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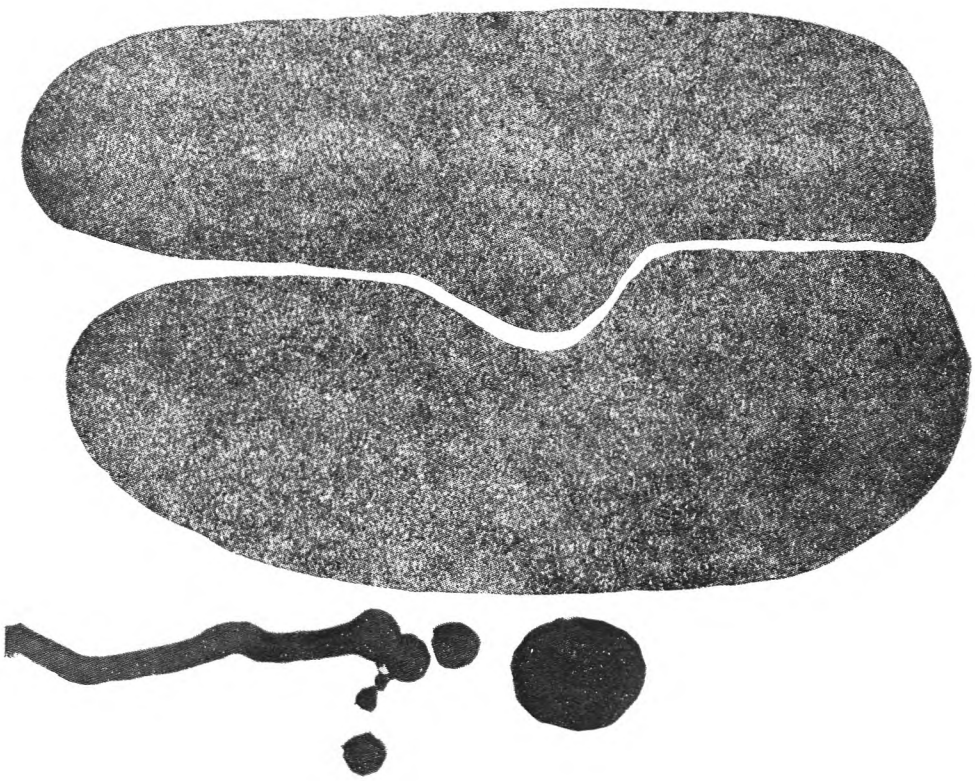

Vol. 6

JOURNAL OF THE BALINT SOCIETY

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Editorial

The Balint Society was founded in 1970, and one of its most successful ventures was the organisation of the first International Balint Conference in London in 1972, where there was a very useful exchange of ideas between the members of Balint groups at home and abroad. In subsequent international conferences in Brussels in 1974, and in Paris in 1976, it became increasingly clear that many flourishing 'Balint' groups were not being run on the lines laid down by Michael Balint; and indeed at the last conference in Paris considerable feeling was expressed between the French and the Belgians over the way they ran their respective groups. In this country, too, there are some leaders running 'Balint' groups, who do not follow the original principles laid down by Balint of focussing on the patient and the doctor patient relationship, and of dealing with the patient's personal problems not directly, but through scrutiny of the doctor/patient relationship.

There are other ways of dealing with the psychological problems of patients seen in general practice and elsewhere, such as those demonstrated by the Belgians at the Paris conference, where more emphasis was laid during the demonstration seminar on the problems of the doctor than on those of the patient.What has yet to be demonstrated is which method gives the best results.

The seminars developed and run by Michael and Enid Balint 25 years ago, and carried on ever since, have inspired many doctors to approach medicine in a new way, and to introduce new teaching techniques to enable their colleagues to understand more about human behaviour and the mental processes responsible for symptoms of stress masquerading as symptoms of organic disease. But in the rapidly changing conditions of today, some of those inspired doctors have chosen to break away from tradition and forge new techniques. This is all to the good, but the original members of the Balint Society would like to ensure that the basic principles laid down by the Balints are incorporated in these new techniques.

The responsibility for organising the fourth International Balint Conference has once again fallen on the Balint Society, and it is hoped to organise this conference in London early in September 1978. It is up to the members of the Society to work hard to make this conference a success and, if possible, to demonstrate to their colleagues abroad that the principles of running seminars, which Michael and Enid Balint originally laid down, give more lasting results.

STEPHEN PASMORE

The Editor would welcome personal views of members, details of new appointments, lectures given and so on, for publication in the Journal.

Lists of publications by members, together with reprints, will be useful for the Society's library.

Manuscripts and communications for publication in the Journal should be forwarded to the Editor.

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

Past numbers of the Journal of the Balint Society are available at 80 p. (including postage) from: Mrs. Rogers, 15 Marian Close, Hayes, Middlesex.

The Academic General Practitioner

Michael Balint Memorial Lecture given on 9th December 1975 by Marshall Marinker, Leicestershire Professor of Community Health, University of Leicester.

The title which I have chosen is 'The Academic General Practitioner'. The word academic carries semantic overtones not only of the scholarly and the intellectually sceptical (both of which would have won the approval of Michael Balint), but also of a certain arid inhumanity and a shift of focus from the real world of experience to a theoretical plane of disembodied ideas, meanings which would not have appealed to him at all. I hope tonight to convey to you that general practice as an academic discipline attempts to be both scholarly and sceptical, but that in its essence it seeks to stay in touch with the human experience and to confront every theory with the evidence that we have from each encounter between the doctor and his patient. Inevitably I can give you only a partial view of general practice as an academic discipline and of its place in the medical curriculum. The fact that so much of what I have to say would be held to be common ground by so many of my academic colleagues in general practice who never worked in one of Balint's seminars, attests to the profound influence which his thinking has had on our subject.

The creation of the College of General Practitioners in 1952 allowed general practice to make articulate its heritage, to explore its role and to map out its boundaries of health and care. The journey of discovery that began with Michael Balint's first seminar in 1950 made possible that cartography in which we can now recognise the cardinal landmarks of our academic discipline.

In attempting to answer the question 'What is the academic discipline of general practice?', I shall look at the clinical frames of reference within which we teach and research, and suggest to you that the habits of thinking about the encounter between doctor and patient are the most important lessons which we can teach our medical students. The appearance of this sort of medicine in the university has implications for the subsequent training of doctors and for the educational content and teaching methods of vocational training, and calls into question the structure of the research-cum-training seminar which Balint described: learning, unlearning and relearning. Within the medical school itself, the appearance of a strong department of general practice alters and upsets all those other highly ambivalent relationships between academic departments. I shall have something to say about my own highly ambivalent relationship with academic medicine, psychiatry and the behavioural sciences. Lastly, I want to suggest that there may be new and exciting relationships to be formed within the university from which new departures in medical education may be expected, which may prove to be as challenging and upsetting to many doctors as Balint's original work on the nature of patient-centred medicine and on the power of the doctor's apostolic function.

A New Subject

What is general practice? Some twenty years before the Medical Act of 1858, the following notice was displayed at the window of an apothecary's shop in Manchester:

> Surgeon and Apothecary. Prescriptions and family medicines accurately compounded. Teeth extracted at one shilling each. Patent medicines and perfumery. Best London pickles. Fish sauces. Bear's grease. Soda water. Ginger beer. Lemonade, Congreve's matches and Warren's blackening.

You will not be surprised to learn that a subject which set out its field of work and theoretical infra-structure in such demotic terms was not immediately invited to join the curriculum advisory committees of the day. Yet we should not wish completely to deny our heritage. Many of the sophisticated drugs which we offer our patients, much of the complex investigations and surgery to which we subject them have less to do with health than our predecessors' bear's grease or soda water. Neither are the present boundaries of what society regards as the proper business of medicine, less ambitious than the apothecary's meagre span between delivering babies and blackening grates. We have been warned already by such sociologists as Irving Zola against what he calls the medicalisation of society. He argues that the medical model has

become so powerful a metaphor for talking about the human experience that we now extend it into economics, into business management and morality: for example, we describe a visiting accountant as a company doctor and we are told that the public showing of blue movies is the hallmark of a so-called sick society. Polemicist and philosopher Ivan Illich tells us that doctors have expropriated health from people. His central critique of the medical model remains important and practical for those of us who plan health services and those of us who work within them. He says that health is not what doctors have made it: that is a commodity which doctors peddle to the community. Health, he says, is not the property of doctors. It is simply an expression of the culture in which we live.

General practice as an academic subject began as a critique, as an expression of dissatisfaction, a movement of reform or revolution. The description 'revolutionary' refers only to the gap that exists between a new idea and the world of accepted ideas in which it erupts. There were in fact two revolutionary ideas which twenty-five years ago began to change the way in which we talked about general practice. First there was a series of observations about patients and their illnesses outside the world of the hospital. To begin with the quantities of illness were wrong—the doctor working outside the hospital found that the incidence of bronchitis, rheumatic complaints or acute infections was much greater than he had been led to expect by his hospital experience. Not only were the quantities of illness wrong, but the way in which illness was explained in the medical school was no longer helpful to the general practitioner in his everyday work. He had learned about the morbid anatomy and histology of peptic ulcer, and about the sophisticated technology required to support such a diagnosis. In practice he could during the course of one year feel fairly confident about the clinical diagnosis of twenty-five such patients. 250 of his patients, ten times as many as those whose condition can be described in the terms of his undergraduate education, consult him in the course of twelve months because of indigestion which cannot be explained on a basis of secure evidence of physiology, anatomy and pathology.

For centuries the nature of hospital medicine had predicated the selection of clinical conditions. In the 18th century, the Edinburgh Clinic was organised so that 'those cases that seem most instructive' might be brought together. The teaching hospital was invented in order to be a nature reserve in which the student could be shown the wild life of unhealth in the community. It was designed to be a clinical zoo. Michel Foucault, in his *Naissance de la Clinique*, uses the word clinic to mean both clinical medicine and the teaching hospital. He says of it 'Before being a meeting of patient and doctor, a truth to be deciphered and an ignorance, and in order to be such a meeting the clinic must form constitutionally a structured nosological field'. The first text of the revolution which constituted general practice as an academic subject was, therefore, an epidemiological one. One of the major paradigms in which general practice teaching and research has taken place has been epidemiological. I have in mind various national morbidity surveys and innumerable studies of workload, or the distribution of morbidity in families, of regional social class variations, social factors affecting health care utilisation which now form an extensive literature in the subject. But as members of this Society are all too keenly aware, this was really the most moderate wing of the revolution.

I remember well my own puzzlement twelve years ago when I joined the College and decided to undertake a morbidity survey in my own practice. My task was to ascribe a morbidity label to every consultation and later to correlate patterns of health care use and morbidity between different members of the same family. All would have gone well with the research—I was certainly excited by the problems and challenges of research design—had I not encountered in that same year that major sabbateur Michael Balint. Within weeks of being accepted into his seminar, I was faced with the desolate truth that morbidity labels, certainly in the field of general practice, described very little about what is going on in the patient's life but conveyed something of the structure of the doctor's apostolic function. I had not only been misled about the quantities of illness in the community, but I had been misled about the nature of illness itself. The majority of the patients who consulted me were simply not in possession of the required diseases. They persisted in being ill just as though I had never attended those courses of instruction in the medical school. Even when the required diseases could be identified, there were other events occurring, unexplained behaviours to which I had to respond without the compass of a theory or a familiar frame of reference. This was the second text of the revolution.

If I were giving a lecture about general practice to any other society but this one, I would now launch into a series of case descriptions in

order to demonstrate the difference between unorganised and organised illness, the nature of the doctor's apostolic function, the boundaries and possibilities of whole-person medicine. Instead I want to examine with you the implications of our view of medicine for undergraduate education, and in particular to address myself to the problem of what Michael Balint himself called 'relearning'. That is, how to re-integrate disease-centred medicine with patient-centred medicine. My difficulty with epidemiological techniques in general practice was to a large extent predicated by the setting in which I chose to use them and by the questions that I tried unsuccessfully to answer. The sabotage which Michael Balint's ideas worked on my epidemiological study did not destroy epidemiology, only my misunderstanding and abuse of it. I shall return to this theme later.

Education

It seems to me that learning about the doctor/patient relationship takes place during three distinct phases of the doctor's development. The first occurs during the two pre-clinical years, when it is the teacher's aim primarily to focus the attention of the student on the roles of doctor and patient. At this time the student becomes sensitised to the social setting of the clinical encounter and learns that the feelings of the doctor and the patient may be treated as clinical facts. The second phase of learning begins with the clinical attachment of the student in the third year and extends until the student qualifies and begins to practise as an independent clinician. The beginning of the third phase coincides with the beginning of clinical responsibility and lasts for a professional lifetime.

The different focus in these last two phases only became clear to me when, some years ago, I began to experiment with teaching methods. A number of general practitioners, a majority of them trained in Balint seminars, formed a group that became known as the London Teachers' Workshop. We set about an exploration of techniques for teaching whole-person medicine in the one-to-one situation—for example, between a medical student and a general practitioner in the consulting room, or between a teacher and a trainee in a vocational training programme. It is not my intention this evening to talk about our discoveries in this field, but rather to report on one of our findings that has, I think, implications for the use of Balint seminars in the medical school.

To begin with, it was my belief that the London Teachers' Workshop could explore the problems of learning and teaching without particular regard to the stage of development of the learner. That since we were exploring educational theory and method, it seemed not unreasonable to predicate that truths about learning and teaching would be common to both tasks and that the differences would not be categorical ones but differences of complexity. This proved to be a mistake. Experience revealed that there was quite a fundamental difference in the objectives which the learner formulated. The medical student is primarily interested in diagnosis: in the question of aetiology and formulation. At the end of every tutorial it became clear that the student was interested in the answer to the question What is going on?'.

For the vocational trainee, on the other hand, as for the experienced general practitioner in Balint seminars, the central question is not 'What is going on?' but rather the more pragmatic 'What am I going to do?'. It may seem extraordinary that these two aspects of clinical commerce, diagnosis and treatment, should be so differently represented in the interests of these two groups—particularly since we believe that diagnosis and treatment are intimately reflective the one of the other. Yet it becomes clear that the stage of development of the doctor, and in particular the degree of independent clinical responsibility which he assumes, changes the orientation from one of enquiry and reflection to one of action.

My own Department is heavily engaged in teaching epidemiology during the first year; the course is under the control of a senior lecturer in epidemiology, but a number of the practical sessions take as their framework the populations of general practice. I myself try to provide other frames of reference within which the student may work, based on the experience of whole-person medicine in general practice. The first concerns the nature of what I call unhealth. I present them, long before they meet the patient on the ward, with a model of unhealth which I hope will survive the inevitable distortions of a great deal of clinical teaching which must follow. I want briefly to rehearse these ideas with you now. They form a simple, perhaps you will think simplistic, model of whole-person medicine.

The first mode of unhealth is Disease. This is a pathological process, most often physical as in throat infection or cancer of the bronchus, sometimes undetermined in origin as in schizophrenia. The quality which identifies disease is a deviation from structural functional biological norms. There is an objectivity about disease

which doctors are able to see, touch, measure, smell. Diseases are the central facts in the medical view. It is in this sense that the patient may be described as 'the accident of the disease'.

The second mode of unhealth is Illness. Illness is a feeling, an experience of unhealth which is entirely personal, interior to the person of the patient. It most often accompanies disease but the disease may be undeclared—as in the early stages of cancer or tuberculosis or hypertension. Sometimes illness exists where no disease can be found—often after a fruitless search has not so much the character of detective fiction as of a foxhunt, from a view to a death. The labour of love and hate that links the patient's 'I feel ill doctor' with the doctor's 'You have a disease' has been taken, mistakenly I believe, to be the central concern of clinical teaching.

The third mode is Sickness. If illness is an interior and personal mode for the patient, sickness is the external and public mode of unhealth. Sickness is a social role, a status or negotiated position in the world, a bargain struck between the person henceforward called sick and a society which is prepared to recognise and sustain him. The security of this role depends on a number of factors—for example, the possession of that much-treasured mode, disease. Sickness based on illness alone is a very uncertain and debased status. Neither is there equity in sickness between diseases. The chronic sick are much less secure than the acute; the old than the young; the psychiatric than the surgical. Best is an acute dangerous physical disease quickly determined by recovery or death—either will do, both are equally regarded. It is important to remember that if the doctor's task is seen to be the opposition of disease and illness, it must also be seen as the establishment and maintenance of sickness. Patients consult doctors most often not to avoid sickness but for the opposite reason: they come in order to be sick.

The second frame of reference which I give the students in this first term concerns the nature of science, art and truth. Here I am concerned with the processes of thinking about patients and diseases, rather than with theories or facts which may become obsolescent long before the present-day medical student has set up in independent clinical practice. I begin by examining the fiction of inductive thinking in science and explore in a fairly simple way the process of hypothetico-deductive thinking, as Karl Popper explains it. Finding out what is wrong with our patients, like discovering the double helical structure of DNA, proceeds not from the assembly of a vast quantity of information without prejudice as to what that information may mean, but, on the contrary, from making an inspired guess on the basis of a handful of data and then putting that guess to the test. In the clinical experience, the heavy smoker coughs and produces blood: the doctor has already guessed that this patient has a cancer of the bronchus and sets about the business of testing his hypothesis, without recourse to all the panoply of complete history-taking and systematic examination set out in Hutchinson and Hunter's 'Clinical Methods'. In my own case, it was not from reading Karl Popper or Peter Medewar that I first became conscious of the real nature of scientific method. I became conscious of it in my work in the Balint seminar.

I remember how liberating it was to put together the story of a patient's life from a small handful of clues—hesitation over a word, a physical symptom, a habit of not referring to one member of the family, a recoil from the touch of a physical examination. Slowly the truth dawned on me that what we were all engaged in was the application of the scientific method, to a wider span of the human experience than was admitted in a traditional medical education. But it was the scientific nature of the work, the scrupulous testing of our guesses, by confronting them with the reality of the patient's next consultation, which allowed us to move forward.

The second theme of my lecture is the difference between science and art, and the nature of truth. I cannot tell you that I was successful in this enterprise. Among other things, I read the students a poem by Robert Frost. The poem concerns a beautiful Hollywood film-star who has grown old and ugly and, because she was improvident in her youth, poor also. Now she washes the steps of the great picture-palace where once she starred. If only she had been careful and mercenary in her youth, says the poet, she would not now have sunk so low.

> 'Make the Stock Exchange your own.
> If need be occupy a throne,
> So no one then can call you crone.'

But she did not, and the poem ends:

> '. . . better to die
> With boughten friendship at your side
> Than none at all. Provide! Provide!'

I asked the students to tell me what they thought the poet was trying to say. Was he saying that if we are not provident in our society, we deserved to suffer, to die lonely? Yes, he was saying precisely this. But was he not also being ironic, was he not saying the opposite, that men and women should not have to behave like this?

Yes, that is precisely what he was saying. The truth of poetry, the truth of art, is enshrined in ambiguity, in wit, pun, allusion. The truth of science, in contrast, is enshrined in single-valued language, in symbol rather than word. A patient's experience of unhealth will be expressed to the doctor both verbally and non-verbally in the language of art. Clinical medicine will demand of the doctor that he accepts this kind of data, and that he handles it with scientific method: in the words of Peter Medewar 'Imaginative conjecture and criticism, in that order, underlie the physician's diagnosis of his patient's ailment'. I believe that the task of general practice in the medical school is not only to extend the range of those imaginative conjectures which doctors make in order to encompass a whole-person medicine, but, as importantly, to insist on the scientific method. Too often it is not scientific method which the student learns but its sly counterfeit, technological information.

These ideas about the nature of unhealth, about the nature of science in medicine, erupt in the medical school in a hostile environment. They are not welcomed, by and large, by colleagues in the academic clinical departments. It is not my intention tonight to rehearse the possible reasons for this hostility, nor to argue my own case, since I would be astonished, not to say a little threatened, were I to discover that these ideas represented anything other to you than self-evident truths. My only reason for referring to the hostility of the intellectual environment in which we carry out our teaching is to say that I welcome it and that I think that we do a great disservice to medical education when we try to minimise the differences between us. On the contrary, I believe that the medical student from the first day of his induction course should be confronted with these different perspectives of medicine. I want to enter an important caveat, however. The location of these different points of view are not necessarily predicated in the title of a subject or a department. There are, as many of you will know, important academic departments of, say, gynaecology or paediatrics or surgery, where whole-person medicine is practised and taught. There are also departments of general practice where lip-service is paid to whole-person medicine, but where it is neither practised nor taught. It is the ideas which are important and not necessarily the clinical setting in which they are made manifest.

Perhaps my most ambivalent relationship is with the Department of Psychiatry. I must make it clear that I am not referring to the excellent personal relationship which I have with the Professor of Psychiatry in my own medical school, but with psychiatry as a discipline, as a subject in the medical curriculum. I have been able to identify a few aspects of this ambivalence, though I am certain that my sophisticated audience tonight will recognise that I have turned a blind eye to the most significant.

First, there is the problem of residual ambivalence in the relationship between general practitioners and psychiatrist group leaders of Balint groups. Of course, as Balint himself pointed out time and again, the whole-person medicine which emerged from his teaching-cum-research seminars resulted from meeting between general practice and psychoanalysis and not simply from the explanation of general practice by psychoanalysis. Time and again, Balint wrote that we were colleagues and not teachers and pupils. Nonetheless, if for no other reason than that Michael Balint and the other group leaders were in fact psychiatrists, academic general practice, which sees whole-person medicine as the core of its own discipline, has to accept the uncomfortable fact that whole-person medicine was in large measure a gift from psychiatry.

A further source of difficulty is the fact that psychiatry embraces a large number of conflicting theories and practices. Much of contemporary psychiatry announces its hostility to the concepts of whole-person medicine and yet departments of psychiatry make the assumption that they are uniquely placed in the medical school to teach about the doctor/patient relationship. There are two dangers here. The first is that in the desire to remain disease-centred, to make safe the doctor's journey through the miasma of mental unhealth, modern psychiatry, with its emphasis on the objective and the replicable, may increase the student's distrust of his own feelings. But there are much more serious anxieties about the teaching of the doctor/patient relationship in the setting of the psychiatric department. First, the student may learn that a concern with the doctor/patient relationship is relevant only in the study and care of the mentally ill. Second, he may learn that whenever he becomes aware of the central fact of the doctor/patient relationship in the clinical encounter, the patient is probably suffering from a psychiatric illness. Quite apart from the intentions of the curriculum, students learn most by modelling themselves on their teachers. For this reason it is only possible to teach the medical student about whole-person medicine if he is provided with a model of doctors, and in particular general practitioners, who practise

rather than preach it.

In our own medical school, we have set ourselves the task of teaching the medical student about man in society, about the relationship between the doctor and his patient, long before the formal clinical attachments of the third year. Who is going to be responsible for this sort of teaching in the first two years of the medical school, which we used to call pre-clinical, although the term is now no longer an acceptable part of medical educational theology. I want to say a few words about the growing importance of the behavioural sciences in the medical school. Following the recommendations of the Royal Commission on Medical Education, it became very fashionable a few years ago to speculate about the enormous impact on medical education which would follow the introduction of the behavioural sciences into the curriculum. Indeed many of us, myself included, were wont to talk about general practice as the laboratory for the behavioural sciences. I am beginning to suspect that our enthusiasm was exaggerated and misplaced. The lessons of sociology, in particular the ways in which individual behaviour may be affected by the culture within which the individual was brought up, the social class with which he identifies himself, and the role and status in society which he adopts and which is ascribed to him—these lessons may be very useful for understanding the distribution of unhealth in the community; the difficulties which individual patients have in seeking health care; the assumptions which patients and doctors make about their transactions. But the use to which this knowledge can be put in the one to one situation of the consultation is strictly limited. The limitation is similar to the limitation on the use that we can put our knowledge of epidemiology—for example the incidence and prevalence of a disease, and the specific diagnosis that we have to make of an individual patient. Although they are the same kind of limitations, the limitations of sociology are infinitely greater than those of epidemiology. Similarly with psychology, and I refer to the psychology now regarded as respectable and scientific in most academic departments, the findings of learning theorists, while they may shed useful light on the rationale of behaviour therapists, have very little to say about the doctor/patient relationship or about the self-awareness of the doctor, which is the prerequisite of a whole-person medicine.

There is a danger that whole-person medicine may come to be seen as a product of sociology and psychology. This would be as meaningless as to suggest that traditional clinical medicine itself was simply a product of anatomy and physiology. Sociology and psychology, anatomy and physiology, are what the philosopher Thomas Kuhn describes as primary paradigms. Clinical medicine and the whole-person medicine of general practice are secondary paradigms, models of behaviour and problem-solving which utilise basic sciences but which function at a different level of human experience.

I have come to believe that we may have looked in the wrong direction when we looked to the behavioural scientists to provide for our medical students a groundwork in the humanity of medicine. Instead of looking to the departments of sociology and psychology, I now believe that we ought to have looked to the departments of English or European Literature. While the behavioural sciences seem to me to provide the doctor with a very limited vocabulary for expressing the encounter between doctor and patient, penetrating analysis by a literary critic of Dickens or Trollope or Iris Murdoch or John Donne, may open the imaginations of our laboratory-based students to a wide range of human communication and a more profound understanding of the human experience. Such discussions following a visit to the theatre to see Shakespeare's *King Lear* or Eliot's *The Family Reunion* or TennesseeWilliams' *Cat on a Hot Tin Roof* or Albee's *Who's Afraid of Virgina Woolf*, would teach the student more about family life than a hundred lectures on family structure and role theory. An evening reading Richard Hoggart's *The Uses of Literacy* will teach more about culture and class than a library of sociology textbooks. In the future it may be that sociology will be taught in the medical school as an annexe of epidimiology and psychology as an annexe of psychiatry. Personally I should like to forge the strongest links between my own department and the department of English in my own University. Little is said about the contribution of psychoanalysis to whole-person medicine because (in much the same way as Michael Balint himself eschewed the jargon of psychoanalysis in his dealings with general practitioners) we have always felt a little uneasy about the gifts which psychoanalysis has made to us. It is also true that there are other gifts to whole-person medicine than those made by psychoanalysis, and that there are few enough psychoanalysts with an interest in our sort of work to be able to make more than a token contribution to medical education. Psychoanalysis has also given its invaluable gifts to literary criticism. Like general practice,

literary criticism has also other gifts, from other paradigms which seek to explain and interpret human life. It may be through the teaching of literary criticism, through the application of its techniques to the doctor/patient relationship, that we can look for a further leap forward in the sort of medicine which we are all trying to create.

Conclusion

The publication of *The Doctor, His Patient and the Illness* has fundamentally changed the culture of general practice. It can now be safely assumed that the value judgments implicit in this literature, a point of view that comprehends both illness-centred and person-centred medicine, are central to the philosophy of the academic in general practice. The task, perhaps the most important task, of changing attitudes has already been well accomplished in general practice. It is the acquisition of knowledge and skills that still challenges us.

You will remember that in the formulating of an overall diagnosis we learned in the setting of the Balint seminar to be very critical of high technology medicine. We were aware that the pursuit of disease diagnoses could be carried out with technological mastery only matched by the determination of the physician to ignore straight scientific thinking. The analogy between this sort of diagnostic process and the detective story was the discovery of one of our seminars: in practice the pursuit of diagnosis has often not so much the characteristic of the detective story as of a fox-hunt, from a view to a death. Central now to the concern of my Department is the development of an economical language of organic diagnosis. Such a language, which is one of the prerequisites of whole-person medicine, requires both a grammar and a vocabulary. By grammar, I mean the rules to be followed in handling clinical information: how the information will be obtained, sometimes in what sequence, how the reliability of data will be checked, and how they will be validated. By vocabulary, I mean the so-called facts of clinical medicine: the names and characteristics of diseases and syndromes; but even more important the reliability and significance of clinical findings and the results of empirical research.

The teaching of organic medicine from general practice will not mirror the layout of classic texts of clinical medicine. The framework of disease titles, aetiology, pathology, clinical features, pharmacology and prognosis presents the student not with the reality of clinical practice but with ideal diseases, abstractions to which the patient can only poorly approximate. For example, in the classical text the diagnosis is described first and the laboratory findings are listed in its support. This may be a logical way of setting out a nosography, but it is a poor guide to clinical work where it is not the diagnosis which is supported by the test, but the test by the diagnosis. By the application of such logic, it is possible to argue cogently that, for example, the use of the barium meal in the diagnosis of abdominal pain is almost never justified in the setting of general practice—a salutary finding after years of compaigning to make contrast media x-rays universally available to the general practitioner.

The hope is that, with the emergence of such criteria of good work, it may eventually be possible to audit the quality of medical care in general practice. But how are we ever to measure the effects of high-quality, low technology whole-person medicine? Of course we will begin our audit in physical terms, in terms of organic disease. Our first aim is to limit the harm of which modern technological medicine is so fearfully capable. As for whole-person medicine, as for the high quality use of the doctor/patient relationship, we may in the end have to accept that the act of consulting constitutes it own reason. Michael Balint wrote in *The Doctor His Patient and the Illness* 'every illness is also the vehicle for a plea for love and attention'. There will be much future controversy about the usefulness of whole-person medicine, and this will mirror the old controversy about counselling and psychotherapy. Does this sort of human activity produce something, some sort of resolution, some measurable change in behaviour which can be labelled healthy? In his monograph *The Faith of the Counsellors*, Paul Halmos takes the view that counselling is an act of tenderness which is total, indivisible and personal and so immeasurable. He says '. . . the ideology of counselling has become an ally of love's growth among men'.

In conclusion I want to pay my own personal homage to the man whose memory we honour tonight. I hope that I have been able to persuade you that his taste for adventure and experiment informs the growing academic subject which owes so much to his own teaching and research. The whole-person medicine of general practice which had its academic roots in those early seminars of the 1950s is no less than a medicine constructed on a human scale. It is practised not as a technological manipulation but as a special

sort of relationship between two people, the doctor and his patient. When at some future date the definitive history of our subject comes to be written, I believe that the gift of Michael Balint to academic general practice will be seen to be simply this: that he rooted our practice in the values of science, which Jacob Bronowski described as creativity, the habit of truth and the sense of human dignity. But more important still, that within these stern criteria he made our medicine a strong ally of love's growth among men.

From the Annual General Meeting held on 22nd June 1976

President's Report—

Dr Clyne spoke of the efforts we had made and are still making as a society to improve the work of all general practitioners. The skills of medical school must be blended with the new ideas of Balint. We were reminded of Professor Marinker's Balint Memorial Lecture, in that a background in the arts and literature, as well as in science, is a great assert to the understanding of human relationships.

There are new groups in formation, including one for trainees. Dr Jack Norell is Dean of Studies at the Royal College of General Practitioners. Dr Paul Freeling is to become lecturer in General Practice at St George's Hospital Medical School.

The Society is represented at the newly formed International Balint Federation, which had just organised the Paris conference. The next international Conference will be in London in 1978, under Dr Clyne's organisation, with a committee of helpers.

Secretary's Report—

The numbers of the Society had risen to 130. During the year we have seen the following groups started by Enid Balint and Michael Courtenay, a group for trainees in Battersea; David Morris, a group for paediatricians; Mary Hare and James Carne, a group for trainers in Amersham, who had originally asked for help in setting up a Balint group for trainees, rather than for themselves; Dr Zweig has started a group for general practitioners and others in Guildford.

Occasional request are received for information from doctors throughout the country, but we have not yet heard of any groups arising from local effort, like Dr Skinner's group in Derbys There must be trainee case-discussion group, based on the doctor/patient relationship in places. and we would like to know about them.

At the recent conference in Paris the British were well represented by Dr Hare and Dr Courtenay's group, a round table and papers read by British members.

CYRIL GILL

The Family and its Doctor*

by MICHAEL BALINT

It is generally believed that if a family has stayed with a doctor for some time and has got to know the doctor and trust him, there will be no serious secrets between them; the doctor and his patients can talk to each other freely and frankly about practically everything. In this paper I intend to examine how far this belief is true and, if we find any restrictions, what their meaning is, from which side they have been imposed and, lastly, how they influence the doctor's therapeutic work and his relationship to the family.

A friend of mine, admittedly a psychiatrist, one day complained to me that they had had to give up their doctor, who had been well liked by all of them, children and adults alike. He was a very good doctor, conscientious and pleasant, but he had a curious habit: for instance, when a child had a sore throat or an upset tummy he invariably used to enquire whether there had been some emotional upset in the family, how the child got on with his parents, or did Mummy and Daddy have a row, etc. In the end the children found this questioning ridiculous and unbearable; they revolted and refused to see the doctor. It is likely that a number of people will fell sympathetic towards the children and will agree with them that this constant questioning was irritating and that these topics were no concern of the doctor.

Before we take sides in this issue let me report another case which was discussed recently in a Research Seminar of General Practitioners in which we are studying the implications of any interruption of pregnancy. A sceptical but very conscientious doctor reported about Louise, a girl of not quite seventeen who had left school a few months before and was in her first job as a secretary but still looked very much like a schoolgirl. She came complaining of recent irregularity in her menstrual periods and asked for some pills to regulate them. On being questioned she told the doctor that her periods had been regular until about eight weeks previously, but that she had had no period since. The doctor, who knew the family well, was rather surprised and, as a first step, arranged for a pregnancy test, which proved to be positive.

The next afternoon Louise, when confronted with this fact, admitted after some struggle that she had had intercourse about two months before, and then asked for an abortion. The doctor advised her to discuss the matter with her mother in the first place since they would need her help and collaboration. Louise brought her mother the same evening without having told her the whole truth; on hearing the story the mother was understandably upset, so the doctor advised mother and daughter to talk the whole situation over and come back the next day.

Returning the next day, the two women unanimously asked for an abortion. It was obvious that, although badly shaken Louise's mother accepted the facts, taking charge of the whole matter so that things should be arranged in a sensible way to protect her daughter from unnecessary suffering. Practically all the talking was done by the mother, but the doctor was able to establish that Louise had got to know the 'boy friend' only about four months before, and since the intercourse had had no contact with him. The doctor then agreed to their request and arranged interviews with a psychiatrist and with a gynaecologist.

At this point, rather shamefacedly, he produced Louise's medical records. We learned that at the age of eleven Louise had complained of blurred vision, headaches and photophobia. She saw an ophthalmologist, who found no organic causes but described her as 'tense and a little emotionally disturbed.' At the age of fourteen she came with pains in her chest under her breast; on examination nothing organic was found. Six months later she had fairly severe pains on the right side of the abdomen, and her appendix was removed. In spite of this the same sort of pains returned, on and off; a rather bad bout of pain occurred when she was about sixteen. The doctor summed up that very probably he had missed all the pointers, meaning that the causes for this sort of pregnancy could have been diagnosed well before the event and the pregnancy perhaps even prevented.

We learned from the doctor—not from the medical notes—that Louise's father was a big man, a steady worker, who went out of his way to be kind to other children. Her mother was somewhat rigid but kind and efficient; for the last four or five years she had been working again as

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* *This paper was the first of the Winter Lectures to the Public for* 1970, *and was published in the Scientific Bulletin* (*No.* 53, 1971) *of the British Psycho-Analytical Society and the Institute of Psycho-Analysis to whom we are grateful for permission to re-publish it here.*

a secretary. Louise has a brother about two years older who is never ill and so the doctor has had hardly any contact with him.

The family has been on the doctor's list for about six years. During all these years he restricted himself to taking seriously any so-called organic illness that was presented to him but did not ask questions about any possible 'emotional problems'. Retrospectively he recognised that questions could have been asked about the general emotional atmosphere in the family, about how warm and intimate the parents' relationship with each other and with their children had been, why Mother had decided to start working and what effect this had had on Louise, whether she felt that Father was perhaps nicer to other children than to his own, and so on. We know for certain that Louise's varied complaints had started when Mother returned to work, and that she was much more afraid of her father than of her mother. Then we have the mother's impressive behaviour: first, seriously shaken by the news, then quickly regaining her balance and from then on taking full control of the situation without one word of reproach or blame either to Louise or to herself and without any attempt at involving, or asking help from, her husband.

A whole host of questions could be asked at this point. Should one consider this objective, matter-of-fact way of tackling a painful problem as a sign of a kind and efficient but emotionally cold atmosphere in the family? Does it point to a similarly friendly and kind but dispassionate and somewhat cold relationship between the parents, the woman shouldering the unpleasant and taxing problems while protecting her kind and perhaps not so strong husband; all of which might have had all sorts of undesirable effects on Louise? Is it the doctor's duty to find out how things are in this area? But, if he decides that he ought to know more, he must ask questions about secrets kept hidden from him, questions which might upset the parents as well as the children and might create serious tensions between himself and the family. We may add that examining the emotional background in a family is especially difficult when the doctor has formed the opinion as he had in this case—that the family is living in friendship and peace, that they are really 'nice people' who are fond of each other. And, rather a disquieting remark, this sort of inquiry or probing was exactly what in our first case, that of my psychiatrist friend, the children and parents resented so much.

This will be the central problem of this Paper. How much must the doctor know about the family who are under his care, and which areas may remain unknown to him? Looking at the problem from the other side, how much of their intimate feelings and experiences should patients discuss openly with their doctors, and how much and which of them may they keep to themselves? All these issues are complicated still further, of course, by the fact that, as a rule, these areas concern not one person only but also the most intimate relationships between two or more people, such as husband and wife, parents and children and so on, which means that one must decide whether or not to reveal not only one's own secrets but also those of one's nearest and dearest.

Comparing the two cases just reported, the conclusion is obvious: it is just as dangerous for the doctor to ask too many questions, that is to be too curious, as to ask very few—not to be curious enough. Remarkably, this important problem of medical practice is not even mentioned by the ordinary textbooks; with this problem—as with many other awkward ones—medicine has adopted the policy of ignoring its existence.

Every medical examination starts with 'taking a medical history.' This is the art of obtaining from the patient a detailed description of the history of his complaints such as his pains, disquieting sensations, changes in the functions of his body, etc., etc., and putting all this information into a concise logical form.

This procedure is based on two complementary assumptions: a) that doctors can think of and ask all the right and necessary questions, and b) that patients will be willing and able to answer these questions honestly and not try to keep any secrets from their doctors. As our two case histories convincingly show, neither of these two assumptions is valid.

Patients have secrets and are vexed by a doctor who tries clumsily to get hold of them; on the other hand, doctors do not like asking 'indiscreet' questions and they may become so inhibited that they do not even think of asking them. It happens quite often that when the need for such an exploration is suggested, the doctor's response is serious indignation.

Instead of pretending that the problem does not exist, or getting indignant about its implications, I propose that we should accept that every human being and every family will have some secrets and that it is for the individual to decide how much ought to be revealed to his doctor. A corollary problem will be what sort of skills the doctor must acquire in order that this disclosure shall be an painless as possible.

I wish to get quickly out of our way what is called 'social expectation'. In the last 50 years or so, people in the western world have become much less secretive about their bodies. This means that we doctors encounter hardly any difficulty when we have to examine our patients' bodies; with some skill and tact we can inspect and palpate even the most intimate parts without causing too much embarrassment or unpleasantness. Not entirely, but to a considerable extent, this change has been achieved by the steady educational efforts of the medical profession. In contrast, the public have not yet been educated to permit the examination of their private and intimate feelings and emotions. It is even questionable whether emotions can tolerate this disclosure as well as the body can: it might happen that this disclosure for the sake of an objective examination may rob these intimate emotions and feelings of some of their value, and may cheapen them. It is not impossible that something of this kind might have happened with regard to the body. We have as yet no answer to this important question, but as a doctor I must emphasise the importance of emotions as possible causes of serious illness and therefore plead for some medical privilege for studying them. This privilege, however, presupposes that we doctors learn a new, additional technique of observation. The basis of scientific medicine is the technique of reliable observation of hard objective facts and biological events. If the doctor wants to explore the realm of secrets, of intimate feelings and emotions, he must become familiar with the language of private intimate emotions and feelings and not only with that of biological facts. In other words he must learn to understand vaguely defined and vaguely expressed half sentences, hints and allusions about sentiments, and not try to translate this sort of information into hard facts or events. Our last case history will illustrate what I mean by this.

The usual argument against accepting the existence and the importance of this sort of communication is that they are beyond the field of a self-respecting scientist. They are not exact, and should therefore be left to poets, novelists and other such artists. In any case, these communications have no tangible basis; they are so vague that their real meaning is a matter of guesswork. How can one rely on inexact communications which cannot be couched in unequivocal sentences either by the emitter or the receiver?

My answer is that though all these arguments are correct they are irrelevant for the problem we are discussing. Let us take, for example, music: it is intangible, vague; its message cannot be expressed in exact statements, but still it has a definite message which can be understood and even responded to. Of course this can only be done if one is familiar with, and not antagonistic to, the specific idiom of that particular piece of music. A good illustration for this is the difficulty that we have in understanding oriental music, of the difficulty of the older generation among us in understanding modern or pop music.

This is one of the fields where we psychoanalysts can be of considerable help to medicine in general. One of our most important, and definitely one of our most frequent, tasks is to understand what the patient 'tries to convey' to his analyst—not by concise and exact statements but by using vague hints, allusions and half-sentences as just mentioned. It is in this way that the analyst acquires his familiarity with the language of the unconscious; a certain amount of this familiarity is essential for the understanding of the many indirect ways that the patient uses when expected to talk about his secret intimate feelings.

The same sort of sensitivity will enable the doctor to be content with these vague allusions and not force his patient to spell out everything in so many words if there is no compelling need for it: on the other hand, the doctor will be better able to help his patient to accept, and to talk about, feelings and events which until that moment have been only half real to him. A good example of this is the sequence of Louise's varying complaints in our second case: she started with her eyes, then came pains under her breast; this was followed by pains in the lower part of the abdomen. Anyone familiar with the language of the unconscious will be able to recognise the direction towards the genital parts of the body. This was what the doctor meant when he said that the danger of some trouble with the genitals, e.g. a possible unwanted pregnancy, could have been diagnosed much earlier. But even if he had been able to recognise this risk, what could he have done to prevent it? The answer is, exploring the sexual and other emotional tensions in Louise, and very likely in the other members of the family, especially the parents. Our last question is—how this could be done?

We psychoanalysts can be of considerable help in this field, too, by reminding our colleagues that this is another area in which the patient cannot be treated as a passive object in the way he is generally treated in medicine, but as an equal partner. During the whole of the examination it must be as evident for the patient as for

the doctor that every detail that he discloses, even if it causes uneasiness or pain, is essential for the understanding and better treatment of his illness. It is equally important for the patient to feel that his doctor is honestly interested and is not acting out of curiosity or any other phoney motive. A brief anecdote will illustrate what I have in mind.

A young boy of five was seen by a dermatologist for a slight eczema on his face. He was given Cortisone ointment and, after some weeks, was taken by his father for a follow-up. The dermatologist was pleased with the result and, being a pleasant man, tried to make friends with the boy. He started by asking whether he liked playing football etc. The boy chatted with him in quite a friendly way but when they eventually departed he asked his father most indignantly, 'Does he really think that football has anything to do with my rash?'.

This shows how the usual way of 'creating a friendly atmosphere' by well-meant but irrelevant enquiries and remarks is often felt by the patient to be irritating, hypocritical or dishonest. Of course, not everyone is as astute, or as frank, as this little boy was with his father. Nonetheless we doctors must never forget that the straight and narrow path is the safest, and every pretence, even the friendliest, may mean taking unnecessary risks.

I have talked a great deal about the secrets of any individual patient or of a whole family, but said very little about the reasons why they must be kept so secret. I mentioned only that they pertain to the individual's feelings about himself on the one hand and to his relationship with his nearest and dearest, like his spouse or his sexual partner, his children or his parents, like his most important friends, and enemies, on the other.

There are many more causes for this secretiveness; the trouble with them is that all of them belong to the borderland between the conscious and the unconscious mind. This means that they are rather vague and ill defined, which fact must be accepted; any attempt at describing them unequivocally must fail by creating distortion rather than order. The most important group of causes consists of the triplets fear, shame and guilt. Equally correctly it could be described as one multifaced cause which, seen from one angle may appear as fear, from another angle as shame, and from a third as guilt.

Let us take an example which will occur in our last case—fear or distaste of violence. When getting more familiar with the patient one gets the impression that the affect in question could be expressed better by the phrase 'having always been anxious and inhibited for fear of possibly hurting or damaging people'. An equally correct description would be 'the patient is deeply ashamed for being such a horrible woman who, at times, has violent wishes to hurt and damage people, wishes which she feels must be strictly controlled and inhibited'. Yet another equally correct description would be, 'the patient feels guilty for having had such violent wishes which, though she has tried to control and inhibit them most anxiously, might have got out of hand and might have hurt and damaged people very badly'. May I add that in some cases it is most important that patient and therapist should be able to find the one formula which is the right one, while in other cases this is unimportant; the only important thing is that the doctor should help his patient to talk about this secret, no matter in what sort of words or sentences.

There are many such vague conglomerations of causes. One well-known one is the fear, shame or guilt at having done something horrible to one's child or children, an irreparable damage, either by omission or commission. Another such conglomeration is about one's own sexual value or lack of value; this, as a rule, is inseparably connected with one's feelings towards one's own body and towards that of one's partner's. The few I have enumerated here are perhaps the most frequent ones, but there are many others.

The next question we have to discuss now is what a doctor could do when he reaches the conclusion that some secret of this sort lies at the root of his patient's complaints. This is, of course, a most complex question of medical technique which cannot be properly appraised in a short talk like mine now. Instead I shall report a case which will illustrate one method whereby a doctor was enabled to help his patient in an acceptable degree. The case is taken from another seminar in which we are trying to define some acceptable methods for dealing with the patient's or the family's secrets.

This demands a somewhat different approach from the doctor. To emphasise this difference we coined the phrase that, in these cases, in addition to the 'traditional diagnosis' the doctor must also reach an 'overall diagnosis' which comprises the illness brought to him and also the patient's whole personality with his conflicts, problems and difficulties.

The case will start with one individual member, but it will soon become evident that it is, in fact, about a whole family. The individual member, Miss O., joined Dr. C.'s list in 1967 when her previous doctor died. She was then 68, single, a

retired clerk. She was living in a self-contained flat in her brother's house. He was about one year younger and had married late, a woman of about his own age. There was another self-contained flat in the house which was occupied by Miss C., also a single woman, in her late fifties, a very close friend of Miss O.; they spent a great deal of time in each other's company. Unlike Miss O., these three people had been on the doctor's list for many years. One more important detail is that when Miss O.'s mother became seriously ill, well up in her nineties, Miss O. insisted that she should be transferred to her flat, where she nursed her most devotedly until she died. The mother was also the doctor's patient, so he knew Miss O. very well indeed. He knew, for instance, that Miss O. was a kind woman, interested in church work, in helping people in trouble, but found cruelty and violence distasteful and revolting. When joining the practice, Miss O. came in with a host of complaints which the doctor had some difficulty in sorting out. Eventually they could be traced back to a chronic overdose of Diamox, a potent drug prescribed for glaucoma by a consultant. When this drug was stopped all the symptoms disappeared. The doctor soon discovered also that the patient had been treated previously by two more consultants, so came to the conclusion that Miss O. was in all probability somewhat over-anxious about her health. Then followed a completely uneventful period, Miss O. seeing the doctor at intervals of 6-8 weeks.

By comparison, the medical records of the other members of the family are very slight. Mr. O., like his sister, is good-looking, well-preserved and always well dressed. He has had only minor illness like bronchitis; in fact, he is hardly ever ill. In contrast to him, his wife looks much older and has some anginal pains. The last member of this set-up, Miss C., is a somewhat tense and anxious woman but, apart from occasional colds, she has usually been well. Of course, she knows all the members of the O. family intimately.

In the Summer of 1968 Miss O. appeared again, complaining of being under the weather, of poor sleep and some giddiness. After a thorough physical examination the doctor came to the traditional diagnosis of anxiety and depression.

Although Dr. C. had known that she—like her mother—ever since her childhood had been suffering, especially during weekends, from migrainous headaches which considerably interfered with her enjoyment of life, until this interview he had not tried to probe deeper into Miss O's possible personal problems. Thinking that this was an opportune moment, he asked her what she could tell him about herself. First she said, 'Nothing', but then it slowly was established that Miss O. had often been ill in the past, that she was afraid of violence and of becoming a burden to other people, and that she and Miss C. were very close friends, that she used to be equally friendly with her brother, but that when she brought her mother to the house her brother became jealous of the intimacy between the two women. At this point the doctor probed further, asking whether the brother's marriage had made any difference to Miss O., to which she gave an evasive answer. Instead of pressing further, Dr. C. remarked that Miss O. was apparently anxious to impress everyone that she had no disturbed feelings. She responded by obviously relaxing and easing up, which enabled the doctor to say that her poor sleep might be partly caused by her being unhappy at being alone in bed; she did not protest at this suggestion. The doctor stopped here because he thought that the patient had told him as much as she could and that at this moment any attempt to get more from her would cause serious resistances. He felt that during this interview he and his patient got on to a 'different level' and that this had been acknowledged by both of them, though without any words.

May I repeat here that every case reported became a research case and was followed up systematically at periods of 12-18 months. Right from the start we accepted the principle that without explicit predictions in the initial phase no follow-up could verify or refute any idea. With this principle in mind each doctor was asked to state in his initial report, which was recorded and then transcribed: (1) two diagnoses for each case—the traditional and the overall diagnoses (2) his therapeutic plans for both and (3) his prediction for both.

In Miss O's case the traditional diagnosis was: migraine, general tension, insomnia. The overall diagnosis was: (1) very strong family ties, obligation to care for other people; (2) fear of cruelty and violence; (3) secretiveness about her own emotional and sexual life; possibly only weak heterosexual urges, with some more or less conscious—homosexual ones; (4) tension between brother and sister, possibly because of jealousy: (a) about mother (b) about sister-in-law (c) about Miss C.

The doctor added that, realising that Miss O. expected to receive some medication for her presenting symptoms—the traditional diagnosis—he prescribed some hypnotic and some tonic, while the treatment for the overall diagnosis

consisted of showing to the patient: (a) that there was no need between them to use pretence organic illness if she wanted some help from him and (b) that he had some idea of what sort of problems the patient was struggling with but that he was in no hurry to force her to talk about them right now. For the future his plan was to explore with his patient how far she could—and needed to—talk about her intimate problems.

The first response by Miss O. was very encouraging. She made an appointment to see Dr. C. a week later, when she started, perhaps to test the doctor's sincerity, by complaining in the old way about another attack of migraine. The doctor simply waiting, she then changed her approach and added that her attacks of migraine spoilt her enjoyment of life, and then started to talk about her fear of becoming a burden, no matter to whom; she must feel that she had done her duty and not given offence. Then she said, 'I have been thinking a lot about what you said about my secretiveness', and added that, in fact, she had not talked much about herself until now. A pause followed, tolerated by both of them, and then quite unexpectedly she said, 'You remind me of my father'.

Then came a long story about her mild father and her stern mother who used to be cross with him and tell him off, whereupon Father left the room but used to creep back, asking meekly, 'Are you still cross with me?'. The doctor admitted that at first he was not very pleased to be felt so meek and mild, but then realised that there was no criticism, only affection, in Miss O's story. She talked about her brothers, who were similar to thier mother and saw to it that she had her corners knocked off. Dr. C. commented here that perhaps these experiences were the reason why she got on so much better with women than with men; she thought a bit and then agreed that this might be so. After a while the doctor asked what sort of tension was in the house—was it true that Miss O. was jealous of her sister-in-law—and he learned that, quite to the contrary, the sister-in-law was jealous of the close friendship between the two spinsters, Miss O. and Miss C.

On being questioned, he reported that on this occasion he did not find it necessary to prescribe anything, although the patient had started the session by complaining about her migraines. Apparently the patient did not expect anything either, since she went away quite satisfied.

The doctor was able to state his predictions more explicitly. These were: (1) it is very likely that Miss O. will maintain the 'new level' in her relationship with the doctor provided (2) that the doctor does not try to push and hurry her; (3) probably she will continue to offer all sorts of somatic 'illnesses'; but (4) these will not be very impressive provided the doctor will take them seriously but not allow her to get off the 'new level', that is, back to her absolute secretiveness.

As already stated, it is an integral part of our research to follow up systematically at regular intervals all the patients who have been reported to our seminars. Miss O's turn came about 11 months after she had first been reported. During this period Miss O. was seen four times; as I just mentioned, she used to see the doctor every 6 to 8 weeks. During the same period her friend, Miss C., was seen twice, about the average, and her brother four times, definitely more than average, while her sister-in-law was not seen at all.

There was an undramatic though steady development in Miss O's relationship with her doctor. Each time she presented some apparently organic complaints, and each time she seemed to welcome it that no organic cause could be found. The 'different level' was maintained, she talked more freely about herself, but it was always she who decided when to stop. First she admitted that since the discussions she had been able to be more self-assertive, especially with her brother. At a later visit she mentioned that she had formerly been dominated by her brother, who thought he was always right, although usually he was not; now she had no difficulty in remaining firm with him. Although she still hated and disliked violence, this situation was somewhat better now, but her fear of becoming ill and a burden to other people was still very strong. All this, however, was said in a way that the doctor could not make use of. Nevertheless, he tried to enquire about the influence of possible stresses at home, but she brushed this off, saying that now she was able to be much more forceful than before and that there were now no stresses.

Remarkably, out of the blue, Miss C. told the doctor her whole life history. It was obvious that the two women must have discussed what happened between Miss O. and Dr. C. Very likely Miss C. wanted to have equal treatment, but only if she could be sure that the doctor would leave her alone. Apart from this, she confirmed that Miss O. could now stand up for herself.

The brother's visits were only for minor illnesses, like singing in the ear, slight bronchitis, etc. Each time he mentioned that his sister was much more lively in everything she did and that it was much to his liking.

In the next follow-up period Miss O's case was brought up for discussion fifteen months after

the first follow up report. During this time Mr. and Mrs. O. had not consulted Dr. C. at all, Miss O. saw him 5 times and so did Miss C.

The frequency of Miss O's attendances remained the same as in the previous follow-up period, i.e. 1 in every three months. She came complaining of sleeplessness, influenza, and in the post-influenzal period, of some gastritis. There was no complaint of migraine, of being run down, or any other signs of depression. Dr. C. felt that the tension had been considerably reduced and he apparently reverted to his old ways, because he gave her some hypnotics for her sleeplessness and a mixture of magnesia for gastritis. It will be remembered that in his therapeutic plan given two years before he had decided not to give drugs if this could be avoided.

Apparently the relationship between the borther and sister had settled on to a new level because the brother was not mentioned at all. Instead of him, Miss C. was mentioned several times as being bossy and difficult, especially before the holiday which all of them were taking together. On returning from the holiday things in this relationship seemed to have become calmer, Miss O. reporting that although Miss C. was difficult she could tolerate it.

Miss C. came five times during this period which was definitely more frequent than her average. She complained of an irritating itching of her skin and of some other annoying minor symptoms. She was anxious that the doctor should appreciate that life for her was hard and that she had to suffer. This he did and then tried to use the opportunity to let her talk of her life history which she had presented to him out of the blue about a year ago, but she responded evasively.

One more important detail must be mentioned here. After the clearing up of the symptoms of he Diamox overdose, during which there was fairly close collaboration between Dr. C. and the ophthalmic surgeon, the two doctors had no contact with each other. Dr. C. assumed that Miss O., like all the glaucoma patients, went on having periodic checks with the surgeon, but he did not bother to find out more about it. About February 1970 he received a note from the surgeon informing him that as the intraocular tension in Miss O's eye had become somewhat high and could not be reduced by medication, an iris inclusion would be performed in a couple of week's time. The operation was successful, the tension was reduced and her sight got a bit better.

What had happened in this case? An intimidated and frightened spinster who had never been able to express her real feeling was enabled to get in touch with herself, to become aware of some of her feelings of guilt and shame, and to talk about them up to a point. The principal topics that she was helped with were: her love for her meek father, her dislike of her domineering mother and brothers; her dislike of violent scenes on the one hand and her fear of becoming weak and dependent on the other; and, lastly, her dislike of being alone. These were all secrets which almost certainly had never been mentioned to anyone. The patient's response to this ventilation was (a) less frequent visits to the doctor; (b) less insistence on presenting organic illnesses, and (c) a definite change in her subdued behaviour towards a more realistic self-assertiveness. As she brushed aside a number of tentative overtures by the doctor, he decided to accept for the time being what had been achieved and not to press for more.

During a period of two years the results as described in the previous paragraph were maintained. Miss O. used the doctor at the reduced rate of about once in three months, she was able to make peace with her brother without giving up her newly gained self-assertiveness; she was able to talk about the strains in her relationship with Miss C., and perhaps through this was enabled to tolerate these strains better. Her lifelong attacks of migraine have completely gone for the time being, as well as the feeling of being run down and all the other symptoms of a mild depression.

Everything points to a considerable reduction of tension in Miss O's except for one single detail—the increase of intraocular tension in her glaucomatous eye, necessitating an operation. Glaucoma is definitely a candidate for a place among the psychosomatic illness although the evidence is not yet convincing. If this proposition is reflected, we need not bother more. In a case of chronic simple galucoma one iris inclusion at 70, especially if Diamox cannot be used, is a fairly normal event. If, on the other hand, we accept the idea of a psychosomatic condition, the possibility of the tension being removed from all other spheres of life and being accumulated in the eyes cannot be excluded altogether. We know that Dr. C. did not bother to keep up a close contact with the surgeon and did not do anything even after he received the information about the forthcoming operation. It must be added that this would be a fairly normal procedure between a general practitioner and one of his consultants who got to know and trust each other. Still we have to ask, as was done in the seminar, would it have made a difference if Dr. C. had watched the changes in the intraocular tension together with

the surgeon? We do not know the answer, but the case will be followed up.

In spite of this uncertain detail, this is definitely an acceptable result, considering that she is a 70 year old spinster who has never had any contact with a man and has retired from work for some years. Yet, in spite of this acceptable result, there can be no doubt that Dr. C. tacitly agreed with his patient's wish to stop, not to probe further into her personal problems, i.e. her secrets. It is not too difficult to form some idea of what this 'more' could be. Dislike of violence is usually associated with dislike of passion in any form, especially of passionate sexuality. The roots of this dislike are probably in an apprehensive attitude towards sexual and aggressive drives and towards everything pertaining to or originating from the body, resulting in the experiencing of every bodily sensation as a danger or threat, i.e. as an 'illness'. In consequence, these people as a rule have an impoverished and uneventful sexual life—like Miss O. I left it intentionally undecided whether this general attitude is due to inborn or environmental factors; it is very likely that in Miss O's case both factors played their share.

This sort of uncertain attitude, inhibited still further by anxious over control, will very likely characterise her attitude towards her brother, who must be fairly similar to herself. The indications for this assumption are his late marriage, the fact that he has no children, that he is inclined to be bossy on the surface but is rather weak underneath.

The same sort of mixture of closeness and distance must be true about her friendship with Miss C. who, though very pleased at Miss O's increased self-assertiveness, was probably jealous enough to want something of this sort for herself and went to the doctor to tell him, out of the blue, her whole life history but put him off by clearly indicating that she did not want anything that would go further.

And, lastly, we have the sister-in-law, about whom it was reported that she was jealous of Miss O. for her friendship with Miss C. and possibly also for the intimate relationship between the two O's, brother and sister. The fact that she has not seen the doctor for almost a whole year is in full agreement with this hypothesis.

Taking all this into consideration we may get a still better understanding of what happened between Miss O. and her doctor. For the first two years or so she managed to keep him at arm's length and even now, when he had enabled her to open up, she was to be the one to decide how far they should go.

We must not forget, however, that these are only assumptions, the validity of which must first be ascertained. At the present stage of our research in medical technique we advocate that the doctor must have all these assumptions at his fingertips all the time, but in contrast to psychological custom, he must not be in a hurry to find out how far they are valid because this might put the patient—and the family—under too great strain. In other words, he must always be on the alert but must wait patiently for the *right moment*. For the time being we cannot yet define what the right moment is, nor how to recognise it, and we must rely on a sort of subjective asessment of the atmosphere between patient and doctor.

We realise that this is a new idea, one demanding a new attitude from the doctor and his patient. In the traditional illness-centred medicine all the examinations are expected to be done in a limited time span in the same way as can easily be adopted by an uninvolved observer towards an unemotional and detached object. Our new idea that both patient and doctor must wait for the right moment is not easy of acceptance by either of them. The patient is anxious and wants *to know*, i.e. hear from his doctor within a reasonable time what is wrong with him and what can be done about it. The acceptance of waiting is perhaps still more difficult for the doctor who, during his whole training, had continually impressed upon him the principle; no real therapy without reliable diagnosis: reliable diagnosis meaning the examination without much delay of all the parts and part functions of the body which might be thought of as possibly pathologically affected.

Miss O's examination has been going on for about a year and is still unfinished. True, we have learned a great deal about her, but a very large part—almost certainly the larger part—of her problems and conflicts have remained unexamined. In spite of this, *we intend* to wait, indefinitely, for the right moment.

This unexamined area of her life and personality is the sum total of her secrets. We think that if she were forced to talk about them the danger is very great that she would give inexact or distorted information which might mislead the doctor and might result in costly consequences for both of them. So we come back to the idea of choosing the right moment.

The case history presented may give some idea what we mean by this choosing. It is something of a middle way between not asking any questions and asking too many. It also shows when and where the doctor stopped with his enquiries and what the results were that he was able to achieve.

The Leaders, The Doctors and Their Patients*

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This paper is concerned with the task of leaders of Balint seminars as seen on this twenty-fifth anniversary of the commencement of the first seminar led by Michael and Enid Balint. I shall not dwell on the historical aspects of the movement but concentrate on what has emerged from the experience.

Most of the leaders have been psycho-analysts, and Michael Balint always maintained that this was as it should be. On the other hand he led research projects in which the relationship between doctor and patient was of paramount importance in the work, even if this work fell short of dealing with a transference, and was carried out by non-analysed doctors. It is therefore possible that the idea of having a non-analysed seminar leader might not have remained abhorrent to him where there was a great scarcity of potential psycho-analyst leaders as there is in Britain at the moment. General practitioners who have worked in Balint groups and have shown aptitude for leadership are, in fact, leading groups. After all, being a psycho-analyst is not of itself sufficient training for Balint seminar leadership, as it requires a further specialised experience working in a group as an associate in order to understand the general practice setting and the particular problems that it poses.

Analysed or not the problems encountered by leaders seem remarkably similar when these are discussed at a seminar-leaders' workshop, and the main task is that of conceptualisation of all that is going on. Fear of losing the group is particularly common when leading a group for the first time. As the expectations of the doctors forming the group are usually unrealistic and idealised, the leader has the task of showing that the problems of the general practitioners are understood by him, as well as being aware of and able to handle some aspects of the unconscious conflicts that arise in the course of the work, both in the doctor/patient relationships of the patients presented in the seminar and also between the doctors themselves.

The leader's negative feelings towards some of the doctors in the group can be a problem in its own right, and it is here that the model of the leader as a doctor making relationships is put most keenly to the test. The problem is heightened by the fact that it is a training and not either a didactic or a therapeutic group, for in practice the distinction between these categories can wear very thin.

The temptation to treat cases presented by the group is ever present, all the more because it may appear an easy way of avoiding the negative feeling towards certain group members as mentioned above.

Although the leader must of necessity make a diagnosis for himself in each case presented for his own clarity of thought, it must not be used for giving a didactic lesson on how to handle the patient. Such a course would lead to a patronising relationship towards the group and therefore ignore the need for the leaders to learn from the group members; this two-way exchange being one of the cornerstones in the new approach pioneered by the Balints in the further training of general practitioners. I still vividly remember my own astonishment in finding that the Balints really wanted to hear about the work of a general practitioner. No other specialist had ever seemed to think that anything of value might happen in that context.

However much the leader is aware of these precepts, only those who have tried to practice Balint leadership can really appreciate how difficult it is to constantly adhere to these golden rules, even in spite of long experience.

The leader's problems may be seen to be all contained in the over-riding need to allow the doctors in the group to do most of the work themselves, and only to supply insights into the group/doctor; doctor/patient relationships as they arise, mediated by a number of 'ground-rules' which will be discussed when the technical questions are studied later on in this paper.

The insights are difficult to define, and although founded on the concept of there being unconscious mental problems, are not based on any particular theoretical structure.

As Enid Balint[1] proposed 'the main contribution of the psychoanalyst can make to medicine is to establish the naturalness of man himself; particularly those aspects of man which seem most irrational and unacceptable; aspects in

* *This paper was read at the 3rd World Congress of the International College of Psychosomatic Medicine, held at the Catholic University in Rome in September 1975.*

which some part of the mind can, by a trained observer, just be perceived; which is not wholly defended; and which, once it is perceived, each man's uniqueness can show through.' She stresses the word 'mind'—not 'the unconscious', and continues by saying 'if doctors appreciate the uniqueness of their patients and if psychoanalysts can help doctors to do this and to tolerate some periods of confusion—where there are no familiar roads to follow—then their contribution to medicine can be significant.'

It is something of this kind which is the task of the leader of a Balint seminar.

A final problem is where there are co-leaders in a group, something which has been a feature of Balint seminars since the Balints themselves formed the first seminar, and has become virtually mandatory in the case of groups led by doctors who are not psychoanalysts.

In this situation it is vital that the leaders should work together and not compete. That is not to say that one should merely echo the other. On the contrary, it is often just as useful to point out a negative finding as illustrating the other side of the coin. The very contrast will serve to underline the positive aspects which may have been focussed on by the other leader.

There is no doubt that co-leadership does provide a further safeguard for the group when the leaders are relatively inexperienced, but at a more advanced level the task of co-leadership is perhaps more demanding than the more usual arrangement of having a single leader.

Essentially then the task of the leaders is a professional relationship in which they offer their trained observation and receive the range of experience of the work of a number of different doctors.

To attempt to illustrate this let me recount a case reported in the seminar led by Dr. Hare and myself. A woman doctor recounted how a patient of hers, a young man, was very depressed but because of what appeared as his flaunting of apparent homosexuality in dress, gait and the voluptuous furnishings of his flat, somehow did not fully engage her professional sympathy. Although she had attempted to treat his depression, she had been unable to make progress. He had acutely embarrassed her one day by finding that they were both travelling to London on the same train, he sat next to her and talked and gesticulated in his usual manner, attracting the attention of all the people in the railway carriage in which they were travelling. By the time he had minced up the platform of the terminal station with her she felt she never wanted to see him again.

The task of the leaders involved trying to understand the case themselves in terms of the highly-charged doctor/patient relationship in which a depressed young man was making a woman doctor angry. It suggested that the homosexual aspect was likely to be exaggerated, in that a woman doctor might be expected to be less uncomfortable with a homosexual man than a man doctor, and that the adoption of an exaggerated role both confirmed this and suggested that it might be the patient's defence against his depression.

The elements of the diagnosis were not communicated to the group, however, but instead there was an attempt to focus on the patient as an individual in distress, and to understand why it was so important for him to sustain the doctor-patient relationship, even though the doctor was less than enthusiastic about it. The doctor's discomfort was, moreover, accepted and an attempt made to understand it.

The following week the doctor reported that he had come late for his next appointment and she had expressed her anger to him about this. He immediately made her feel regret for this by recounting how he had been waiting for a bus a long time in the rain on his way to her consulting rooms. She suddenly looked at him afresh and realised that his clothes were *not* outrageous, it was just the aura he gave out together with her knowledge of how he decorated his flat and so on. She was amazed at this view of the patient, because she had thought that the previous seminar discussion had not been helpful, but suddenly found herself able to relate to a particular human being, and no longer restricted by labelling him, incorrectly at that, as an exhibitionist homosexual.

Turning to the consideration of the doctors who are members of Balint seminars one might expect those joining groups at the present time to have a more realistic expectation of their function than those who made up the initial seminar a quarter of a century ago, for a great deal has already been published about the work of the seminars in that time. At the outset the doctors of the first groups had no published material to guide them, but were motivated for reasons of their own. In the event the difference between the 'old guard' and the new generation appears to be small and this is, of course, related to the fact that the training has little to do with absorbing new information, and everything to do with the doctors as individuals.

Indeed, it was the experience of the Balints with social workers that led to their work with general practitioners. This was no accident. It is

an unfortunate side-effect of most systems of medical education that the long technical training tends to submerge the humanity of medical students, with the result that the human distress of patients, which is readily perceived by students in the first year of clinical work, may come to be ignored or even resented by a newly qualified doctor. It is, alas, also true that he would not be equipped with the skills to treat this distress even if it were recognised.

Such a doctor will possess two major characteristics in the approach to patients. One will be the conscious and very powerful need to 'organise' complaints into disease categories in order to apply the benefits of traditional medicine for the good of the patient; the other will be the unconscious, and very powerful expectations of how patients should behave under the doctor's care. The latter is the Balint concept of the 'apostolic function'.[2]

To remind you, the apostolic function means in the first place that every doctor has a vague, but almost unshakably firm idea of how a patient ought to behave when ill. Although this idea is anything but explicit and concrete, it is immensely powerful, and influences practically every detail of the doctor's work with patients. It was almost as if every doctor had revealed knowledge of what was right and what was 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. It was this that suggested the name of the 'apostolic function'.

In the case of a doctor entering general practice, the failure of attempts to organise all complaints into the textbook diseases learnt in his traditional medical education will gradually emerge over a number of years, and this may lead to a quest for new solutions by further training. This quest may lead to attempts to expand the medical textbooks by describing the unclassifiable conditions in similar terms to those already in existence, but alternatively the appreciation of distress in an individual may be re-awakened, together with hints that somehow illness is connected with the person as a whole, rather than an accidental process.

Even this realisation will not affect the apostolic function, the roots of which are largely unconscious, and it is no doubt because of this factor that doctors joining seminars now are not so different from their predesessors as might have been expected. Even if the symptoms of patients are seen in emotional terms as well as organic pathology, this is still an *intellectual* appreciation and may, as will be illustrated later, produce new difficulties in the doctor's work with patients, rather than make the treatment easier.

The first requirement of the leaders of a potential group must be to arrange a selection interview with the intention of mutually assessing whether the training is the kind the doctor is seeking on the one hand, and whether the doctor is really seeking personal treatment rather than training on the other.

This procedure leads directly into the main aim of Balint groups, namely to allow a greater freedom of the doctor to work with patients, and a greater understanding of him or herself. This involves a change in attitudes in the direction of being able to accept distress without retreating behind the defences built up by the formal medical education.

This leads directly to the Balint concept of the doctor as a drug. This concept was raised repeatedly in *The Doctor, his Patient and the Illness*, and has been reviewed in the light of later developments by Enid Balint[3].

In the book Michael Balint stated that one of the chief aims of the doctors would be to start devising a new pharmacology. That is to say, to describe in what dose the doctor himself should be prescribed, the side effects and so on. As Enid Balint says even the most experienced Balint-trained doctors still only have a partial answer to the question as to the dosage in which the doctor should prescribe himself, and the history of the development of the training could be described in attempts to solve—or different approaches to —this problem. For her the work of the Balints stands or falls by whether each general practitioner can realise what his function is. If the doctor knows how he wants to spend his professional life, then his patients will be satisfied too, will know how they want to be patients, and will not hope for what the doctor cannot give, any more than they would expect any other professional to have the expertise of another. If a patient gets what he needs from a general practitioner (and a general practitioner gives what he needs to his patients) then there is satisfaction and health, and not a discrepancy between need and provision for need.

In this context the leader has a major task in discouraging the development of cynical attitudes towards patients reported in the seminar, as this is clearly a defence mechanism in the face of distress. In simple terms the aim is to lessen the doctors' anxieties, the need to be always in control of the situation, the need to be always therapeutically potent, and so to liberate his compassion towards the patient. This requires a mixture of responsibility with flexibility, involv-

ing an increased capacity to tolerate symptoms.

It is hoped that these changes will occur within the exchanges between the group members rather than from direct teaching by the leaders, although teaching may be appropriate from time to time, perhaps especially in order to prevent a group attitude of a cynical nature appearing in the early months, as well as demonstrating a change in what is seen to be worth observing in the framework of the doctor/patient relationship.

Another aim is to allow the freeing of the doctors' imagination, without letting it run away with the doctor, and allowing him to tolerate the change involved. It is an old medical aphorism that if you don't think of a diagnosis you cannot make it, and equally if an atmosphere where the free airing of imagination is not generated, then the group members will not be able to stretch their imaginations to encompass the private worlds of their patients and so begin to appreciate the true scope of their own private worlds as a useful tool in understanding those of their patients.

Closely related to this is the lessening of rigidity in the doctors. This is perhaps another way of saying that the understanding by each doctor of his own apostolic function will allow a greater flexibility in his work. At the same time this may bring pressure on his personal make-up and give rise to a major difficulty for the leader: namely in the words of Michael Balint[2] in dealing with this aspect. 'By far the greatest part of the phenomena which constitute the 'apostolic function' are expressions of the doctor's . . . personality. It is not surprising that the doctor was generally the last to become aware of his own peculiarities, and in particular the last to welcome them in black and white.'

It is also the leaders task to protect the doctors from personal over-exposure in the group ambience, for it must not be allowed to develop into a therapeutic group, and although the Balint method is to insist on working through the doctors' difficulties in terms of the doctor/patient relationship, the emotional experiences involved must be constantly monitored by the leader. It may be that one doctor prefers men patients to women patients, or to concentrate on sexual problems of young women, but these patterns must always be discussed in terms of the patients presented, and not directly in terms of the doctor's personality.

It cannot be stressed too much that all this is very hard work, both on the part of the leader and the doctors, and even after long experience it is very difficult to follow the precepts, just as it is hard to be a good doctor, because this does not depend on occasional flashes of brilliance, but on delivering sound medical care to each and every patient.

Let me try and illustrate some of these points with a case. A man of 25, of oriental origin, came to the doctor complaining of passing flatus uncontrollably while at work. This was doubly distressing to him as he feared the smell would attract the attention of his collegues at work, but was also extremely rude in terms of his own cultural concepts. The doctor concluded that the symptom was emotionally determined and immediately launched a wide-ranging enquiry into his emotional state, and after spending some time with the patient gave him a further appointment in two weeks time. The patient was dissatisfied with this, partly because his expectation was to receive some medication to control his symptom, and also because he felt that relief was urgent and that an interval of two weeks was unacceptably long. The doctor was annoyed at this rejection of his time consuming attempts at a more satisfying solution, but nevertheless gave the patient some tablets to try, and agreed to see him in a week.

The reaction of the group involved a good deal of laughter, as the symptom was seen to be comic. The doctor had also chosen a very English pseudonym for the patient, which had also occasioned mirth. The leaders had initially to call the attention of the group to the very real distress the patient exhibited, with the realisation that the laughter had been a mechanism to defend themselves against identifying with the distress. On the other hand while the reporting doctor had probably made a sound intellectual diagnosis, he had attempted a psychotherapeutic approach on a theoretical basis (rather like giving a psychotherapeutic injection), and had failed to make a relationship with the patient in a way the latter could comprehend.

At a follow-up of the case the doctor reported that when the patient had first returned the symptom was unchanged, but in discussing his anxiety again, he was able to show the patient that an emotional element was at least a major factor in the continuance of the distressing symptom. At this stage the prescription of a minor tranquilliser disposed of the symptom, almost to the chagrin of the doctor whose psychotherapeutic intentions were immaculate. It was seen by the seminar that the doctor had closed the gap between the patient's expectations and his own to effect a successful conclusion, and that the tranquilliser was a symbol of the new communication between a doctor who wished foar

talking-cure and a patient who wanted magic.

This shows how much the development of skill in handling patients is related more to what the patient is trying to convey to the doctor, and what the patient expects to get from the doctor. Both these important concepts were studied in the research on the brief general practice contact described in the book *Six Minutes for the Patient*[1]. The doctor's desire, however correct and well-intentioned, in proceeding with a formal psychotherapeutic approach to the patient's problem, must be governed by the patient's need and expectations.

It is an unfortunate finding that in cases where there is great similarity between the doctor's own unsolved problems and those of the patient, there is often an increase in interest on the doctor's part and at the same time a diminution in the effectiveness of the doctor's work. He is, indeed, drawn into working with patients with similar problems to his own and so work with cases which are least suitable for him.

It is the leader's task to allow every doctor in the group to come to understand something about himself in the context of his relationship with a number of patients reported to the seminar, and it is the understanding of the individual function which may lead to the classic Balint aim of a considerable though limited change in the doctor's personality[2], and that this is demonstrated by the capacity to really listen to the patient, and constitutes a new skill.

Turning now to the technical questions involved in the interaction between leaders and doctors, the leader is bound to become a model in some sense ideally remaining not too authotarian but always responsible, and the way he relates to the doctors in the group will inevitably partly determine any change in the attitude of the doctors towards their patients.

The focussing of group attention on the doctor/patient relationship remains the golden rule for leaders of Balint seminars, but it is vital to constantly vary the precise means of doing this as it is imperative to reiterate it in every case presented.

Such remarks as 'what is going on here?', or 'what is the patient doing to Dr. X?' are two of the countless ways in which the group can be led to examine what is occurring in the doctor/patient relationship. Nevertheless it is probably wise to actually spell it out in terms of an enquiry about the relationship from time to time, and especially in the early months of a newly constituted group.

There is an enduring and powerful tendency on the part of doctors to concentrate on the historical aspects of the patient's experience, which is often fascinating, and to largely ignore the dynamic aspects of the interview as it is proceeding, and often even when considered in terms of afterthoughts. The facility of being able to constantly monitor one's interaction with a patient is perhaps one of the hardest tasks that face a doctor, and from the leader's point of view may be harder even than to encourage the indentification of negative findings. To discern what is not being talked about by the patient is particularly difficult in the general practice setting because a global view of the patient's functioning is difficult to achieve within the severe time constraints involved.

Another way of approaching the relationship problem is for the leader to enquire about the patient, 'what sort of person is this?'While this is obviously already one half of the consideration of the doctor/patient relationship, and also a safeguard against too much concern about the historical aspects of a case as mentioned above, it is furthermore a pointer as to what sort of treatment is indicated. In addition the kind of patients a doctor selects to present to the group will reflect recurring problems of his own which may stand in the way of helping some of his patients, and in the case of the last example the doctor was allowed to realise that the girl was the sort of patient with which he often ran into difficulties.

On the other hand it is important that the leader does not launch into statements about the probable psychopathology of a patient, firstly because it cannot be known with sufficient accuracy at second-hand, and secondly because it is largely inappropriate in the general practice setting. Indeed it is often counter-productive by allowing patients to be labelled in a way which tends to restrict action on the part of the doctor rather than free it.

In the case of a woman of 45 who was very upset when she found her eldest, seventeen year old son's bed empty one morning, although she knew he was sleeping with his girl-friend regularly, the doctor reported that she had expressed her feelings to him. This seemed to amount to her expressing the feeling that her husband was no support to her in this context, and to the doctor noticing that her eyes were brimming with tears. But the doctor had somehow been unable to talk to her, admitting to bafflement but not anxiety. The leader did not make any remark on the nature of the cause of the patient's distress, which was probably not far to seek, but concentrated on the undoubted fact that the patient must have done something to the doctor to block the free communication between

them.

It must be remembered that unashamed 'teaching' is not always inappropriate. On the contrary it is sometimes vital for the leaders to state certain things to allow the doctors to take away something positive from a session, or to nip in the bud any vicious tendencies (a cynical approach to patients for instance) which may be seen to be developing. Leaders are, after all, leaders and remain ultimately responsible for the group.

Take the case of a woman of 35, divorced but whose ex-husband had come to live nearby. She exhausted the doctor with complaints and was eventually referred for exhaustive investigations without any pathology being found. Even when she was returned to his care he seemed in no hurry to meet her again, and was content to give her a repeat prescription for a minor tranquilliser. The leader raised the question of a very atypical rejective referral of this patient by the doctor, and pointed out the common theme of how she found difficulty in making relationships, which seemed to be always either too close and demanding or too remote to be productive.

Another area where teaching is useful concerns the concept of the 'Overall Diagnosis' which was coined by the Balints to describe the bringing together of the medical and personal aspects of a patient into a unified whole. Although this is necessarily very difficult to achieve in the general practice setting where information is limited, an equivalent 'Working Diagnosis' is an approximation which is often much more easily discernible than appears at first sight in a case discussion.

Often the conjuction of a working diagnosis, constructed from the medical history and what is known by the doctor about the patient as a person, especially in terms of the continuing doctor/patient relationship, will shed an entirely new light on the situation.

Take the case of a man in his thirties complaining of impotence. The problem had emerged when his wife sought advice for subfertility, but he had responded by saying he wasn't ready for fatherhood. He had been brought up by his grandparents, who slept in different rooms, and actually slept in the same bed as his grandfather who was a martinet. At first the doctor found the patient very uncommunicative, and arranged a joint interview with his wife. During this interview the patient began to talk freely, and at such length that the doctor felt obliged to cut him short, and at a subsequent interview he relapsed into his usual uncommunicativeness. It was seen that the historical and doctor/patient relational aspects reinforced each other allowing a working diagnosis to be made. It is particularly important in a complicated presentation such as this not to allow salient points to be submerged in the cross-currents of group discussion.

The question of whether or not to make group interpretations has often been debated by leaders. On the whole the Balints appear to have avoided them, apart from such general observations as 'Dr. Y's case seems to have made us all rather depressed.'

More cogent interpretations vis-a-vis the doctor/patient relationship may impinge too strongly on the personalities of the doctors and will have the undesirable tendency to shift the centre of gravity of the group away from the training, and towards the therapeutic end of the spectrum of group work. But as has been said above, this does not preclude allowing the doctors to see that they tend to bring up similar kinds of patients recurrently without enquiring into why this is so. However it may be necessary from time to time to protect a doctor from too much personal exposure while insight is gradually gained.

Is it then possible to see the leaders' task more clearly? Perhaps it might be summarised as encouraging the development of an atmosphere in which a group of doctors can explore their own personalities in the context of their work with patients and so, by greater insight into themselves, gain a greater flexibility and new skills in understanding their patients as people in distress.

At the same time the leaders will protect the doctors from too painful an exposure of themselves, and enable them to enjoy their work more. In return for this the leaders will be provided with a wider and richer experience of person-orientated medicine than is likely to be available in their own professional ambits, and moreover allow their own insights to reach out more widely through the work of the doctors in the seminar.

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