, as she lifts her hand to open the car door, as she and the nurse drive away, the rubbish vanishing in the rear-view mirror.

From her window, Asha raises her hand to pull back the curtain, to watch them go. Light, faint as water, falls across the floorboards of her room. Nina sees the ellipse

of a face through grimy glass, fabric draped across a forehead, a single, wary eye. Then the curtain drops.

In the last seconds, Nina's mind wanders, to the shoes lying on her desk in her flat. The flat she shares with her fiancé, its bay windows overlooking the park. They are nestled in their box, on a bed of lilac tissue, the glint of seed pearls like the bubbles in champagne.

*You should wear your hair up.* Before they left the dress shop, her mother had stood behind her, piled the swathes of hair between her fingers as she had not done since Nina was a child. For a few seconds, Nina allowed herself to become visible in the ornate mirror propped against the wall, her hair clasped in her mother's hands.

*We'll look again next week,* her mother said, letting the hair fall. *Plenty of time to find the perfect dress.*

'It's time,' says Jo now.

They have fallen silent, as the clock hands crept towards the hour, and now, as one, they glance up, as if for confirmation. A sense, as they shuffle back their chairs, of a collective exhalation. Gathering bags and coats, they turn to each other, picking up threads of conversation from an hour before. Gavin packs his Tupperware box in his rucksack, buckles his cycling helmet. Standing, Rachel gives herself a little shake, as if to release the tension in her limbs. She blinks, seemingly surprised at the light streaming through the blinds.

They leave the desks where they are against the wall. As she passes, Nina feels her legs flinch from the dark space beneath. There are no rats here. Still, she feels exposed, tensed for the scurry, the brush of whiskers, as she tosses her leftover sandwich into the bin by the door.

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## **A Medical Student's Experience of Balint**

Balint Society Essay Prize 2020 Joint Winner - Student

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## **Introduction<sup>1</sup>**

In selecting the student selected component this year, I felt inexplicably drawn to the Balint project. Balint represented an opportunity to consider my interactions with patients or those between patients and doctors that left me feeling stuck, conflicted, or unsettled, without clarity about how to process the experience and integrate the learnings into practice. The importance of empathic awareness is impressed upon us constantly in medical training, but to date, much of this has focused on formal training in communication skills, which although essential, has often neglected the subtleties of the relationship that could not be taught didactically but that are painstakingly acquired through practice and reflection on such practice. Balint represented an opportunity to develop self-awareness and to more deeply consider the doctor patient relationship and the potential dynamics that drive it. In this essay I describe my experience of adapting to the Balint approach, the process of examining many of the assumptions and unconscious biases I realised I held, the benefits and constraints of my role as a medical student and how the Balint group safely held a place for vulnerability in practice.

## **Balint Process**

Although I approached Balint with some understanding of the purpose, the method was elusive initially and I found we spent much of the initial sessions debating the facts and merits of the case, which while interesting, did not materially alter our understanding. In much of our medical training the process is deductive and largely prescriptive. The Balint process was the antithesis to the “expert’s mind” we had been cultivating, requiring instead a “beginner’s mind”, which values uncovering what is not known and which expresses an openness to multiple

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<sup>1</sup> Resha Jazrawi is a graduate student at St George's University with a keen interest in psychology, psychiatry and the interactions between the body and mind.

possibilities.<sup>2</sup> We were regularly reminded that our feelings, impressions, and fantasies were considered key to understanding the case. While this requirement to suspend logic and rationale and place myself in the experience of another person was not entirely unfamiliar, for me it was a question of having permission to work in this way. I felt that I was being asked to go off piste, to draw on the assumptions I was constantly being cautioned against, to consider multiple possibilities rather than identifying the right one, to use the facts of the case not to draw reasonable conclusions, but as a spring board to the various unconscious processes driving the interaction.

Furthermore, it was suggested repeatedly that the most valuable work would come from exploration of our “fantasies” with respect to the case. This required “flights of imagination”;<sup>3</sup> a leap of faith that required us to imagine a patient’s broader life and life history. I often found myself intensely uncomfortable when asked to speculate on what history or motivation could drive a person to behave in a certain way. I felt frustrated by the limits of the information supplied and stymied by my desire to ensure my own personal experiences and projections weren’t creeping into my interpretation of events. Looking back, it seems impossible to think that I could have tried to circumvent any projections I may have brought to bear onto the work. Over time, I realised that I couldn’t subtract myself from the process and that maybe it wasn’t necessary to do so. At times, my fantasies were relevant, informative, and insightful; other times I’d reconsider my perspective in light of other more compelling contributions. Ultimately, I

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<sup>2</sup> Courtenay, MJF. (1992). A Plain Doctor’s Guide to Balint Work. *Journal of Balint Society*, 59(2): 183-185.

<sup>3</sup> Kulp, B. and Sternlieb, J. (2016). *Burnout, Balint Group, and New Beginnings: Unearthing the Next Step to Optimizing Triple Aim*. Poster presented at LVHN Research Scholar Program Poster Session, Lehigh Valley Health Network, PA.

concluded that to step into someone else's experience, I had to extrapolate, at least to some extent, from my own.

Over time, I felt there was a deeper understanding, both individually and collectively, of the requirement to fully inhabit the role of the actors in the scene by imagining what they might feel and experience. As we gave ourselves permission to go with our instincts, fantasies and feelings, the whole group came alive. There was a noticeable shift in the energy of the group. It felt less clunky, cerebral, intellectualised and effortful, yet paradoxically far more real. It seemed easier to speculate, unravel personality differences, motivations and upbringing when I no longer felt tied to getting it right. There was often a specific point in each case, where a feeling, an image or a fantasy would be contributed, and I could feel a tangible upswing in the engagement and energy of the group. It wasn't so much that we'd cracked the case, but rather that one of our fantasies had a certain resonance to it, or that there was some joy or satisfaction in making a connection no matter how seemingly small, about an interaction that had been previously unresolved.

This process required a degree of disinhibition and courage and I appreciated the honesty and willingness of our group in divulging all the stark and uncomfortable aspects of cases and our personal reactions to them. In the beginning I was perturbed by constant reminders to use the word "I" but over time realised that this had two effects. It ensured I spoke for myself and therefore owned my own experiences. Secondly, this holding of my own experience surprisingly made me feel more confident about it as I didn't need to put it forward tentatively not knowing if it applied to others or had their approval. Furthermore, I hadn't considered how using "we" exerted a subtle effect. Over time I found myself resisting it as it didn't always apply to me. This was described as the "collectivising" of a group experience and using the word "I" promoted specific and idiosyncratic responses to the source material and allowed for the uniqueness

of different positions to emerge. This was key as these discordant voices were often those that radically altered my understanding of a case or shed light on something that had previously eluded us.

Another aspect of this willingness to engage with the uncertainty of the process was receptivity and openness to feelings, imagery, metaphors and analogies which arose. For me these explained the essence of cases far more holistically than debating why a situation was jarring or difficult. I realised that much of my information came from the physical experience in my body which told me something about the possible feelings that were present at the time e.g. when a presenter described working with a patient she felt manipulated by, I felt trapped in the room. In one of the cases the facilitators pointed out that the pace of contributions seemed defensive, as if we were avoiding getting too stuck into the feelings and experience of the case. I realised this mania and chaos reflected the case, where a patient, relative, doctor and student were trying to work through a long incomprehensible list of clinical complaints using a scatter gun approach, seemingly to little avail. These experiences highlighted how what happens in the group often reflects the experience of the case, and also that I could use my physical experience and the feelings in the room, both proactively and retrospectively, to understand a case.

I also found imagery immensely helpful in making a sense of experiences I had struggled with. In a case I brought I had felt disturbed by an interaction between a patient and a doctor. I described the doctor as a fairy, batting cases away with a lightness of touch I both envied and distrusted. Exploring this imagery enabled me to get a better grasp of the case and my disquiet, and also helped others in my group to visualise my experience to help me work through it. This openness to playfulness meant that sometimes the left field view, metaphor or analogy was the key to energising or redirecting the discussion e.g. a complex case with an abusive patient made much more sense when we considered it as a stage

performance, with curtains, an audience and various actors playing different characters at different times. Although these ideas seemed wacky and eccentric, they deepened our understanding of the case as well as enabling us to see the humour in it, painting a picture that we could explore, build or reject to get under the skin of a case.

This process highlighted the merits of multiplicity; although affirming the commonality of experience was reassuring and validating, the diversity of the group meant that there were a myriad of perspectives and possibilities brought to light in considering cases. Before Balint, I used to take solace in the idea of our similarity. However, in many cases, hearing the contributions of those who saw it differently resonated better than my initial impressions of a situation and I found myself learning more from these alternative perspectives e.g. understanding the pressures on a surgeon in a case, or re-evaluating my potential contribution as a medical student. I found that over the course of a discussion my reactions changed to a case; not because I had adopted another person's perspective, but more that through the evolution of the discussion I had a different feeling about the individuals and the situation, or perhaps a more rounded one.

### **Confronting my biases**

For me, the diversity of perspectives was instrumental in challenging some of the most firmly held assumptions I had that were potential barriers to effective practice with patients. I realised in presenting a case to the group that my own biases had come into play in my struggle to relate to a patient with a needle phobia. The group's exploration of the case made me appreciate the myriad of reasons that may have caused the patient to be fearful and to present late, and the possible reasons for the less instrumental approach taken by the doctor. This made me reflect on the nature of the interaction and how doctors have to meet patients where they are at and manage their own state consistently to be able to do so. I had worried about

the requirement for constant adaptation to different patients, but I realised during the evolution of our discussion that it's possible to do this and still be authentic; that these connections are just as meaningful despite the absence of any assurance of sustaining them. This case made me explore my ambivalence about this work and also some of the unconscious biases I had about a style that was different to my own.

Related to this, much of the discussion in Balint gave rise to reflections on what constitutes a "good doctor". In describing a case that involved two consultants with opposing styles, I had erroneously assumed that the more affable doctor was the most competent one, more able to build a rapport with the patient and elicit relevant information. It was a reminder of my bias in preferring doctors with a style similar to my own and accrediting competency accordingly, and that there are likely multiple approaches and personality types that can all work effectively.

This theme recurred during Balint and I noticed that many of the cases involved narratives where doctors had demonstrated disregard for patients, sometimes even seeming callous in their approach e.g. disregarding the emotional aspects of an attempted suicide presentation or reminding a terminally ill patient they are the cause through their lifestyle choices. Despite my initial anger, reflecting on these cases with others enabled me to understand the feelings and experiences driving the doctors in these situations. Despite not condoning their behaviour, I could appreciate the frustration, the desire to have patients take ownership for aspects of their health that could affect change, a sense of weariness after years of similar cases, the desire to focus on whatever pragmatic actions may yield guaranteed results, as well as the undeniable experience of holding ultimate responsibility for decisions pertaining to patients' treatment and case management. In one case a participant described her fantasy regarding a surgeon called to assess a surgical patient who was acutely unwell. She explained how a degree of self-

protectiveness may be required; how a surgeon literally has their hands in the patient's body, and while consciously they may know that there are many reasons why patients don't recover, ultimately surgeons must feel a great deal of this onus of responsibility. If surgeons see countless patients daily, perhaps they can't afford to worry about every last outcome, otherwise it would be impossible to do the job. I realised that this is not so much about detachment as about having boundaries, and this explanation radically altered my perception of the surgeon's approach to the case.

Another aspect that was reflected on was the experience of the patient. The Balint experience brought home to me that when we hear patients' medical histories, we are hearing their stories too and that there is something quite intimate about this. These interactions though brief, inevitably constitute part of the therapeutic process. Part of our role in treating patients is to do what we can to restore them to equilibrium, and also as health professionals, to hear the impact of that loss of equilibrium on their lives.

This raises the question of what treatment is and the concept of the therapeutic contract. I realised that there are both explicit and tacit expectations embedded in the therapeutic contract; that we give patients time, privacy and protect their interests. Similarly, we expect patients to have treatable conditions and instances where this isn't the case, for example, a functional disorder, can be far more difficult to negotiate and may bring up our biases or helplessness in not being able to effect any change. That unidentifiable yet palpable connection that happens between patients and doctors or students feels like the key thing that makes that encounter successful and examples of profound connections described by participants made me question the limits of my influence as a medical student.

### **Reflections on being a medical student**

One case brought by a presenter described how his rapport with a patient was scuppered due to the presence of the patient's parents. This gave rise to discussions about the contribution of medical students and the extent to which we can assert our boundaries. This reminded me of previous situations where my perception of my lack of knowledge and status prevented me from asserting myself or requesting support, despite knowing that when I do ask for help the learning has been tremendous. Thus, my sense of my own insignificance has been disempowering, causing me to subjugate my needs and disregard the contribution I make. I realised that my perception of my own significance tips far more than just one case, it influences and shapes multiple interactions that can determine both my learning and the formation of effective and authentic relationships with others.

Related to this conversation around boundaries and needs, I realised that its permissible to dislike patients, uncomfortable as this may be. A case of a patient with a conversion disorder brought home the frustration I've felt when I couldn't relate to a patient or get a clerking on track. This reminded me how obstructive my own high standards can be and how my expectations of perfectionism permeate not just my own experience but my interactions with others, and how sometimes I need to be more accepting of mistakes and inexperience, and courageous in seeking support.

One case we explored involved an attempted suicide which the doctor addressed in an entirely detached and pragmatic manner. The presenter felt prevented from connecting with the patient due to the doctor's approach. This case highlighted the extent to which I feel I can be authentic with patients. On my GP placement I rotated across 11 doctors and noticed that I often mirrored the relationship the doctor had with the patient i.e. exhibiting friendliness or a more formal approach depending on the style of the doctor. I felt to behave differently would be inappropriate or an invasion of the doctor's relationship with their

patient. This could be quite disempowering and listening to the approaches of others I realised this experience was not entirely universal, but might be a matter of perception and the indelible sense of hierarchies which pervade all clinical environments and are at best implicitly sensed and at worst explicitly reinforced. I realised that perhaps there is a middle ground; interacting with the patient but maintaining an awareness and respect for the primary relationship between the doctor and the patient.

### **Vulnerability and safety in practice**

A key realisation in the Balint group was that the learning required a degree of openness and vulnerability and this vulnerability could be safely held by the group and the facilitators. Part of the benefit of Balint was not having to pretend to be impervious to all our experiences with patients, particularly the emotional aspects of the work which could be moving, painful, difficult or scary. In one of the cases the presenter described a very profound connection with a patient that left her feeling the need to conceal her emotional reaction to the experience. It reminded me of a similar experience with a terminally ill patient and I was left considering the degree of vulnerability allowed or disallowed in clinical environments, where issues of life and death are encountered daily. It showed me how sometimes strength can lie in vulnerability as it enables me to be open and connect with others, and also of the importance of having a safe place to process such experiences.

### **Conclusion**

The benefits of my Balint experience were far reaching; supporting me in grappling with difficult cases and generating explanations that allowed for a deeper and more compelling understanding of the agendas of doctors, patients and medical students, and the dynamics underpinning these relationships. The differing perspectives challenged many assumptions and biases I was unaware of, including

an appreciation of styles different from my own, an acknowledgment of the value of my contribution as a medical student, and my indisputable right to boundaries and support. The experience gave me insight into why I've experienced seemingly innocuous interactions as challenging for reasons not fully understood or openly navigated. There was also an acknowledgement of the power I hold when I'm attuned, and how sometimes seemingly inconsequential actions, such as truly connecting with a patient, potentially make all the difference; a sense that although treatment includes the use of medication, the actions associated with its management go far beyond it.

All of this was aided by the inductive nature of the process in Balint. Here there were no clear diagnoses or treatment plans, and learning to use patterns, connections and insights from the case material enabled me to understand experiences at an unconscious level <sup>4</sup>. I found it liberating that energy was less invested in figuring out what was right and wrong about the case, but rather the feelings and motivations that underpinned the actions and reactions of the different players. I felt this approach brought a case to life and I found it liberating to engage aspects of myself not usually mobilised, relying on instincts, feelings, fantasies, and metaphors to get beneath the thin veneer of explanations I had reverted to at the outset. This process gave me an insight into how to access and use my feelings in a more constructive way; without being steeped in emotions and using them to usurp reason, but rather as a reminder to check in with myself and reflect, an approach for managing vulnerability constructively and navigating the inevitable difficulties, joys and challenges inherent in the doctor-patient relationship.

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<sup>4</sup> Suzuki, S. (1970.) *Zen Mind, Beginner's Mind*. New York: Weatherhill.

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## **A Reflective Account: Understanding the Psychological Challenges of Medical Practice**

Balint Society Essay Prize 2020 Joint Winner - Student

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Reflection is a critical component of the continuous professional development which is required in the medical field. Balint groups provide an informal but protected environment in which affecting patient encounters can be explored, analysed and examined collaboratively. They not only provide an opportunity to gain a deeper appreciation for the complexities of the medical student-patient relationship, they also provide a medium in which thoughts and feelings can be discussed openly and honestly. This essay focuses on an encounter I had during a home visit with a general practitioner (GP) which was particularly difficult. It will explore the challenges I experienced during and after the interaction, the discussion the encounter stimulated within the Balint group, what I have learnt about myself and what I will take forward with me after this experience.

My case involved a 54-year-old gentleman, who was morbidly obese, a smoker and had an amputated leg. The patient was suffering from chronic obstructive pulmonary disorder (COPD), high blood pressure and had been recently admitted to hospital due to difficulties breathing and haemoptysis. His chest x-ray revealed a large pleural effusion, due to a suspected malignancy, and he was referred onto the two-week suspected cancer pathway by the hospital doctors and discharged. However, the patient had not been informed in the hospital what the referral was for nor the suspicion of lung cancer. Thus, the GP had to elicit what the patient understood, break the bad news to him as well as take a brief history and examine him.

On entering the patient's room, there was a strong smell of cigarettes. The patient, laying in his bed, appeared apathetic. I immediately felt nauseous and uncomfortable as I have always found the smell of cigarettes intolerable. Already, I established there was a barrier between the patient and myself. I could not focus

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<sup>1</sup> Vikram Kohli is a medical student at GKT School of Medicine, Faculty of Life Sciences and Medicine, King's College London.

on anything other than the smell of tobacco and found the experience quite overwhelming. On deeper reflection, I realised the response may be in part due to members of my own family who smoke regularly. My family members are aware of how sick I feel when I smell cigarettes thus they do not smoke around me. However, despite multiple attempts to encourage and support them in quitting, for various reasons they return to their smoking habit, which I find extremely challenging to accept as a medical student, due to the damage I know they are causing to themselves.

On reflection, I appreciate that the visceral reaction and feeling of repulsion and nausea may not just have been due to the smell itself, but at least partially evoked by my own personal aversion to my family's consumption of tobacco. It reminds me of a scenario in which I have not been able to use the knowledge I have to change damaging health behaviours within my own family. Not only has this made me conscious of a personal bias, it has also taught me that while a clinician has the unique opportunity of impacting the health of patients positively, this does not necessarily mean they will always have the same success within their own family. This disparity between me as a medical student and me as a person is both interesting and challenging, with often the line between the two becoming blurred. It has highlighted to me that being a medical student comes with certain responsibilities and privileges, which I as a family member do not have.

A significant proportion of the consultation involved the patient expressing anger about the care received from doctors, blaming them for the condition he found himself in. The GP later confirmed that on numerous occasions, she and the healthcare team had tried to support him in quitting smoking, but he had never been receptive to the support. The patient was diagnosed with COPD fifteen years ago and was made well aware of the strong link between smoking and lung cancer. I found it frustrating that he chose blame, rather than gratitude as a response to

healthcare professionals who were trying to help and absolved himself of responsibility for his plight.

Frustration is not an emotion I have experienced often during clinical contact, however, on reflection I have realised it was not the patient's dissatisfaction with his care that I found difficult to witness, but rather the manner in which the doctors were discussed. Transitioning from pre-clinical to clinical medicine has exposed me to the admirable work-ethic of doctors and seeing them belittled by this patient evoked an almost child-like defensive response, where I felt the need to not only defend but to remind the patient of how fortunate we are to receive such care. However, I was able to put aside rather than voice these feelings to the patient because I did not want to affect how I behaved with the patient clinically.

This stimulated much discussion in the group and an interesting point raised was that perhaps the patient's shame and embarrassment with himself and how far his health had spiralled out of control was manifesting as anger towards the doctors. This interesting viewpoint made me consider the possibility that blaming the doctors could be a coping mechanism for the patient, and rather than being frustrated by the response, a clinician should provide an opportunity for patients to voice such thoughts, as vocalising them may be somewhat therapeutic for the patient. Moreover, as a future doctor, I should encourage and be receptive to direct feedback from patients, even if it reflects who they are as a person as much as it does the professionals working with them, as this is key to improving the medical profession and maintaining the sacred trust that exists between the public and doctors. However, criticism should be given in a constructive manner, which does not demean or denigrate the character of particular healthcare professionals.

The feeling of frustration also arose from how preventable the lung cancer was. Interacting with a patient with a challenging diagnosis like lung cancer, I was acutely aware of the possible alternative outcome if this patient had stopped smoking. I think all clinicians find the myriad of 'what ifs' challenging. The group

explored our natural tendency as medical students to look for self-imposed damaging health behaviours, which are risk factors for the diagnosis the patient is presenting with. On closer reflection, I have realised an inclination in me to try and elucidate the cause of a condition and contributory risk-factors, due to the manner in which pathology has been taught to me. There is a strange kind of comfort in thinking that life is not completely unfair, rather patients have contributed to their own pathological states. The group also discussed how we are pre-disposed to absolve the doctor of responsibility and shift the blame onto the patient for their condition. It was fascinating to observe the blame being shifted between doctor and patient, by each party to the other respectively. It highlighted to me the complexities of medical practice and how the manner in which pathology has been taught to me has had an integral impact on the way in which I view patients.

A poignant moment during the history was when the patient said, 'I might stop smoking now', creating a sudden change in atmosphere. Being aware that the diagnosis of lung cancer was almost certain, and that the patient's life expectancy was no more than a year, this moment evoked both sadness and cynicism in me. The cynicism resulted from both the timing of his desire to quit smoking, when it would have very little impact on his condition, and doubting whether the patient would actually quit this time. The patient's candid admission exposed a vulnerability which I found saddening and touching. The look in the patient's eyes and disappointment with himself in his voice as he spoke about quitting lead me to realise both how hopeless and helpless this man truly was. One member in the group remarked that perhaps admitting he needed to stop smoking was an open confession to himself and the doctor that something was seriously wrong. This has taught me the value of non-verbal communication and how there are two concurrent streams of communication running between a doctor and a patient: the first being verbal communication, and the second being an unspoken dialogue, which neither party is truly conscious of, in which raw emotions are being

expressed. Being able to differentiate between the two but to also acknowledge both streams of communication leads to greater patient satisfaction and allows a fuller appreciation for the psychosocial issues surrounding a patient.

As mentioned previously, this patient was morbidly obese. This created an immediate connection between me and the patient because I was overweight for the majority of my high-school years and obese during sixth form. Although, now I maintain a healthy weight, I have a unique appreciation for the manner in which obese people are demonised by society. There is a widely held belief in society that obesity is a self-created problem and the simple 'eat less, move more' motto is the solution. From my own personal experience, I know this simplistic view of obesity to be incorrect. It is a chronically underappreciated fact that obesity is as much a psychological condition as it is a physical state. Interestingly, group members stated that describing the patient as obese contributed to a negative image of the patient and perhaps made it more difficult for them to empathise with the patient due to his weight. This further reinforced to me how poorly obesity is understood on a psychological and emotional level by clinicians and society as a whole, as well as highlighting to me the negative connotations surrounding obesity.

The negative image arises from the idea that obesity is self-inflicted, thus patients are not entitled to the empathy and considerations a person in the 'sick role' normally receives. For me, as opposed to acting as a barrier to empathising with the patient, his weight engendered empathy and a deeper understanding of an aspect of his life. I have realised due to this, that my own personal struggle with my weight will be a positive tool that I can use to build rapport with and help both patients and fellow clinicians. On further reflection, I found it interesting to see how my approach to the patient's obesity was in complete contrast to how I thought of his smoking habit. This exemplified to me my biases and made me reflect on the reasons patients smoke and the difficulties faced when attempting to quit.

Reflection has given me a greater level of consciousness of my personal biases and I believe this will prove hugely beneficial to me as a future clinician.

Throughout the consultation, I felt a multitude of emotions, but I explained to the group that it would be unprofessional to express certain feelings. This stimulated discussion amongst group members regarding what thoughts and feelings are appropriate to share with a patient. There was a consensus that doctors are performers and certain thoughts should be kept to oneself. Further exploring this, group members expressed that having a façade made them feel more comfortable during patient care and how the ability to 'perform' was beneficial for both patients and doctors. This led me to reflect on my own personal understanding of the nature of my current role and future role as a clinician. I have always viewed medicine as both an art and a science and I have found that whilst interacting with patients, I am playing the role of a medical student. Being able to have a barrier both helps me to deal with the level of suffering I am exposed to on a regular basis and also to cope with what I experience internally whilst fulfilling the demands of my role.

There was much dialogue about whether having a barrier causes authenticity to be lost in patient interactions. On reflection, I believe that my professional demeanour does not detract from the authenticity of the interaction. As human beings, albeit unconsciously, we behave differently with different people in our lives: our friends, family, work colleagues and patients. I have genuine conversations with patients, however, it is another aspect of my personality which I bring to the fore during these interactions. When faced with situations that are particularly meaningful to us, or hook childhood memories, the struggle is to remain in the moment as a professional. Moreover, the medical student-patient interaction is an honest but professional relationship and I think it is entirely appropriate to remain conscious of this during consultations. I am of the

view that professionalism and authenticity are not at odds, rather they are congruent with one another, each aiding the other in patient consultations.

This led to a wider discussion about how refreshing it is to see doctors talk openly with us. After the consultation concluded, I discussed with the doctor how emotionally challenging the experience was as well as how trivial yet poignant I found his admission that he would now like to quit smoking. The doctor echoed my thoughts and I found it almost relieving to know a practising clinician, with years of experience, felt emotions similar to my own. I found the honesty and openness of the interaction between us uplifting. My relief was a result of the realisation that doctors do, to a certain extent, perform in front of patients and that despite the doctor having years more experience than me we both shared a common human emotional response. It provided a degree of validation to my feelings and allowed me to relate to the doctor both in her role as a clinician and as a person with innate emotional responses. This has taught me the importance of engaging in open and frank conversations with my colleagues to work through feelings rather than keeping these to myself.

One of the reasons for accompanying the GP on this visit was to observe her breaking bad news. I was rather surprised by the subtlety with which the matter was discussed. The doctor elicited what the patient knew, and the patient remarked 'I know something is very wrong with my lungs'. She explained to the patient that he had a two-week referral and the need for further testing, however, at no point did she mention the word cancer. I was astonished at the hesitancy of the doctor to mention the word 'cancer', especially when there was a very high probability of this diagnosis. I discussed this with the doctor after the consultation, and she explained to me that there was not a lot that could be done anyway and thus she did not see any advantage to explaining the strong suspicion.

This hesitancy both in the hospital doctors and the GP to openly discuss their suspicion lead me to reflect. I felt as though each person was passing the buck

forward and did not want to be the one to use the word cancer. It exposed to me a more vulnerable side in the clinicians which I found humbling and deeply revealing. Their desire to not be the doctor who mentions the potential diagnosis seemed to be because they were fearful of the response this might elicit from the patient. Moreover, witnessing practising clinicians struggling with certain aspects of patient care helped to remove this image of doctors as perfect people who have no weaknesses. This helped instil confidence in me and also relieved the burden I have felt of trying to be the infallible medical student. In future, I will take into account the anxiety in giving a certain diagnosis due to fear of the patient's reaction, however, I will endeavour to place the patient's needs first and accept the bitter truth that sometimes you just need to have the courage and be the one to do it. It has also occurred to me, on reflection, that giving bad news to someone less directly may be the final opportunity for the individual to make a clear connection between their actions and their condition.

To conclude, reflection in the Balint groups has been hugely beneficial to me for a number of reasons. It has not only provided me with a safe forum in which to discuss and explore my own thoughts and feelings, it has facilitated honest and illuminating conversations with fellow medical students, which have enriched and broadened my perspectives on the cases presented. Reflection has given me a greater level of awareness about my own innate emotional responses to situations, and I strongly believe this consciousness will be useful in future patient interactions. In particular, the manner in which both the patient's smoking habit and obesity elicited strong yet opposing responses was both unexpected and thought-provoking. This has armed me with a greater understanding of how my own past and current life experiences have shaped the person I am and the clinician I will be. I have had the opportunity to gain a greater appreciation for medicine as an art and learnt that being a doctor requires elements of performance, however, the performance aspect need not detract from the authenticity of the interaction. I

have observed both individual strengths and weaknesses of clinicians which has aided me in abandoning this notion of doctors as flawless individuals, rather I have realised that we are all on a journey of continuous professional development.

In fact, lifelong learning, continuous development of our ability to interact with patients and a capability to acknowledge honestly our limitations are the very essence of the joy of studying and practising medicine. As I continue my journey through medicine, I am going to incorporate a greater degree of reflection into both my consultations with patients, as well as the thoughts and feelings the interactions provoked in me. Ultimately, I have realised that reflection is the foundation upon which lifelong professional development rests.

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

## **‘The Others’: A Poem by Rosalie Cattermole<sup>1</sup>**

Balint Society Essay Submission Entry 2020 - Student

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## The Others

“You have cancer”.

But what about the others

My son

My brother

My Husband

My mother

How are they?

“It is untreatable”

But what about the others

How shall I treat *them*?

Don't tell them

Do tell them

I'm worried about them

“We cannot operate”

But how will *they* operate?

If I tell them the truth

How will they cope?

Just when they need me

I can't need them.

“We are aiming for comfort”

But I have such discomfort

Do I have to tell them?

I'm treating *them* for comfort

I'll wait a bit longer

"You have weeks to live"

Weeks to tell the others

I'm already a burden

My son's too sensitive

I'm hiding my pain

"You're in the hospice now"

Where are they?

I'm ready to die

But what about them?

"What about you?"

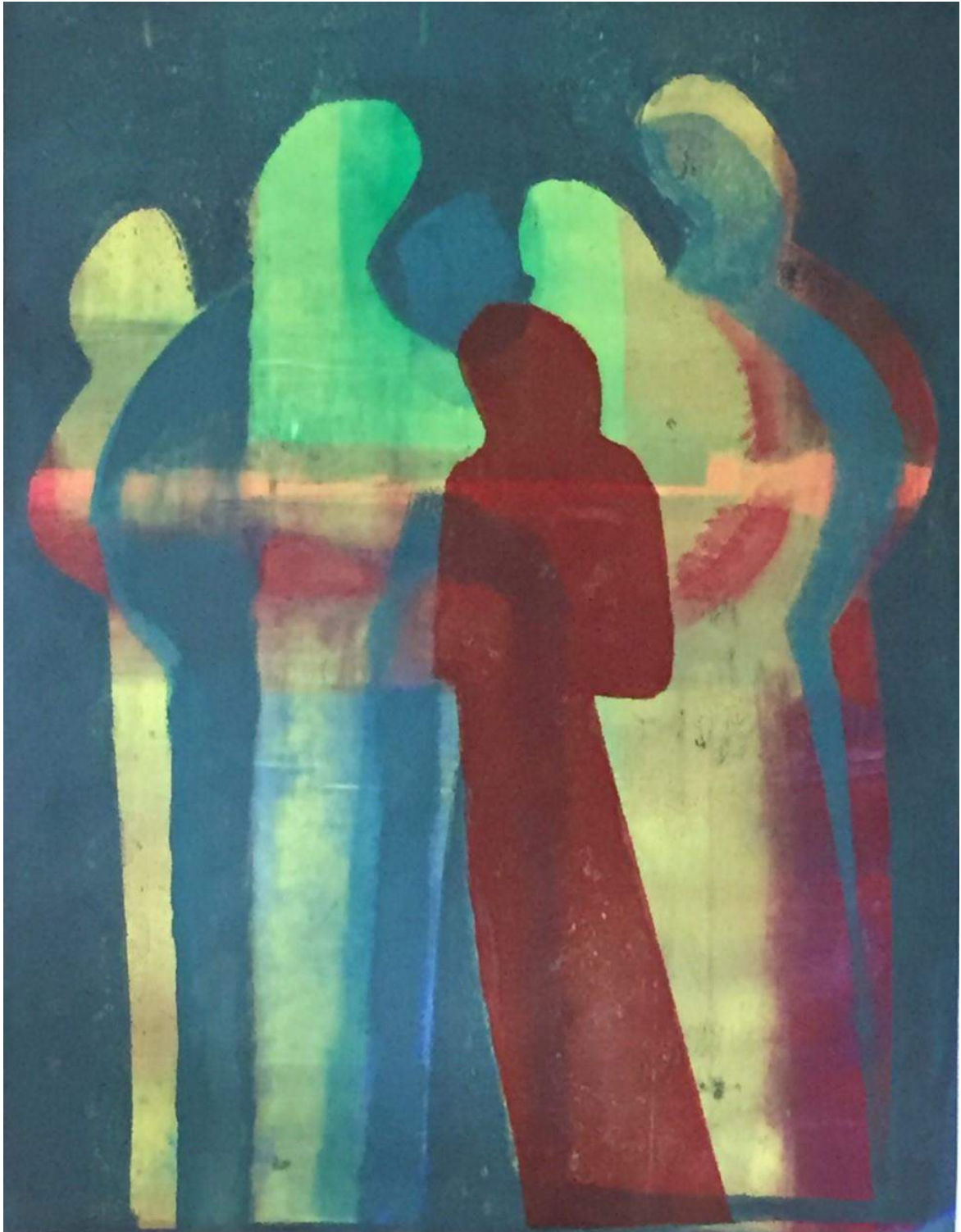
What about me?

I forgot about me

I was worried about them

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Rosalie Cattermole, Final year medical student from Leicester Medical School. About to undertake Academic Foundation Programme in Cellular Pathology in London. She wrote this poem during her 4<sup>th</sup> year Cancer Care block where she found it so important to consider the emotional impact of Cancer. Interested in Paediatrics, and especially the impact of the Doctor-Family relationship in Child Safeguarding.



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Artwork by Penny Elder.

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JOURNAL OF THE BALINT SOCIETY, VOLUME 48, ISSUE 1, FEBRUARY 2021

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

Opening Address at the 21<sup>st</sup> International Balint Federation Conference

Andrew Elder<sup>1</sup>

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**Opening address at the 21st International Balint Federation conference 'Seeing Medicine through other eyes' Porto, Portugal, September 2019**

*'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 21<sup>st</sup> International Balint Conference to give an opening talk on the subject of the conference – Balint: seeing medicine through other eyes.<sup>1</sup> 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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<sup>1</sup> Andrew Elder was an Inner London GP (1972-2008). Honorary Academic Staff Tavistock and Portman NHS Foundation Trust. Balint Group leader. Past President Balint Society (UK) and Co-ordinator of International Balint Federation (IBF) Leadership Taskforce for its first six years. Awarded Honorary Doctorate (2017) for work in primary care and mental health.

I discovered was the scientific method by which the unconscious can be studied'.<sup>2</sup>

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*<sup>3</sup> 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.<sup>4</sup> 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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<sup>2</sup> 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.

<sup>3</sup> Balint, M. (1957). *The Doctor, his Patient and the Illness*. London: Pitman Publishing Ltd.

<sup>4</sup> 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’.<sup>5</sup>

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’.<sup>6</sup> 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<sup>6</sup>**

*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*

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<sup>5</sup> Courtenay, M. (2007). The doctor, the genius and his illness. *Proceedings of the 15<sup>th</sup> International Balint Congress* (Lisbon).

<sup>6</sup> 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 Sacks was surely right when he wrote, in his great masterpiece *Awakenings*<sup>7</sup>: '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

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<sup>7</sup> 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*<sup>8</sup>, 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.

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<sup>8</sup> 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.<sup>9</sup> 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

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<sup>9</sup> 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*<sup>10</sup>, 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

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<sup>10</sup> 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'<sup>11</sup> 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*

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<sup>11</sup> 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.'*<sup>12</sup>

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.'*<sup>13</sup>

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,*

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<sup>12</sup> Rovelli, C. (2018). *The Order of Time* London: Penguin.

<sup>13</sup> 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 <sup>6</sup> 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.<sup>14</sup>

'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*'.<sup>14</sup> 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

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<sup>14</sup> McWhinney, I. (1998). The physician as healer: the legacy of Michael Balint. *Proceedings of 11<sup>th</sup> 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).<sup>15</sup>

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,

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<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup> 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

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<sup>16</sup> 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: 19th International Balint Congress (Metz).

<sup>17</sup> 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 21<sup>st</sup> 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.*

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## **The Balint Experience in Iran**

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I dreamt<sup>1</sup> that I am in a cemetery sitting over my father's grave. Father has been sleeping under mounds of earth for many years now. The inscription on the cold gravestone reads, "Death due to Corona!". Mehrnaz is sitting by my side reading me the message she has brought from Dr Brown. Next to the grave I see the certificate for Balint Group work marked "excellent" and signed by several teachers. I wondered to myself why Dr Brown's name, who was my supervisor, is missing. On waking, the death of my father and Corona come to my mind. These days coronavirus is playing the trumpet of death and its terrifying shadow is cast over the world. The death of my father confronts me with my own death. My own death and the end of the Balint Group I have been running for 6 months. The dream links these two together. As if, the certificate, not bearing the name of Dr Brown, brings to my mind something I need to do: in the face of the existential anxiety aroused by the ending of the group, I begin writing.

The announcement for the Balint group workshops in the Razei Hospital three years ago, attended by Dr Ray Brown and Mrs Mehrnaz Shahabi, introduced me to the unfamiliar word, "Balint". In a Google search, I found that Balint group work was first introduced in 1950 by Michael Balint in Britain. After a 70-year journey, it has reached the borders of my country. After such a long journey, it is either tired and worn out, or more complete and mature. The two-day Balint workshops and groups in the Razi Hospital (a psychiatric hospital in the south of Tehran) were very well attended and received by varied therapeutic disciplines – psychiatrists, psychiatric trainees, psychologists, nurses, psychotherapists and social workers. It felt like getting into a pool where one has to learn how to swim by swimming. In the four groups which were held, I had the opportunity to have

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the experiences of being observer, group member, case presenter and group leader. Amongst these, the role of the presenter was a unique experience for me. With my chair pushed back, I observed my presentation of a case being responded to, interacted with and absorbed by the group members, and with that, of course, parts of my own self. Feelings one by one emerged and reached the level of my awareness. The group exploration and fantasies of my feelings towards the patient was possible to bear because of the sense of safety I experienced, because I felt looked after and supported by the group leaders, and indeed the group. In speaking about my relationship with my patients, I felt a type of development which I think of as similar to the "Aha experience" described by Alfred Adler.

After this workshop, I co-led a group with Dr Mansoureh Kiani-Dehkordi (psychiatrist) for psychiatric nurses, which ran for one year. The nurses' prevalent experience of suffering and stress in their profession continuously veered the group towards discussing general shared problems at work. The most valuable experiences I gained from co-leading this group were seeing the role of the leader in preventing the group from falling into discussing shared professional difficulties and redirecting it into exploring the specific patient-nurse relationships; and seeing the care to be taken in the composition of the group so as to avoid the nursing profession's hierarchical structure (the group was a mix of auxiliary, general, head nurse, and supervisor).

While I was in the process of running this group, I began to work on setting up a second group which was held in a suitable private facility outside the hospital. The attendees for this group worked independently of each other in different locations and had in common that they were all very experienced counsellors and mature women. The group structure then had some similarities to groups run for general practitioners as practiced by Michael Balint. The duration of the group was 90 minutes, held fortnightly, and by agreement from the start, ran for six months.

For the counsellors the Balint group work was a new experience. The group members began with the expectation of finding solutions, diagnoses and making judgements about optimum treatments. This was similar to my own attitude when I first began the Balint group work and in supervision. My group gradually caught on to the exploratory nature of Balint group work and the centrality of the emotional colouring and attitudes in the doctor-patient relationships. I understood that the first quality of a Balint group leader, after having made clear the particular guidelines and behavioural protocol, is patience and tolerance of the pressure from the group to arrive at or to receive a solution. I learnt the seemingly unrelated tunes that little by little come together and in the process of the group find a coordinated song and riverbed. As the group leader, after about 3 months, I no longer felt the same degree of anxiety arising from the pressure from the group members to provide solutions and supervision. I started observing a river flowing with the least intervention and facilitation on my part.

The supportive role of the group leader and the resultant feeling of safety in all group members, particularly the presenter, enabled freer self-revelation. I noted how attention to and understanding of the main theme of the group directs the leader's attention and focus on what the group is avoiding. I believe I acquired skills in mirroring the content and feelings; questioning and commenting on these enabled the group members to notice their avoidances. However, there were times that despite such interventions, avoidance persisted and, at these times, I experienced the anxiety that the group is moving away from its main task but an inner voice invited me to be patient and accept the current that the group had chosen. The queries, explorations, free associations, and personal revelations of group members were helpful to the presenter and also enabled the group members to face and experience their own values, feelings and needs in the group. I thought the group found its own shared current and idiom with the encouragement and

support of the group leader. What the group learnt from this experience was that we did not have to arrive at a correct answer, clear picture, or optimal solution. Here there is no optimal and finite answer getting full marks. Here there is no marking, no grading, and no perfect answer. What happens is an experience of somethings coming to light and some barriers lifted. Like the incidence of having got trapped in the lift with the group members just before starting the group and the familiar experience of claustrophobia which all of us have experienced at least once in our mothers' wombs. The shared claustrophobia in the lift stirred up fears and insecurities which was then reflected in the choice of the narrative by the presenter and her experience of claustrophobia in the relationship with her patient and her mother. This also impacted on my leading the group. In this session, I intervened and talked more than necessary. I was struggling to overcome the salient sense of claustrophobia in the group. I had got frightened!!! Why did the presenter choose this particular narrative? Balint provided an opportunity to experience a sense of freedom from the blockages of logic, rationalisation, and perfectionism. Dr Brown's voice echoes in my ear, completeness depends on the perspective; what might be right from one angle may not be so right from another. Maryam in the group who continuously hid behind logical explanations, offering diagnoses, and detailed exploration of facts, avoiding her spontaneous associations to have a say, provoked a confrontation in the group over logic versus feelings. With the supervision guidance from Dr Brown, she moved closer to and became more harmonious with the group.

Another necessary quality of a Balint group leader is compassion and empathy. Just as the personality of a doctor or therapist is the most important tool of treatment in the therapeutic relationship, so is the personality of the group leader the most important tool or technique in the facilitation and leading of the group. This fact is borne out by research evidence. The feed-back from the group members

at the end of the group was that what they viewed as my supportive and empathic qualities as a leader enabled and guided their experience of the emotional interaction with their patients. However, there was a conflict between one member and others in relation to the question of personal boundaries. She tended to focus on the diagnosis and treatment and was not sufficiently sensitive in relation to the presenter's privacy. Following repeated confrontations, in the fifth session, a change of behaviour occurred and the group became more unified in its work. Another group member though admittedly pleased with the positive impact of the group on her interactions with her patients, had been predominantly silent throughout.

The dream of the end of the Balint group under the supervision of Dr Brown led me to start writing about my Balint group experiences with the hope for my Balint group work to continue. "If we learn to die well, we learn to live well, and vice versa" and I hope that Balint group work will continue to live well in Iran.

### **Author Note**

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## **A Poem by Kai R Scott-Bridge<sup>1</sup>**

Balint Society Essay Submission Entry 2020 - Student

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Fifty-six diazepam  
Was not enough  
To shorten your lifespan  
By enough  
You sit and stare, deadpan  
Voice gruff  
Foot slough picking, thinking new plans

But I see you sad, angry man  
Not the drug seeker or hitman  
I see the fear in your eyes as they scan  
These visions of your own old man

But still you bite and steal,  
Reject meal, smoke spice and deny your foot to heal,  
Want to die, to stop living the lie  
That you're okay, that says 'I can'

In this I am the middleman  
Between you and your master plan  
Who wants to deal in better than  
What you want for yourself now

But me in my naivety  
Of youth and incredulity  
Had hopes that you'd not use and flee  
Flung as wide as those ward doors

As you ran, and so began, the long career as a mind medicine man

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Kai R Scott-Bridge is a 5th year medical student at the University of Sheffield, MA Cognitive Studies. Interested in integrating Balint and humanities into medical education; forever grateful to the patients who offer up their vivid experience to be penned.

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## **Reducing Doctor Burnout: A Qualitative Analysis of Some Junior Doctors' Experience of Participating in a Balint Group**

Monika Gorny<sup>1</sup>, Toby Stevens<sup>2</sup>, Lawrence Congdon<sup>3</sup>, and Amy Jebreel<sup>4</sup>

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## Introduction<sup>1</sup>

*'At the centre of medicine there is always a human relationship  
between a patient and a doctor'<sup>2</sup>*

Enid and Michael Balint developed the Balint Group in the 1950s, whereby General Practitioners were able to freely explore the counter-transference and general psychodynamic forces at work in the doctor-patient relationship. Since the publication of Michael Balint's *The Doctor his Patient and the Illness*<sup>2</sup> Balint groups have been established throughout the world and have become a staple of psychiatric training.

There is emerging evidence to suggest that Balint groups may contribute to medical students and doctors overcoming feelings of despair and isolation.<sup>3</sup> Balint groups may also encourage doctors to foster a greater understanding of emotional factors which encompass the patient's condition. Regular meetings of the group may help to develop compassion, empathy and improve communication skills.

A recent survey in 2018 by the General Medical Council found that a quarter of 70,000 doctors felt burnt out.<sup>4</sup> According to the findings, 63% of doctors felt worn out at the end of the day often or always and 49% found work emotionally exhausting, to a high or very high degree.<sup>5</sup>

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<sup>2</sup> Balint, M. (1957). *The doctor, his patient and the illness*. Oxford, England: International Universities Press.

<sup>3</sup> Sung, A. D., Collins, M. E., Smith, A. K., Sanders, A. M., Quinn, M. A., Block, S. D., & Arnold, R. M. (2008). Crying: Experiences and attitudes of third-year medical students and interns. *Teaching and Learning in Medicine*, 21: 180–187.

<sup>4</sup> General Medical Council. (2018). *Training Environments 2018: Key findings from the national training surveys*.

<sup>5</sup> General Medical Council. (2019). *The state of medical education and practice in the UK*.

Additionally, it was noted that 62% of doctors find it difficult to engage in reflective practice.<sup>5</sup>

It is hoped that increasing participation of junior doctors at Balint groups during Foundation training could help to reduce burn out.<sup>6</sup>

Balint groups have now been set up in a medical school in London, for medical students, and at a busy central London teaching hospital for Foundation Year 1 (FY1) doctors on their surgical placement. This paper's focus is the Balint Group for Surgical FY1s first set up by two psychiatrists in 2014.

### **Aims**

To explore the experience of the FY1 surgical doctors taking part in a 12 week Balint group, using pre and post feedback questionnaires, as well as the experience of the co-leaders facilitating it.

### **Methods**

#### *Structure of the Balint groups*

FY1 doctors at a busy central London teaching hospital, undertaking their placement in a branch of surgery (colorectal, upper gastrointestinal, breast, orthopaedic and gynaecology) were invited to take part in 13 weekly Balint group sessions; an introductory session, where the Balint group concept is being explained, and 12 full case discussions. Each lasted one hour. The reason surgical placements were chosen was to give all of the junior doctor FY1 cohort a chance to participate in a 6-12 person Balint group. The vast majority of the FY1 doctors undertake a 4-month placement in surgery as part of their first year of training as a doctor.

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<sup>6</sup> Kjeldmand, D. & Holmström, I. (2008) Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *Ann Fam Med*, 6(2): 138-145.

The group size facilitated cohesion, as, every week, various people were on annual leave, nights or zero days, meaning that the groups slightly varied in size from week to week. The group were informed that the first 3 sessions were compulsory but we would strongly encourage attendance for the entire 4-month period, to get the most from the experience.

The two Balint co-leaders were not Balint accredited, however, they were all Psychiatry trainees with previous experience of taking part in Balint groups. Each of the co-leaders co-led two consecutive groups. This meant that there was always one trainee who had experience in leading a group. All of the co-leaders took part in a leadership training day at St Pancras Hospital and were supervised regularly, every 3-4 weeks, by a Balint accredited supervisor.

The FY1s, who attended at least 50% of the Balint sessions, received a certificate.

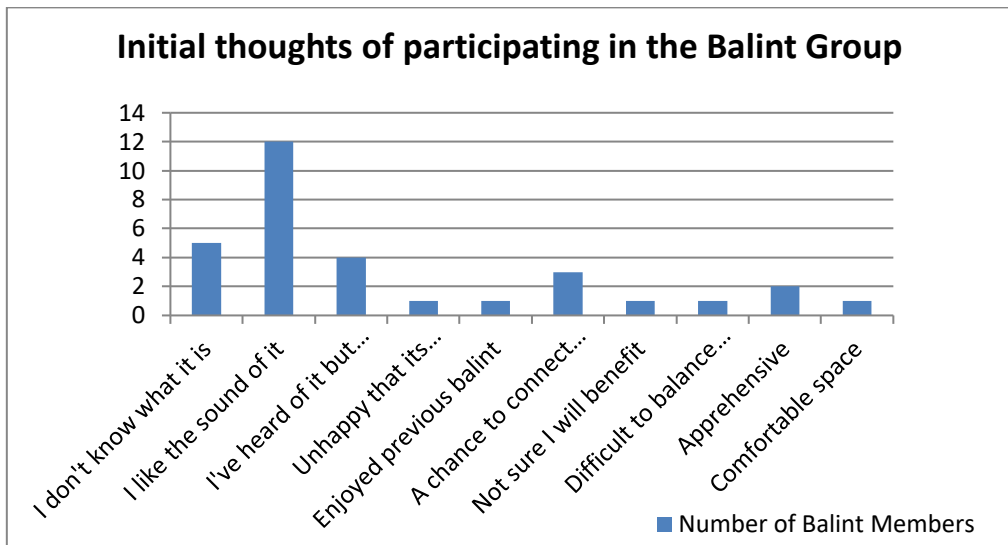
## **Materials**

Four consecutive cohorts of surgical FY1s (August 2018-November 2019) were chosen for the purpose of this study. Pre- and post-group questionnaires were handed out at the first and last sessions respectively. FY1s who weren't able to attend the last group were emailed the questionnaires. Both pre-group and post-group questionnaire contained 11 Likert scale type of questions. In addition the pre-group questionnaire also contained an open question and a multiple choice question and the post-group questionnaire contained 3 open questions and a further multiple choice one.

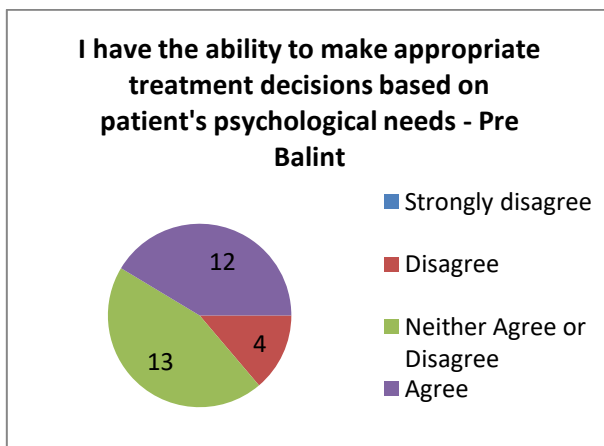
In total 29 of pre-group questionnaires and 14 of post-questionnaires were collected from the 32 participants of the above groups.

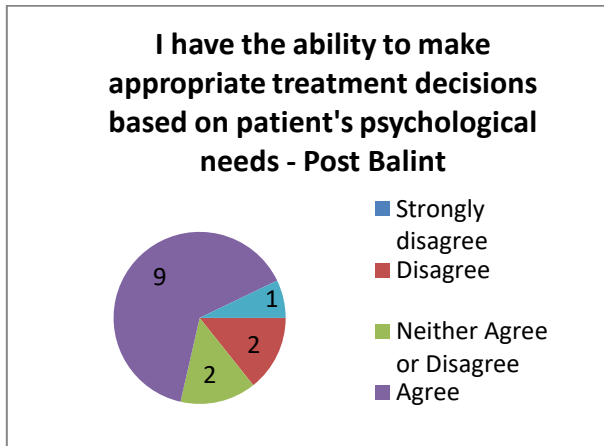
**Results**

Prior to starting with the Balint Groups only 4 out of the 29 questionnaire respondents had previously experienced a Balint Group and thus it was a new experience for 86% of the members. The group was split as to what their expectations of a Balint Group were. There were 15 positive responses, 11 responders who felt apprehensive or neutral and 3 who responded negatively.

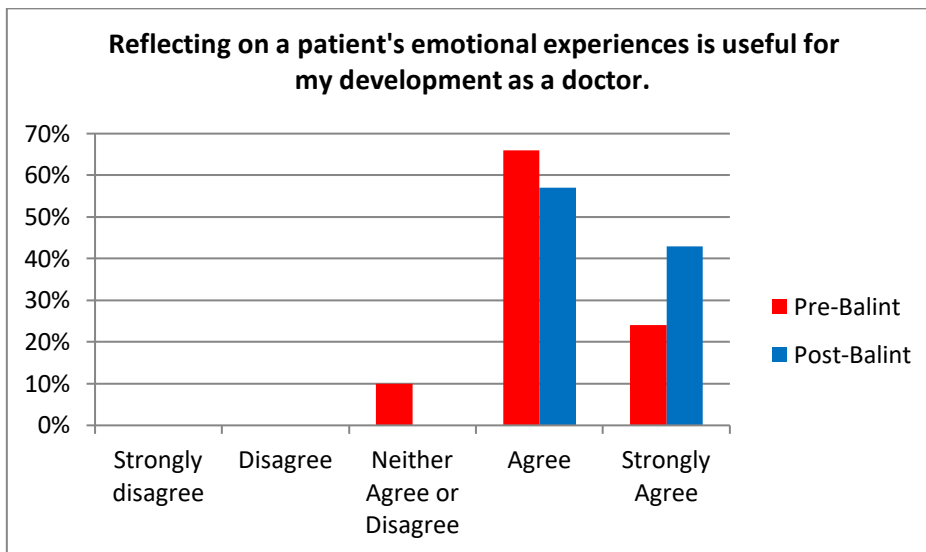


For the question of whether people felt they had that they had the ability to make appropriate treatment decision based on a patient’s psychological needs: In the pre-Balint feedback 4 (14%) disagreed, 13 (45%) neither agreed or disagreed whilst 12 (41%) agreed. In the post Balint feedback, a similar percentage 14% (2 members) felt that they still disagreed, however only 2 (14%) felt that they neither agreed or disagreed and 9 (64%) now felt that they agreed and 1 person (7%) strongly agreed.



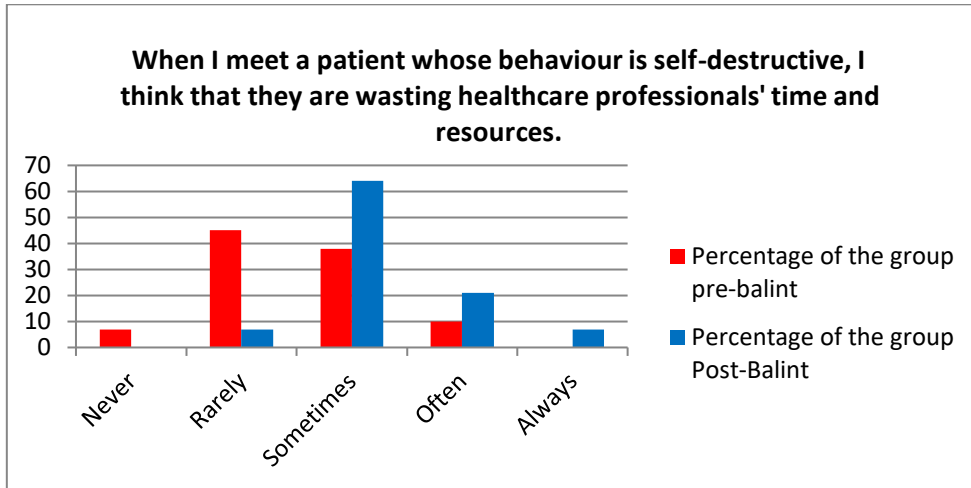


In the Post-Balint feedback more Balint members felt that reflecting on a patient's emotional experiences is useful for their development as a doctor. 100% either agreed or strongly agreed in the post-Balint questionnaire, with 43% (6) of those strongly agreeing. In the pre-Balint group 10% (3 members) neither agreed or disagreed with that statement and 24% (7) strongly agreed.

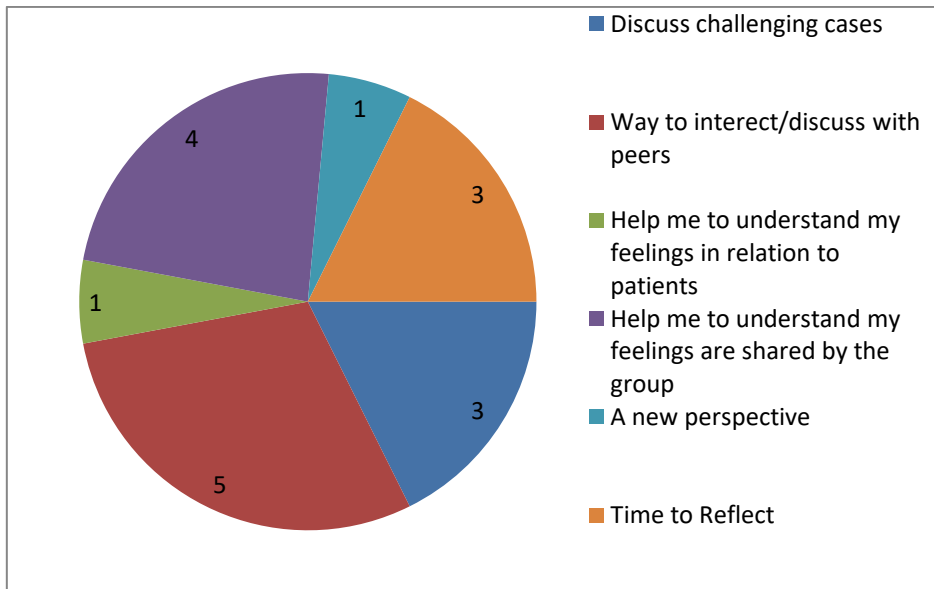


In the pre-questionnaire group 7% (2 members) of the group never thought that self-destructive behaviour wasted people's time and 45% (13 members) rarely thought that and only 10% (3 members) had that thought often and 0 people felt that they always thought that people were time-wasting. In the post-Balint questionnaire only 1 member (7%) rarely thought that a patient's self-destructive behaviour wasted health care professionals time. 64% of the group (9 members)

sometimes thought that and 21% (3 members) thought it often and 7% (1) always thought this.



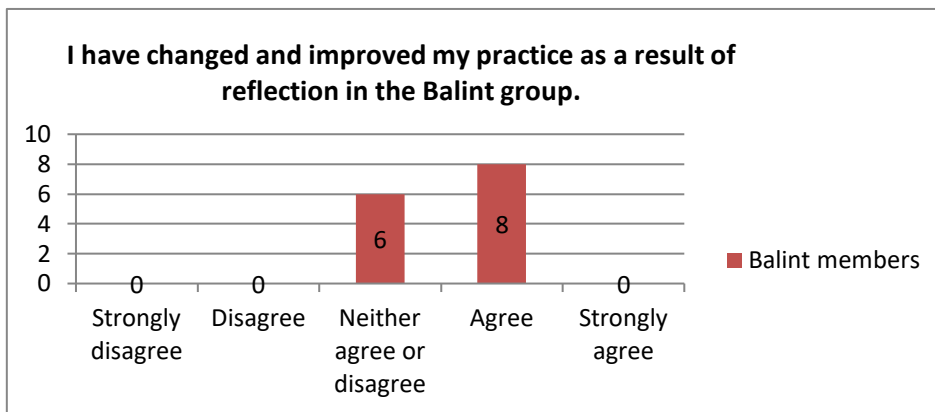
From our post-Balint feedback all 14 respondent would recommend Balint Groups to their peers. In terms of what they found most useful and some people responded more than once, the two most popular reasons were that people found that it was a good way to interact with their peers and to help them understand their feelings are shared by the group.



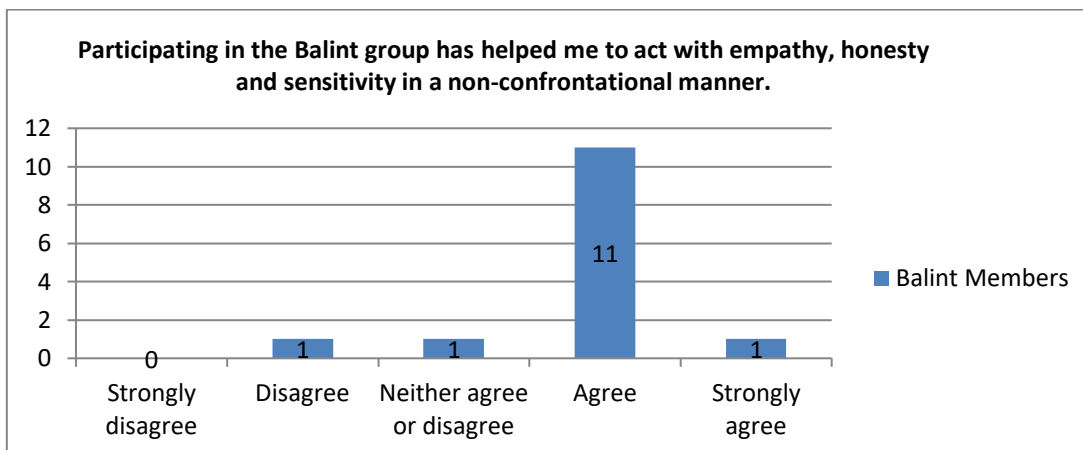
In terms of how the group felt the Balint Group could be improved, four members felt that the main issues were timing, making it difficult for them to always prioritise the session due to clashes with ward rounds or other teaching. Another three felt that the group should be larger to make the group feel less intense and

more people should benefit from the Balint and a larger group would make it run more regularly. One further respondent felt that the Balint Group needed more structure and intervention from the leaders to help the conversation flow.

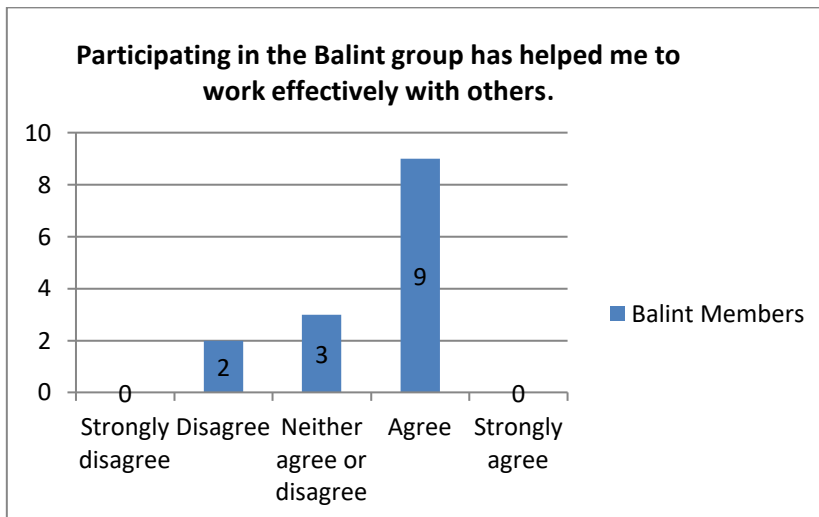
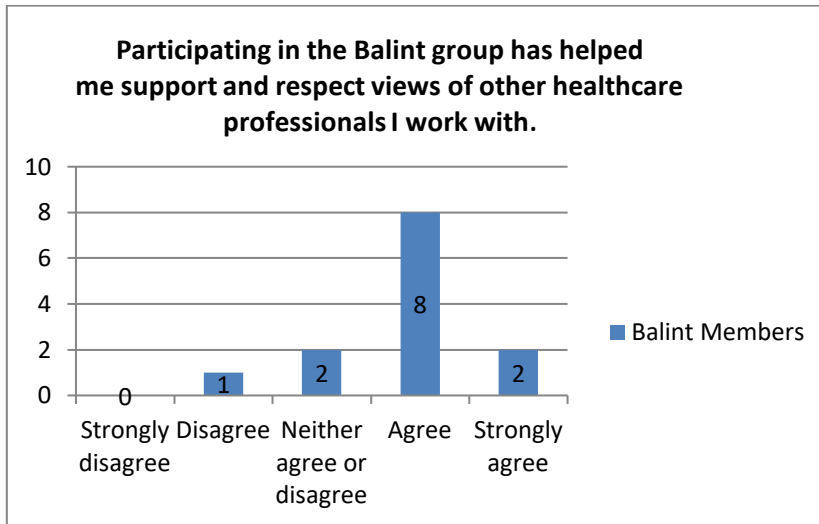
We asked a set of questions as to what the effect of being in a Balint Group was for the members. 57% (8) of the group felt that they had changed and improved their practice as a result of the Balint. The remaining 43% (6) neither agreed or disagreed that it had, but no-one disagreed or strongly disagreed.



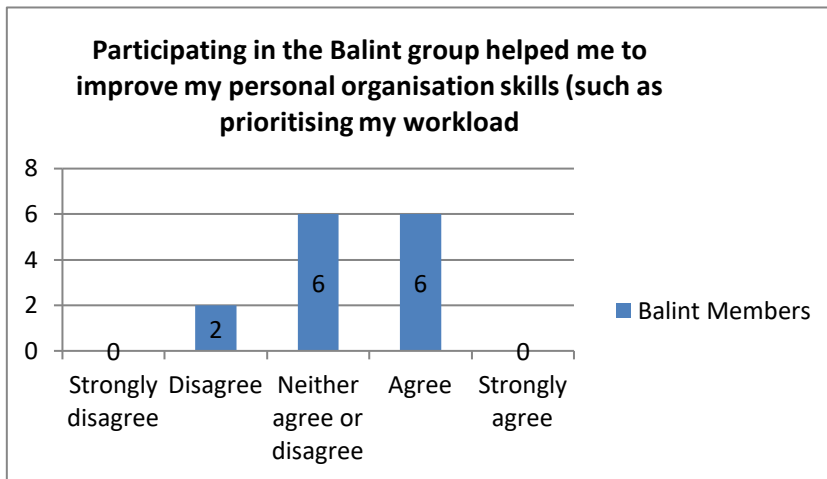
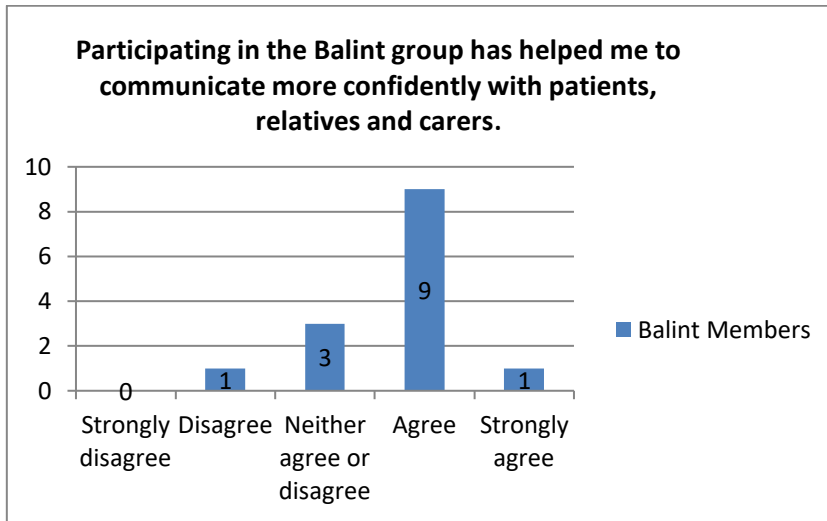
86% agreed or strongly agreed that participating in the Balint group had helped them act with empathy, honesty and sensitivity, only 1 person (7%) felt it had not helped them do this. 71% (10) felt it helped them communicate with more understanding and empathy. This corresponded to a majority of 79% agreeing or strongly agreeing that it helped them deliver patient centred care.



We asked group members whether they felt that participating in the Balint group had helped them work more effectively with others 9 (64%) people felt it had and 2 (14%) disagreed. 71% either agreed or strongly agreed that it helped them support and respect views of other health care professionals they work with, with 1 (7%) disagreeing.



The majority of the group 71% (10) either agreed or strongly agreed that it helped them communicate more confidently with patients, relatives and carers. In terms of improving personal organisational skills, the group were more divided with 6 (42%) feeling that participating in a Balint Group helped. 2 (14%) felt that it hadn't.



### Themes arising during the Groups

There were a number of common themes that were raised in groups across the different Balint cohorts. Some of the common themes included: the doctor-patient relationship, the relationship between F1s and other multi-disciplinary professionals and the relationship between F1s and their consultants. Emerging from medical school and taking on the responsibility of being a doctor presents clear challenges. Some of these challenges were evidently present in the discussions of the group.

There were cases where FY1s were moved by the plight of their patients and a desire to go beyond the requirements of their role. There was a running theme that FY1s felt they were left by their consultants with the most difficult patients to

find for themselves, often feeling isolated and unsupported. And further themes explored their negative feelings towards patients, such as anger, disgust and frustration.

The co-leaders, throughout the course of the groups, made a number of observations. It was noted that at the beginning of the groups patients were referred to by bed numbers and surgical issues in a clinical, impersonal way. As the group progressed, they began to relate to their patients bringing more holistic insights into their social circumstances, personalities and potential internal struggles.

Another observation was that there tended to be a few members of the group who were actively engaged in a more psychologically minded way who tended to be more present. There were other members of the group, who tended to be more sporadic in their attendance, who tended to bring more concrete interpretations. Finally, there were one or two members in each cohort who only attended the compulsory sessions.

### **Limitations**

An important limit of this study is the use of self-report questionnaires. Items in the Pre and Post Balint questionnaires were informed by previous research into possible Balint Group effects (*Systematic Review Citation*). The questionnaires are not validated psychometric tools and as such are of limited use in terms of creating objective data from subjective reports. The development of such a tool was beyond the means and scope of this study but may be an important part for future Balint Group research to help define the 'limited but considerable change' Michael Balint referred to.

Another important limitation was the dropout rate between the initial questionnaire completion and the completion of end-of-group feedback, from 29 responders to 14. We can hypothesize that those who did not return the

questionnaire did so because they found the Balint Group experience unhelpful or were not interested in attending.

Small sample sizes in Balint Group studies are often determined by the nature of the intervention. We attempted to address this problem through collecting data from multiple groups over time. However, this necessarily gives rise to heterogeneity in group sizes, leadership and participation.

In terms of how the Surgical FY1 Balint groups compare to others described in literature it is important to point out that Balint Groups usually number between 6 and 12 participants. Our groups were small and attendance was variable. The initial group sizes were 10, 11 and 11 participants, but attendances varied between 3 and 8 participants on a week-to-week basis. This should be recognised as a potential barrier to developing a sense of group cohesion and safety as well as individual perceived benefits from the intervention.

Balint Groups are traditionally run for upwards of 6 months and our 4-month groups may have been too short to show effect or change.

#### *Discussion & Conclusion*

It is worth underlining once again that the vast majority of the Balint Group participants (86%) were new to the experience. This could have potentially facilitated a higher degree of open-mindedness, as well as curiosity amongst the FY1 doctors, reflected in the volume of questions asked by them in the introductory sessions. Interestingly, the initial thoughts by the participants, relating to the Balint Group, were equally split between negative, apprehensive or neutral (14) and positive ones (14). We could interpret this in multiple ways. It is clear that the Balint Group is a novel concept for the majority of FY1 doctors. There is a definite degree of apprehension reflected in the answers, suggesting that the overall burden of work of the junior doctors is very high and that they are worried to add on yet another weekly commitment. Despite that feeling, half of the participants were

positively curious about the experience and the possibility of having a space to reflect, outside of the ward environment.

Overall the Balint Groups were perceived as a positive, valuable experience. This is clearly shown in the post-group questionnaires, where all the participants agreed that they would recommend the group to a colleague. Interestingly, looking at the data from the open questions in the post-group questionnaire, more of respondents felt the benefits were to do with communication with fellow doctors (12 responses) than experiences with patients (2 responses). That is not to say that the participants did not observe an improvement in the way they communicated with their patients, but the themes of benefiting from peer discussion and feeling understood by the group were shared by the biggest proportion of FY1 doctors. This suggests that they felt safe enough in the space provided and were able to reflect on difficult experiences with empathy and compassion to one another, which had a positive influence over their self-belief and confidence in practice as a doctor.

Once again, the pressure and stressful nature of a junior doctor job was reflected in how the group felt that Balint Group could be improved. It is clear that the timing would always be an issue, because of multiple doctors doing their on calls shifts, having zero or annual days, clashing with the sessions. The suggestion made by 3 participants to increase the group size to allow it to run for the whole year, could be interpreted as them feeling contained by the group and now, at the end of it, struggling to detach themselves, expressing potential feelings of abandonment by the co-leaders.

An important aspect of our results is that not all responses to the group, in terms of the outcomes in the post Balint questionnaires were positive. Some psychodynamic elements are worth considering. Balint groups, as we have shown in our results can expose or bring to the forefront some positive factors such as increasing the awareness of the patients' experience, helping FY1s to respect the

views of other healthcare professionals and act with a greater sense of empathy towards others. However, Balint groups can also unlock or bring to the surface negative aspects of healthcare and the human condition. In one particularly memorable session a group member was brought to tears when considering the effect death can have on a hospital team. To think that only positive elements will be brought out when discussing complex and unwell patients would be naïve. In a similar vein, in a group that runs over 10 sessions, negative or difficult aspects can and were brought out. We would argue therefore that although not all of the results of our project have been positive, the fact that some of these difficult issues such as loss, ambivalence and time wasting were kept in mind is in fact a positive aspect of the development of FY1s as doctors.

Following on this line of argument it is worth mentioning Melanie Klein's theory of the depressive position. Klein's argued "it is only in the depressive position that polar qualities can be seen as different aspects of the same object".<sup>7</sup> Perhaps an important part of the development of the different groups was coming to terms with the depressive position in terms of accepting that there were both good and bad aspects to complex matters such as the doctor patient relationship and patients themselves. This can be witnessed in our results showing there were both positive and negative elements within the same entity. Some members of the group saw patients' self-destructive behaviour as wasting healthcare professionals time and resources. However, those same patients were also considered by the group as worthy of empathic care delivered in a person centred manner. It could therefore be argued that our mixed set of results reflect the depressive position in that both positive and negative aspects of the various groups can be part of the same project.

Bion's theory of containment is a useful way of tying together positive elements brought out in the group as witnessed by the co-facilitators and the

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<sup>7</sup> Grotstein, James S. (1981). *Splitting and projective identification*. New York, NY: Jason Aronson.

feedback received in the form of questionnaires from the various FY1 groups. In an important sense, the group acted as a form of containment for the constituent members. There was a strong sense in all of the groups that being an FY1 was a difficult experience. This was experienced by the group leaders in Bion's lexicon as beta elements, raw emotional experience, which was poured into the group by the presenter. Other members of the group and the co-facilitators were able to carefully attune to the presenter and contain them in the maternal "reverie". Following case discussion sense could be made of these difficult experiences or beta elements which were returned in the form of contained feelings or alpha elements. Perhaps one of the reasons why all the FY1s who participated in the Balint groups would recommend Balint to their peers is the recognition that being a doctor inevitably comes with the experience of difficult, uncontained emotions and feelings. There is a need for these experiences to be contained by the other. These experiences are currently contained in a variety of different forms be they the ward round, supervision or informal discussion with our colleagues. Balint groups offer another medium for containment.

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## **From the Archive, Otto Fenichel to Michael Balint: Struggles, Exile, Searching for a New Home**

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## **A Commentary on the Letters from Otto Fenichel to Michael Balint, 1940 and 1941, Los Angeles<sup>2</sup>**

A sequence of letters from Otto Fenichel<sup>3</sup> captures an intense moment in Michael Balint's life, one of dislocation and loss. Shortly after arriving in the UK in 1939, Balint tragically lost his wife, Alice Balint, a partner in life and thought, who was also a psychoanalyst, and an established figure of the Budapest School of psychoanalysis. He initially settled in Manchester, where he felt unhappy and uprooted. While we only have Otto Fenichel's letters, and not those written by Balint, the letters recapture Balint's search for a new home, after his leaving Budapest, and the many losses that followed. In 1941, Balint was seriously considering emigrating to the United States, and Fenichel was advising him on the situation he would be facing in the receiving country, and on the possibilities to make a living there.

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<sup>2</sup> The Balint Archive is held by the British Psychoanalytical Society.

<sup>3</sup> Otto Fenichel, an Austrian physician and psychoanalyst, was born in Vienna in 1897, and died Los Angeles in 1946. In the spring of 1938 Fenichel and his family left for Los Angeles, fleeing Nazi prosecution. There he joined the Los Angeles Psychoanalytic Study Group. In 1942 he had a key role in founding the San Francisco Psychoanalytic Society. He was invested in the development of a form of psychoanalysis that was capable of sociological explanations and of making contributions to politics. His book, *The Psychoanalytic Theory of Neurosis*, appeared in 1945 and became a reference for analytic training.

The first letter of the sequence is written in June 1940, after Fenichel had received the confirmation that Balint made the crossing to the UK safely, and that he was still alive. The letter marks the tragedy of the times, when the event of survival and the event of making a safe passage to a new country could not be taken for granted. Receiving an envelope with a familiar handwriting was a long-awaited message of life. Being in a historical time without consolation is the atmosphere that Fenichel inscribes for us. It is also a time of profound change and major reorganisations, where the very 'frame' of work is altered: new languages, new countries, new constraints and new forms of negotiating with state institutions and with psychoanalytic institutions.

I received your letter of June 9, for which I thank you very much. You say I tried to send you 'some lines of consolation and encouragement'. I certainly do not like these expressions in events where there is no consolation. Certainly I anticipated that you will continue living, nevertheless, and I am very glad to learn from your letter, that I was right. Yes, many things happened again in the meantime. We all do not know how it is going to continue, but I think also, we all agree that we cannot do anything else than 'make the best of it', to continue our work without overestimating it and its possibilities as long as it is possible. (Letter of Otto Fenichel to Michael Balint, 14 July 1940)

In a letter written by Fenichel on March 15, 1941, we get closer to understanding the difficulties of crossing national boundaries, in the medical and psychoanalytic profession. Fenichel details for Balint what a new move from the United Kingdom to the United States would entail. The medical milieu is not very permeable, and defends the internal logic of the profession and the local realities, faced with the newcomers, the exiled of Europe:

The conditions for examination and [medical] licence vary in the different states and are in general, unfortunately, becoming more difficult from day to day. They are especially difficult in California, where one year internship in an American hospital is required as a pre-condition for admission to the examination. And it is extremely difficult to get such an internship position, because they are overcrowded with American medical students; if you get one, you must be happy and certainly work the whole day, - so that an attempt to obtain

the Californian licence means a year without earning any money. (Letter of Otto Fenichel to Michael Balint, 15 March 1941)

One month later, in a letter written on April 11, 1941, Fenichel seems even more pessimistic about the prospect of Balint's coming to the United States. He shares with Balint the hope that the Fund for Relief and Immigration of the American Psychoanalytic Association might grant him a loan for the first half year in America, but he also informs him that 'now ten times more money than the Fund possesses is needed to make possible the passage and the rescuing of persons whose lives depend on it' (Letter of Otto Fenichel to Michael Balint, 11 April 1941). Fenichel adds a hand-written question on the typed letter, marking his own anxiety and the desire to know about Balint's decision in this difficult situation: 'What will you do?'. Indeed, the scribbled question is one that must have been very loud in the minds of psychoanalysts and medical doctors of the time, faced with life and death questions, including the preservation of their own life.

We can reconstitute Balint's resolution from Fenichel's letter of June 13, 1941. Balint decides to remain the United Kingdom, and he also writes to Fenichel that it is his choice not to appeal to the Fund, in a context where other Europeans are still under a death threat, and need it more than he does. Fenichel writes:

I understand that you, under the circumstances of reality, decided to stay in England, although I am sorry about it. Concerning the Relief Fund of the American Psychoanalytic Association, you certainly are right that it is needed at present for persons whose whole existence of life is dependent of it: but perhaps it would have been possible for you also without this fund's help. (Letter of Otto Fenichel to Michael Balint, 13 June 1941)

In 1941, the 'circumstances of reality' that Fenichel evokes were extremely dark for the European psychoanalysts and doctors fleeing Nazi prosecution.

In another letter of the same period, Fenichel draws Balint's attention to a theme I would call 'infrastructural thinking'. Psychoanalysis will thrive or contract

not in accordance to its practicing the 'right' kind of theory, but in relation to post-war social change, to the new institutional landscape emerging after an important historical trauma.

[...] it seems to me that all this is not of much importance anymore. The future of psychoanalysis, I think, is not depending anymore on the fact whether in this or that psychoanalytic society a correct or wrong theory is advanced – but on the outcome of the war and the structure of societal institutions after the war. Waiting for this future still is much more comfortable here [Los Angeles] than in Manchester.

I understand that the disruption of all connections with Hungary make the difficult conditions of your present life still worse. And I am glad to learn that all those difficulties do not deprive you of your courage to work and that you not only have your analyses but also your meetings, discussions and scientific trips to London. I would like that psychoanalytic work here might be done with more libido than it is. In this respect, I am much more content with new candidates than with old analysts. (Letter of Otto Fenichel to Michael Balint, 12 May 1941)

What we are left with is an image of the importance of transmitting the psychoanalytic craft. Political regimes might fail us, and professional organisations might do so as well, but what endures is the transmission across generations of a method and of a way of producing knowledge.

### **Author Note**

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