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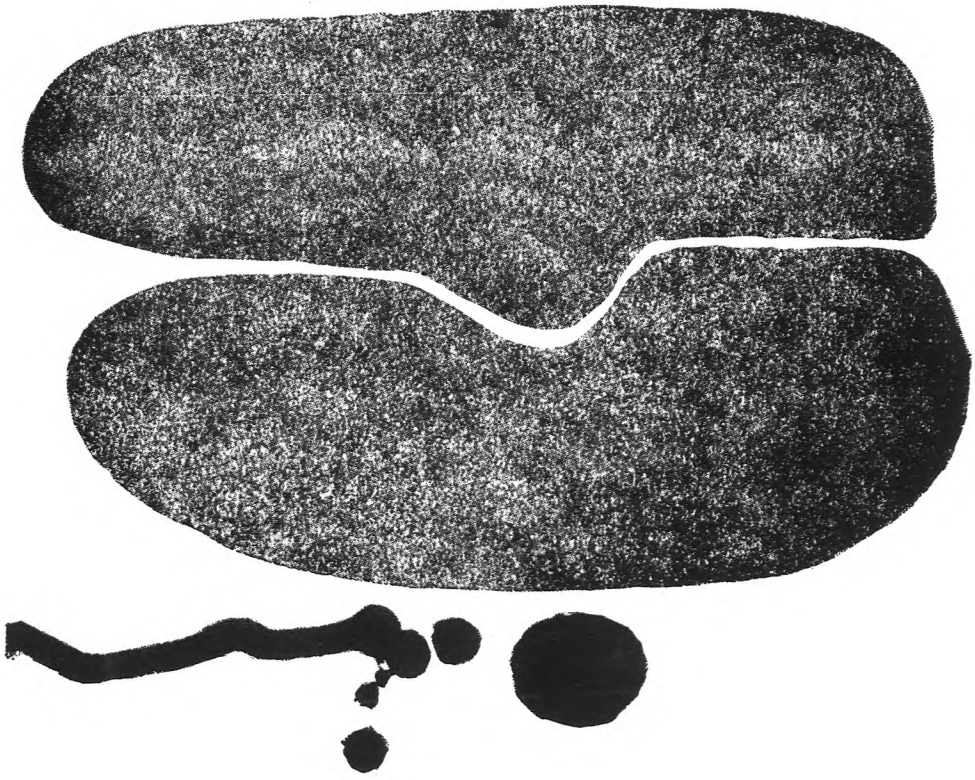

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Editor: Philip Hopkins

Editorial

The hope that the wind of change might blow through the corridors of the Royal College of General Practitioners has been with me for some time, and now it seems happily to have been fulfilled. In his Michael Balint Memorial Lecture, published in this issue, John Horder, President of the College, refers to the College's publication in 1972 of *The Future General Practitioner* as having '. . marked a tide that had already been turning for some years . .' Where there is a tide, there must surely have been a wind, and in its wake have come welcome changes.

The bias of this College publication towards the importance of the psychosocial aspects of medicine shows some part of the changes that have, and still are taking place. As John Horder puts it, the acceptance of this book as '. . a sort of unofficial text for passing the MRCGP examination', in spite of its provocative approach, can only be welcomed by all members of the Balint Society, as it strongly suggests that some of Balint's ideas have become, as John Horder describes it, 'a sort of new orthodoxy'.

A further very welcome sign of the better acceptance of Balintian thinking is the election to Honorary Fellowship of the Royal College of General Practitioners of Enid Balint-Edmonds. The honour is not hers alone, however, as the College is honoured too by having on its Roll such, as Jack Norell described her in his introductory oration (page 10), 'a gracious lady, respected colleague, and tireless worker for general practice'.

Every Balintian must feel proud to have been associated with her and her work, and also in having elected her, together with Michael Balint, as the first Honorary Members of our Society.

It is no coincidence that Enid's paper, *The Doctor/Patient Relationship in the 1980s* appears in this issue alongside John Horder's Michael Balint Memorial Lecture. It seemed natural to place them together, not only because John Horder quotes from, and agrees with her comments which are not only up-to-date, but also because her views seem to be so right, and her conclusions so vital that now must be the time for further development and more acceptance of the work and ideas started so many years ago by Michael and Enid.

In spite of their influence on general practice all over the world, there is still too great a tendency for further fragmentation of the primary medical care system in Britain, and ways must be found to reverse this.

Can we hope that there is any possibility for more co-operation between our Society and the Royal College of General Practitioners while it still has as its president one of Michael Balint's 'Old Guard', John Horder?

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 margains of 4 cm.

The Passage of Time

Michael Balint Memorial Lecture given on
27th January, 1981

by John Horder, PRCGP
General Practitioner, London

I am particularly glad to have a chance to repay a little of two debts to Enid and Michael Balint — *two* debts not so much because they are two people, but rather because for the moment I feel that I am. I started as a general practitioner in 1952 and that was the year in which John Hunt wrote an article in the British Medical Journal and a letter to the Lancet[2] which started the College of General Practitioners. I joined it in that year and have worked in it ever since. In the first fifteen of what is now nearly thirty years, practice dominated my life; in the second fifteen years, the College has increasingly dominated it.

My purpose now is to look back at the influence of the Balints on both these halves of my medical career. First I will describe the story of a patient who asked me to see her twelve years ago. I was summoned to the house on a private consultation and found myself being interviewed by a lady of some size, past middle life, originally from another European country, wearing a fur coat over several other coats and layers of clothing, although the room was warm. I passed the test and she rapidly converted to being a National Health Service patient.

I found myself being consulted for urinary infections which yielded many normal cultures, for backache without signs, and for boils and colds. Particular medicines, antibiotics especially, were requested, at first refused by me, then given under pressure since the problem always became worse without this concession. There would then be a reaction against the drug and the blame was mine alone.

Miss X talked frequently of how her strong and helpful previous doctors named her illnesses and how they treated them. By contrast I could find no names for the illnesses, and so felt inadequate; I resented the indirect control by other unknown doctors but obviously I was expected to follow their lead in every detail.

When she came to the health centre, her presence was always felt from the time of arrival, the consultation would be long and she would invariably catch a cold as a result of the outing. This, together with her continuous pressure, eventually led always to my visiting her at home — where I almost always found her on or in bed dressed again in many layers of clothing in an oppressively hot room. Very full use was also made of my early morning telephone time when she would invariably begin without giving her name and continuing to talk without thought for anyone else wanting to get through to me. This was only one of the ways in which I found her invasive. 'I must keep tabs on you and know where you are and what you are doing'.

Somehow I found this lady very hard to bear. There was a cluster of reasons — great pressure for attention, apparently for organic disorders, yet without objective evidence, making them hard to understand, hard to treat, and whatever I did seemed to be a failure. I resented visiting when there was no serious illness, even though it had been my own decision. She consumed much time, always starting with the distant past when life was good, and reserving essential business until I was overdue to leave. Any remonstrance by me would lead either to an aggressive response or to tears, so that there was no possible redress. I took any excuse to offload the pressure onto specialists when an occasion opened, but the problem always bounced back. In my frustration I wrote a referral letter to a specialist in which I criticised her behaviour and revealed my irritation. One year later she said, 'Dr. X showed me that letter you wrote. Since than I have known I can't trust you'. This really *was* difficult. Can one really believe that Dr. X showed it or did he just leave it lying for her to see? It took years before I stopped hearing about this episode. Yet she deserted Dr. X.

The many complaints without objective signs had long before this decided me to sit down and get her to talk about herself. I had at first thought of her as an old maid living with her sister. She had in fact lost another sister, her favourite brother and her boy friend who was killed as a sailor during the war; she subsequently had spent many years as the girl friend of a married professional man until he died. Behind this there was the tragedy of a prosperous childhood and then the family losing all its money. She had therefore had to earn her living. Shortage of money had forced her to come back to live with her sister, although they had never got on together; indeed she had been warned by a previous doctor to keep apart. Knowing this much changed my attitude to her to some extent.

It was only later when she revealed the full extent of her sister's behaviour towards her that I began to understand better. She at last revealed that all her possessions were subject to minor destruction by cuts and slashes and scratches and that they often disappeared completely. This could only be due either to herself or to her sister. I cannot see what she herself would gain from doing it. Immediately

she showed signs of improving in her health or trying to go out, her sister's attitude would harden. She had revealed all this only after I had known her for many years, out of loyalty to the one member left of her family. I believe that even her exceptional susceptibility to cold must relate in some way to her sister who always lives with the window wide open and seems to have a frozen heart.

I have tried to get the two to part company, but this is like drawing Excalibur out of its stone. I got my patient to accuse her sister in front of me, but the acts of destruction were totally denied and have continued since. Incidentally, the sister is not my patient. I have now given up expecting to change anything in any important way. On the other hand there is now a relationship of mutual trust, much helped for me by spreading the load to telephone contact with a very patient and understanding receptionist in my practice.

What is the point of describing this case? I think it raises many questions. What is primary medical care about? Can I justify the time spent and the trauma involved for both parties in this relationship? Why have I been unable to keep up with my own belief that the patient is always right until proved otherwise? She has repeatedly told me that she needs to be understood and to have sympathy and support, more than I can give her. Why have I not always allowed her to use me as she wants? Should I have done that? Could I? Could you?

I want now to look back at my own life in clinical general practice in order to trace the influence of the Balints; I shall begin by looking at the people and problems that I have found particularly difficult, and then at the beliefs and aims which I think I brought to bear in facing them and trying to help them. As Jan Van Es once put it to me, 'The patient and I are the case'.

Most general practitioners in my generation have found it difficult to understand and cope with physical complaints for which they could find no objective signs. If they tried to go beyond labelling them 'functional' or giving them a mythical causation, like 'rheumatism' or 'low blood pressure', there were the twin problems of how to present 'no physical disease' without insulting the patient, and how to enquire about life events and feelings if one *did* manage to get the patient's co-operation. That, however, was only a problem in my first years. I gradually found the right words and gained confidence and skill.

Uncertainty, the feeling of entering into a trackless desert where one might hurt the patient or more likely make a fool of oneself, was another early difficulty. It was close to the difficulty that stays with me even now, the fear of running into an insoluble problem, of being hard pressed by a patient, cornered back to the wall and having nothing to offer, and yet fearing to say so. Here I was greatly helped years ago by a doctor-patient who was going through a depressive illness. I said on the telephone, 'I don't know what to say because there does not seem to be anything I can do'. She replied, 'What does that matter? The only thing that is important to me is that you are there'.

I suppose that there *may* be doctors who do not find aggressive patients difficult, but I always have done. One notable one was a 60-year-old man who had just assaulted a woman trainee. She called me into her room to take over. I found him shouting under an upturned table. Weeks later when I displeased him myself, he went all round the female lavatories in our health centre with an indelible red pencil. This proved to be the crisis. My partnership decided that this was a character who had always created his own hostile world by doing things like that, and that we should see what a second chance would achieve. From that time he became one of the most loyal patients I have ever known, although life never went straight for him, as indeed it never had, since his prostitute-mother brought him up without a father.

Aggressive patients are difficult, but seductive ones can lead one into more subtle trouble. There was the so-called 'aeroplane girl' that I used to report in 1955 in my Balint group. She presented me with all sorts of pseudo-organic troubles that tickled my MRCP curiosity. They covered a story of sexual intercourse at the age of thirteen with her own brother on the day before he was killed as an aeroplane pilot. Her dreams about red aeroplanes provided plenty of fodder for the members of my group who were either more perceptive or more imaginative than I was. I got into deep water with her, but eventually managed to refer her to Dr. Anthony Storr with whom after three years she did extremely well. She is still in the practice, thirty years later, and is a model patient.

Liars are the patients who have always defeated me. Of course, many patients are, in some sense, near to being liars, because they consult, but fail to reveal their problem, and expect the doctor to cope with them nevertheless. But sooner or later the evidence *will* be presented at the next consultation, or after several years of contact. Above all, this applies to alcoholics and drug addicts. My definition of an alcoholic is someone who tells lies about his drinking. There is no possible relationship with a liar. Contrary wise, I find it desperately difficult to tell lies to a patient who is dying or incurable. Fortunately the climate of opinion has been tending to move towards kindly revelation of the truth.

Marital problems, in the sense not of sexual ones so much as of emotional disharmony, have often found me taking sides. I have had great difficulty with the totally incompatible stories of two marriage partners who are near to breaking. It takes a lot of experience to maintain the detachment and judgement which alone allows a doctor to continue looking after both.

Today, towards the end of my clinical experience, I find the biggest difficulty lies in the concentration of patients I see with multiple problems, or who carry a heavy weight of misery, anxiety or loneliness and seem to use me as the last available port of call. Their problems are seldom ones which I have met before (which surprises me after thirty years) and many are insoluble. All this conspires to

ensure that with ten or fifteen minute appointment slots I invariably keep all but the first patient waiting — the last one for a very long time. Like the patient I described at length, they raise the difficult question, was it worth it? Was it justifiable to give so much time to so few? Yet they seem to need it and I am incapable of working quicker.

There are indeed fast doctors and slow doctors, and one day I would like to watch each sort and compare their clinical aims; they may well have entirely different aims and expectations.

I have been attempting a survey of the patients whose clinical problems I have found most difficult. One might summarise the difficulties as due to lack of understanding, fear of failure, emotional drainage and the constraint of time.

Since doctoring is a two-sided business, I must refer to the ideas and clinical aims which I have held and worked with, even if they may already have been showing through my difficulties. I went into medicine believing that a patient's thoughts, feelings and relationships were as much the doctor's business as his bodily machinery. It has become more and more clear to me that anxiety, misery and emptiness can hurt no less than pain or breathlessness. I have gradually learned to give more and more importance to such influences as an unhappy marriage, loneliness or incapacity to make good relationships, as underlying causes of ill health. For people with such difficulties, to be able merely to rely on getting in touch with the doctor who knows them can be of paramount importance.

There was a day only a year ago when I told a patient, 'You know, I have never seen you look so well, although I have known you for a long time'. 'That's your doing' she said. 'You are the only person I have ever trusted and it has taken 15 years of testing you out'. Let me quickly add that on the same day there was a letter about another patient from her clergyman brother-in-law, an admirable person and most helpful to the patient. 'You must realise' he wrote 'that she trusts no one — neither you nor me'.

Impressed by such things my clinical aims inevitably involve an attempt to get to grips with them. It was always easy for me to agree with Michael Balint that 'frank discussion of personal problems is in many cases a necessary part of the examination'.[3]

Perhaps such obvious ideas now scarcely look like personal biasses, or even like the basis for a special interest within general practice. After all, the Leeuwenhorst educational objectives have been accepted in all European Economic countries, including this one, at least in theory: 'The general practitioner will include and integrate physical, psychological and social factors in his consideration about health and illness' and 'The doctor should be able to demonstrate a capacity for empathy and for forming a specific and effective relationship with patients and for developing a degree of self understanding . . . he will recognise the patient as a unique individual'.[4]

But all that is recent. In the 1940s and 1950s, coming from a totally classical education, without any science at all, through a first intention to specialise in psychiatry, I found myself something of an alien in medicine. Twenty-five years ago the Leeuwenhorst objectives would *not* have been accepted either by the majority of medical teachers, nor even by the majority of general practitioners.

It seems to me that the Greek and Latin classics teach one about people and their behaviour, about the meaning of words and their accurate use, about some of the arts and about the historical view of mankind. General practice made it easier for me to pick up what I learned in my first twenty years than had hospital medicine, with its insistence on chemistry, physiology and pathology — and numeracy. The opportunities and freedom that general practice offered were a revelation to me and a reassurance that I had not made a mistake after all in changing to medicine. I no longer felt an alien. But the sort of things that interested me were liable to be labelled 'mere social work', 'not scientific', 'a waste of medical training'. My teachers and contemporaries expected more lofty aspirations than what they then saw as a signpost to hospital, a specialisation in the trivial, a role without a future.

I have been trying to set a backcloth for the first of two scenes — a backcloth of my experience as a clinician, concentrating on difficulties, because they are more usually interesting than successes. Before looking at the part the Balints have played in shaping this experience, I want to take a quick look back at the case history with which I started. You will probably have noticed that that patient embodied almost all the separate difficulties which I have described later, physical symptoms without objective evidence, a personality reacting sometimes aggresively sometimes seductively, concealing for years a most important problem and then revealing it in the form of a conflict with her sister as severe as one meets in breaking marriages. I might add my own resentment of things that sometimes looked trivial when compared with the other pressures on my time, and again the final question, 'is it worth it?'

Perhaps it will by now be obvious why I joined the first Balint group and remained in it for two years, not as long as some of my fellow members, but longer than several others. I thought I was going to learn about the understanding of patients with psychiatric problems of all sorts. This was not quite what I found, but rather about the doctor's behaviour, his relationship with patients and his own feelings — *my* feelings in other words. Despite having already had a Jungian analysis, I found it hard to reveal my feelings in a group of fairly critical characters, not least Michael, who seemed at that time to be falling over backwards to be neutral and to avoid becoming a father figure. Recently come from the atmosphere of hero models in a teaching hospital, it would have been easy for me to have related to him in that way, indeed it was hard to forgive him for declining. Another disappointment was in what I saw then, and still see, as neglect of other approaches to affective disorders than the psychological or psychoanalytic ones, notably the

physical approach. Electroconvulsive therapy was not something one dared mention, and in 1954 psychotropic drugs were fewer and less useful than today. But the idea that mood changes might have a physiological explanation, as for instance in the premenstrual state, did seem unacceptable at least to the other group-members. On this point, however, I may well have misjudged Michael himself.

The cases I presented were much too difficult and I did not realise it.[5] The 'aeroplane girl' only yielded eventually to a full analysis. Another girl whose constant complaints of pain in the tongue and whose fear of one serious disease after another has now persisted for at least twenty five years, still comes to see my wife and myself although she lives in Brighton. I had little illumination either from the group or from any psychiatric opinion. But whatever the explanation, her life is better, and I believe her failure to turn up for many of her appointments nowadays a good sign.

When I started I did believe that personalities could be influenced to the point of change. I learned in the group that limited aims are essential and that one had to be satisfied with small gains. But since it is only hard work that achieves even small gains in this field, the satisfaction in fact can be very great. I am not sure that I learned to cope with being clinically impotent, that came later partly through the doctor-patient mentioned earlier, and partly through a member of the French Balint Society. What the doctor is, matters at least as much as what he does.

I certainly learned in the group that it helps to recognise quickly when one's own feeling are being stirred up by a patient. It not only prevents an instinctive reaction, but it gives a chance to switch attention and deal with what is probably the more important problem first. It may be difficult to argue that Balint-trained doctors get better results, but it is not difficult to argue that they deal more comfortably with difficult patients. The minimum statement was made by a wicked colleague, 'I used to hate my patients. Since I joined a Balint group, I now know why I do'.

Although the thinking behind them is more important, Michael had a great gift for finding pregnant words. For me the most important is the simplest, about the importance of listening. 'If the doctor asks questions, he will always get answers, but hardly anything more'.[3]

'The doctor as a drug' is easy to understand, but for me not an entirely happy phrase. The doctor's 'apostolic function' is harder to understand and needs experience and reflection, especially the ideas contained in it that doctors help to choose the patient's illness, and that doctors lay down personal rules on how their patients are expected to behave. In it is also an implication that doctors make work and that they themselves determine their own workload as much as patients do. Much of my own talk today is about my own apostolic function.

I have greatly enjoyed re-reading 'The Doctor, his Patient and the Illness'. Even when the second edition came out in 1964,[4] I did not understand it. I think I do now. Why did I leave the group that produced that book? Perhaps because it was a traumatic experience, but certainly in part because I wanted to go my own way and to avoid becoming addicted to the group or to any belief that it had the only worthwhile approach to the problems it dealt with. Some of my colleagues gave the impression that they felt that.

I want now to consider something less personal, the College and its relation to Balint ideas. The College by its name and its first statute is concerned to promote the quality of general practice. This has been the driving force behind almost everything it has attempted, and its fields of activity have been in encouraging organised curiosity, in education from school to retirement and in the external representation of general practice in academic matters and in academic places. It is *not* concerned with terms of service in the health service, or in matters of payment of doctors.

It came into being, as have similar institutions in other countries because of the problem of specialisation. Today one no longer hears the proposition that specialisation removes any need for generalists in medicine, but one did hear that in the 1950's. Disappearance of general practice looked like a real possibility — after all it nearly did disappear in the United State of America, Sweden and Finland. Nobody likes to be pushed out; in certain respects some general practitioners were actually experiencing that in this country in 1948. But at the same time many doctors, and non-doctors too, had a strong belief in the value of the generalist to society and this country had a strong tradition of general practice medicine. These things *made* the College — given the right man at the right moment, John Hunt.

The challenge of specialisation, its increase and its increasing success — forced the College to think about the generalist's role in medicine today, and about his standing in the medical profession. Although the Leeuwenhorst European definition was agreed quickly, it was based on years of thinking by many other people. Nevertheless it was not so easy to put into words which were convincing about the beliefs about the personal doctor which many of us held; it was important not to claim either too much or too little for the role.

Nobody practising medicine can be unaware of the importance of having a good reputation. The reputation of a group within a total profession matters too. It depends partly on the quality of the work done, partly on the nature and responsibility of the role, and partly on the people who choose to do it, their training and their behaviour. The status of a group is something which most people prefer not to talk about, not because it is hard to define, which it is, but because it is embarrassing. I find this hypocritical and naive. Status matters, if only to ensure good recruits to the group. The College is undoubtedly concerned about status as well as about quality.

The relationship of generalist to specialist can be one of two people doing the same job, one better than the other; or one in which two people do differ-

ent jobs on the same level. A relationship of equals with mutual respect seems to me to be the better one, the one that should be usual and basic, and the one which is in fact emerging in a long historical process. But consultation is essential to the whole edifice of medicine and consultation inherently implies not just *another* opinion, but a more informed one. The specialist is better informed in one way and the generalist in another. Each should be prepared to be inferior to the other on occasion, if to listen and to learn is to be inferior.

I have always been deeply grateful to Michael and Enid for their belief in the value of the general practitioner, and in their expression of this belief at a time when it was questioned, unpopular and maybe for them entailed some risk. It was not just a matter of words, they were actually demonstrating *why* the general practitioner was valuable in society, by stressing simple things which were being forgotten or denigrated by doctors at the time; For instance, the importance of listening to what the patient wants to say or of the doctor being there even if he cannot do anything very effective.

I have always been grateful too, for their belief that the general practitioner should take more responsibility. This is what Michael meant when he declined to let me hero-worship, or be a learner to his teacher or be a son to him as a father. I have never looked at specialists and consultants in the same way since. What he said about the teacher/pupil relationship, about outlets for dependent childishness for the doctor, and about the collusion of anonymity to which this can so easily lead, has been an important corrective; but it does mean accepting more difficult responsibilities. It does mean that the buck more often stops here with me, the general practitioner, and I have to carry it.

The College also has been asking general practitioners to take more responsibility. It has always urged them to do their own investigations, to achieve their own diagnoses if possible, and took after people at home if nothing was lost by doing that. It has encouraged them to have special interests up to a point. Why then did the College for years give a cold shoulder to Balint thinking and Balint supporters? A combination of reasons I think, the difficulty of its leading members in looking beyond the limits of their own training, with its emphasis on physiology, physical pathology and achieving diagnosis at all costs; an insistance on numeracy, through epidemiology in particular; numbers are more convincing for purposes of proof and reputation. They are also more orthodox and more respectable within a society which regards 'research' and 'being scientific' as first class tickets for travelling; there was, after all, a fear of the unorthodox in a new institution which was itself accused of being a group of odd people. If we need to look any further, there is a dislike of change in most of us, particularly a change which touches the beliefs and rituals which make us feel secure when we face uncertainty in new and alarming situations.

The publication of *The Future General Practitioner* in 1972 marked a tide which had already been turning for some years. Half of the authors had been members of Balint seminars. The book was written with an intentional bias towards the psychosocial aspects of medicine. It was meant to provoke. That being so, it is surprising that it has been used as a sort of official text for passing the MRCGP examination. As a result of it, some Balint ideas have become a sort of new orthodoxy.

In recommending more and more responsibility for general practitioners, I believe the College may now be going too far. If we add together the exhortations which we have made at different times to do more for psychological problems, more for old people, more for children, more home care, more family planning, more ante- and post-natal care, more screening, more immunisation, more health education, the outcome overall can only be a lack of thoroughness, a tinkering with each aspect. Should we try to reach some agreement about which are the directions which are most important, then draw in our horns again? Does the public and the government need to know what services can be expected of general practitioners and what are the limits of their responsibilities? Contrary wise, should we leave it to the whim of each general practitioner to follow his own special interests? We have some evidence now of the extent of the variation that exists. It is not only the epidemiology of diseases or the expectations of patients that determine the general practitioner's role. At present we present ourselves like the notice outside the department store in New York, 'If you don't know what you are looking for, come inside, we probably have it'. But do we have it? This is a leading issue for the College at present.

Another major issue is continuing education. Until recently, this was thought of as keeping the general practitioner up-to-date. He must know a bit about recent advances in anaesthetics or in radiotherapy etc. Agreed. He must. But what about new thinking his own job? The needs of his own patients, the quality of his own performance, his enthusiasm, his satisfaction and his own health? Has our attention been too exclusively given to initial vocational training and might not the circumstances of practice be an equally powerful determinant of performance in the greater part of our professional career? A recent paper by Ashbaugh and McKeane, about surgery in the United States,[1] has shown that failures are less likely to be due to lack of knowledge than to the doctor's failure to apply what he knows, twenty times less likely.

Will it surprise members of the Balint Society to know that the College is now urging the development of small groups in every locality — not just College members, not necessarily general practitioners only? We want doctors to discuss their own performance in their own practices with their own colleagues, whether within a group practice or in a neighbourhood. We believe that each doctor has something to give and that the small group offers the best setting, in Michael's words, 'To help each to have the courage of his own stupidity'.[2] We want each to hear and see how others do the same job, so that he can accept easily that someone else may be

doing this better than him, while he is doing that better than them. It may be a matter of discussing troublesome cases, it may be a study of prescribing habits. The numeracy of practice activity analysis, with local and national comparisons, may attract some groups. Others may try to make management plans for particular clinical situations, after looking at the variations in their behaviour hitherto; then they would do it again after an interval to see if their behaviour had changed.

I think the essential needs are to identify individuals who will bring groups into being, to leave them free to do it the way they wish, but to provide a national network of two-way communication and opportunities for training people to understand group-work. Whether some of this activity is called medical audit is a side-issue, important in the context of public opinion about our profession and about its sense of responsibility for dealing with its own failures.

The College has always realised the importance of the doctor remaining a learner throughout life. Only more recently has it stressed the importance of the doctor looking at his own performance in comparison with other people's. I do not think I could claim that, as a College, we are yet advocating that he should examine his own feelings and his own personality in action. But I do see this path of humility as the true one both to quality and to respect in the eyes of other doctors, other helping professions and the people whom we are serving. Paradoxically I believe it is also the road to self-confidence.

At the root of this approach to continuing education are the questions, 'What is good doctoring? and how to distinguish better practice from worse?'. Common sense repeats 'By their fruits shall ye know them'. Instead of fruits we now say outcomes. Outcomes are surprisingly difficult to relate to what the doctor is and does. Members of the Balint Society will be on the watch to see that the measurers do not confine their attention to effectiveness and efficiency, but give the acceptability of care the importance which it must have.

As President of the College, I both welcome criticism of the College, and worry about it. I can understand the accusation of elitism, but only as a form of protection for those who have decided not to join. Self-satisfaction is not a distinctive characteristic of College members. If it were, I would miss no opportunity to puncture it. But the accusation of irrelevance is much more worrying. The College is not seen to be useful as a lifelong companion after requiring what is now a useful diploma. It is as much a matter of what the member can give as what he gets. Obviously, the people who have got most from the College are those who have put most into it. Here again I pin my hope on the development of small groups, where members and non-members alike can be active and creative in the pursuit of College ideals and College thinking.

I scarcely have to spell out the influence of the Balints in all that I have been saying about current College business, small groups, talking about one's own cases, looking at performance on the doctor's own ground, learning to criticise oneself in a protective setting, learning even to expose one's own cherished prejudices, and even one's own peculiarities as a person in relation to patients.

Enid wrote a most interesting paper last year called *The Doctor/Patient Relationship in the 1980s*. I have been allowed to read it (now published, see page 12. Ed.). In it she says that Michael's and her work, and the training initiated by what later became the Royal College cannot be assessed independently. It must be obvious that I agree.

The theme of her paper is basically cultural change. Among other subsidiary themes Enid looks at changing ideas about leadership. Should the doctor lead in the consultation? Should one person be leader in any group? She pleads, I think, for sensitive, reluctant leadership. There are many consultations between doctor and patient where the doctor must lead — let us imagine a patient with acute heart failure in the middle of the night. These surely are the exceptions rather than the rule. Our basic job is to help patients lead themselves, and that is much more difficult. When Enid talks of leadership in a group, I think first of a group practice. To quote, 'The leaderless group is over-optimistic but if the work of the group is to be creative, the leader must feel in his heart — know and accept — that he is not superior to other members, only different, as each one of us is different from the other. Leaders are needed but they must allow other members of the group to be prima donnas if they so wish to have their own ideas, to be difficult, to be non-conformists and even to go their own way'.

What about leadership in the College? The context is one of leadership in ideas and communication. Is it too much to hope that issues like minimal standards for accessibility, continuity, record-keeping or the management of certain clinical problems could be thrashed out in small groups and agreement reached at least for each region of the country. Far better that sort of active involvement than being asked to read the product of some central working party. But that sort of thing is not achieved without central organisation, unobtrusive, but persistent. The job of the leader is to draw out the creativeness of others, but that too is a very difficult task.

In this Memorial Lecture I set out to trace the influence of the Balints on my own clinical practice and on the College in which I have worked throughout the same thirty years. Hence my title, 'The Passage of Time'. I had originally intended to stress far more the problem created by time in making the day too short — indeed life too short — *ars longa, vita brevis*. It must be a problem not confined to medicine, a problem for anyone who enjoys his work and sees an unending challenge of unfolding opportunities. But it certainly *is* a problem for the generalist in medicine and I do not think that any of us, except the unimaginative, have found an adequate answer — not even Michael and Enid.

Being not much of a scientist myself, I have avoided the arguments about whether the psychoanalytical approach can be counted as scien-

tific. I admire and value the rigour of scientific method, but it cannot be applied to some of the most important questions in life. We have to live and make decisions despite that.

I have talked a lot about myself tonight. Nevertheless the preparation of this lecture has been a humbling experience. It is so easy to think that one's ideas are one's own invention. They almost never are. I had managed to forget how many of those that I have used in my practice and in the College were either totally derived from Michael and Enid or were coloured by their thinking. But are not even *their* ideas really part of an old and essential tradition?. Enid ends her paper by saying that 'Patients need the respect which is due to a person who falls ill and is in the presence of someone who is trained to respect people as well as illnesses'. That reminds me of Schweitzer's 'Reverence for Life'[8] and of Francis Peabody's' 'For the secret of caring for the patient'[9]. But it goes back much further, to Judaeo-Christian religion 'Do unto others as you would have them do unto you' and to the thinking of the Greeks 'Know thyself'.

It is worth remembering the words of Bernard of Chartres the 12th century cleric. 'We are like dwarfs seated on the shoulders of giants; we see more things than the ancients and things more distant, but this is due neither to the sharpness of our sight nor to the greatness of our stature, but because we are raised and born aloft on that giant mass'.

Doctors and nurses sit astride two shoulders of the giant — that of art and that of science. We were tending to slip off one of them. Michael and Enid have helped us back. Their writings and this Society will continue to do that.

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Honorary Fellowship Oration for Enid Balint-Edmonds

At the Annual General Meeting of the
Royal College of General Practitioners on 15th November, 1980.

Someone who can inspire warm affection as well as the highest professional respect must have very special qualities. Enid Balint-Edmonds deserves in addition our gratitude for her work with groups of general practitioners in the course of which not only have they gained personal and professional growth, but our discipline enhanced standing and purpose.

Her association with general practice has spanned thirty years; the first twenty in the closest collaboration with her late husband, Michael Balint. In the ten years since his death she has further developed the ideas she and Michael explored in the earlier seminars.

A distinguished psychoanalyst in her own right, though not medically qualified, she was from the outset interested in helping other professionals to become adept and more self-sufficient in handling the emotional problems encountered amongst their patients and clients. The system of training which the Balints developed, and which has stood the test of time, was the now familiar small-group, in which doctors presented accounts of their cases to critical but supportive peers; the presence of a skilled leader facilitating the ensuing free discussion, and ensuring the atmosphere of a workshop, not a talk-shop. The theme was a long-established one: 'Listen to the patient, he is telling you the diagnosis'. What was new, was that as well as being encouraged to listen, the doctor was now being trained to hear what the patient was saying.

An early finding of these seminars was that patients — all patients — have feelings. Hard on the heels of this discovery came a second: doctors have feelings. What, if anything, was to be done about these feelings, how they might be harnessed for the purpose of diagnosis and treatment occupied a considerable part of the research effort in subsequent years, but did not dominate it. A number of other research topics came to the fore, including the nature of, and opportunities in, the ordinary general practice consultation.

The familiar consultation had hitherto attracted the attention of only those who were interested in measuring it, usually to two places of decimals. The new insights into the consultation were achieved by practitioners discussing what actually took place during the encounter, tested by follow-ups which either disproved or tended to confirm the group's conjectures. It was a method which was later to become refined and adapted for use in a variety of situations where the problems faced by doctors were not clear cut, but had first to be teased out; and a similar approach can be found in many of today's trainers' workshops, trainees' half-day release courses, and practice audit groups.

Looking back at those early years, years of struggle for the College as well as for the Balints, perhaps one is most struck by the courage, the audaciousness, they displayed. Those were dark days indeed for general practice — few people then would have given much for its chances of surviving as a relevant discipline. Yet, there were the Balints, busying themselves amongst the trivia of an apparently down and out profession.

When some general practitioners were tempted to concentrate almost exclusively on the psychosocial aspects of illness, when it seemed they must choose between being some kind of social worker or practising a pale reflection of hospital medicine, the Balints insisted that whole-patient medicine could only be practised properly by a whole doctor who combined imagination and insight with clinical ability of a high order. While others lurched this way and that, attempting to secure for general practice academic respectability and an effective organisational framework, the Balints held fast to their belief in the fundamental importance of the patient's relationship with his doctor. General practice mattered, but so did the individual, indentifiable practitioner. Many of the ideas which the Balints first explored seem commonplace today; but patient-centred medicine, the whole person, the patient's offer, the drug, doctor, treating the absent patient, dilution of responsibility and the collusion of anonymity — all these notions rested on the premise of the personal doctor.

It was not just on clinical practice that Enid and Michael had such an impact. They made significant contributions to the literature of our profession and encouraged others to do so. They were among the first to undertake serious research into general practice, not just from it; to understand that as specialists hoping to illuminate the field of general practice they needed first to study it. They were the first to establish the distinct role of the specialist working with the general practitioner's problems rather than just teaching on it or taking it away from him. They saw the unique opportunity for general practice in the prevention of a wide range of disorders, through early, low-key interventions, at a stage when the pattern of behaviour was still capable of being influenced. They continually emphasised the importance of teaching the teachers, and of rigorous evaluation. They were the

first to see clearly the connection between research, teaching and learning, and audit: and to employ these in relation to an everyday practice activity.

A general practice without such ideas would now be unimagineable. A College which did not espouse them, unthinkable. Enid Balint was directly and deeply involved in all these influences, but perhaps her most distinct and individual contribution, and the one of the most significance to our College, was in shifting the focus from purely psychotherapeutic procedures and instead looking at the opportunities for being a good doctor in the everyday run-of-the-mill case.

The work continues. In the midst of a busy professional life she has found time to lead a group of trainee general practitioners, meeting each week. And only last month she brought together a number of experienced general practitioners to plan another series of seminars on the ordinary short consultation, in an attempt to get it to yield up more of its mysteries. Psychoanalysis has been her vocation: general practice perhaps her real love.

And so President, colleagues, and friends, I present for honorary fellowship, Enid Balint-Edmonds: a gracious lady, respected colleague, and tireless worker for general practice.

Jack Norell.

A Balint Society Prize Essay

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the use of the 'Drug' Doctor. The first prize — winner will be announced at the 13th Annual General Meeting in June, 1982. Details are obtainable from: Dr. Peter Graham, 149 Altmore Avenue, London E6.

The Doctor/Patient Relationship in the 1980s

by Enid Balint-Edmonds

Writing in 1954 in *The British Medical Journal*[1] and a year later in *The Lancet*[2], Michael Balint described some work which he had started in 1950 on the doctor's relationship with his patient. This work initiated discussions and further work in many parts of the world. It also contributed to some changes in the rules and style of medical treatment. It has paved the way to changes in the style in which doctors and patients face the challenges of illness and pain, and in the atmosphere in which the medical profession uses its skills and knowledge. In the 1950s a new training for general practitioners was started which helped to change their status[3]. Some might think that Balint's work and the training initiated by what later became the Royal College of General Practitioners cannot be assessed independently.

These major changes are seldom noticed or described. Many papers and books have been written about the medical profession since the 1950s, some describing the effect of the doctor on his patient and the illness, but many of them seem to be written without knowledge of the earlier writings and thinking of Michael Balint and his colleagues. For instance, Ivan Illich, a Roman Catholic theologian, apparently unaware that any changes had taken place, wrote in *The Lancet* nearly twenty years after Balint, that the medical establishment itself had become a major threat to health[4]. Unlike Michael Balint's and my own, Illich's attitude to the medical profession is openly hostile and critical. We attempted to understand the problems with which doctors were confronted, their strengths and their weaknesses. Doctors were seen by us to be as human as the patients they were treating. This led to the detailed work which I shall describe.

The changes Balint initiated in medical practice might be seen retrospectively both as promoting and participating in wider cultural change. Already in 1949, J.L. Halliday[5] had drawn attention to the dangers facing the medical profession when he quoted T.S. Eliot who asked, 'Where is the knowledge which we have lost in information?' In a book devoted to the definition of the word 'culture', Eliot offers a definition that brings to mind the difficulties with which I have been faced when trying to describe changes which cannot be seen in isolation, i.e. as only concerning changes in the doctor/patient relationship. These changes are part of general changes. Eliot's definition, 'By culture, I mean first of all what the anthropologists mean: the way of life of a particular people living together in one place. That culture is made visible in their arts, in their social system, in their habits and customs, in their religion. But these things added together do not constitute the culture, though we often speak for convenience as if they did. These things are simply the parts into which a culture can be anatomised, as a human body can. But just as a man is something more than an assemblage of the various constituent parts of his body, so a culture is more than the assemblage of its arts, customs, and religious beliefs. These things all act upon each other, and fully to understand one you have to understand all.' Illich was unaware apparently of the difficulties inherent in change, unlike Eliot, who was certainly aware of them, and of the complicated interaction of one change on another.

In his book *The Doctor, his Patient and the Illness*, Balint described the style in which man is expected to face the challenges of illness and pain and the ways in which the medical profession use their technical skills and knowledge. He showed how each doctor expects each patient to behave in what he feels to be the 'right way' when confronted by an illness, and how the doctor's idea of right and wrong influences the way in which the doctor not only talks to the patient and relates to him, but how he prescribes drugs, and the way in which he expects to be treated by the patient.

Balint questioned the absolute rightness of what he called each doctor's 'apostolic function'.[6] He set about to see whether this function should, or could, be changed. He used the term 'apostolic function' to describe the way in which the doctor demonstrates a vague but almost unshakeably firm idea of how a patient ought to behave when he is 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 his patients. It is almost as if every doctor had a revealed knowledge of what is right and what is wrong for patients to expect to endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients.

Changes have occurred during the last thirty years in doctors' ideas about their apostolic function, which I hope to demonstrate. For instance, during a meeting of a Balint group in the 1950s, a doctor reported that he had seen a rather flashily dressed girl in his surgery, who had a mild cough and who asked for a certificate which would entitle her to a fortnight's holiday. Such requests as we all know, are by no means uncommon. The doctor, on

that occasion, refused to comply and capped his refusal with a short moral sermon. In the discussion in the group, another doctor expressed the opinion that the moral sermon was out of place; he would have advised appealing to the girl's sense of social responsibility by pointing out every citizen's rights and duties under the National Health Service. This doctor offered a less 'Victorian', a more suitably contemporary form of moralism. A third doctor, who I feel was far in advance of his time, found fault with both recommendations and suggested that before doing anything, ie., before responding either positively or negatively to the patient's request, the doctor should have tried to find out why the patient wanted to get more than her 'fair share' in that way. He thought that the doctor should have tried to arrive at a differential diagnosis between what he called neurotic malingering and callous malingering for gain. Nowadays, a great many doctors would think that the third doctor was right and that certainly a sermon on either moral or social responsibility should not be delivered without at least some knowledge of the patient, or without some knowledge of the doctor's own feelings about her need for extra holidays.

Although the cases presented in the early work seem in many ways very similar to those that are reported in our groups today, the emphasis is now different. The emphasis at the beginning was on what the patients requested (had to offer), on the basis of what they themselves saw as their illnesses; and on the ways in which the doctors reponded to the requests, or offers. The responses were often sensible but inappropriate for treatment, and sometimes changed after some work had been done in the groups. It is now easier than it was in the 1950s to do what in fact we first set out to do; which was to study in more detail, in which ways each doctor responds right from the beginning in his contact with each patient. Later we studied the necessity for referring patients for long interviews, or psychotherapy, and we tried to find out whether the doctor's responses could be adequate during ordinary surgery visits; or even more useful than in the long interviews which are based on the psychotherapist's techniques, and are suitable in the psychotherapist's setting.

An early case described in 1957 concerned a patient, a Mrs. C aged 32, married, childless, who had been on the list of the doctor's partner since 1946. She complained then of epigastric and chest pains. The doctor reported, 'My partner sent her for investigation to an eminent physician in April 1946, who reported, "You will be glad to hear that this patient's chest X-ray is quite normal. She seems very pleased at this and I think most of her symptoms are functional, and hope that the reassurance I have given her may be of some help" '

A short while after, the patient was unhappy about the condition of the chest as the pain returned, and she was sent for chest X-ray to a chest clinic. The physician at the chest clinic reported in May 1946, 'You will be pleased to learn that there is no evidence of pulmonary or pleural tuberculosis. I think the epigastric pain originates in the abdominal wall, that is, it is probably muscular or fibrous in origin. Massage might now be tried'. Massage was accordingly tried, but with little success. She continued to be a frequent visitor to the surgery and later had an appendicectomy. The patient continued to have the same complaints as before, and began to the doctor's amazement, to be rather aggressively flirtatious. The doctor rebuked her, and she cried. She went, only to come back the following week, and in subsequent weeks. She received five to ten minutes' chat and a bottle of medicine on each occasion.

Since then, due to a greater awareness of 'personality disorders' as they were then described, she was given a one-hour interview in which, *inter alia*, she told of her childhood, of a father who was in the Navy and away from home most of the time, of a much loved younger brother who died at the time of the onset of her symptoms, of her dyspareunia since the beginning of her marriage, and of her complete inability to have sexual intercourse since her brother's death. Her attitude to the doctor since that interview changed, there were no more efforts to flirt and there was an improvement in her symptoms. But it took four years and an appendicectomy to get to that hour. Perhaps neither doctor nor patient will take so long in the eighties.

In the early work we were content to think that it was good if the doctor did not 'play into the patient's hand', so to speak, by taking unimportant symptoms seriously (although of course it was always realised that that alone was not enough and more had to be done if the patient was to be helped), and there are frequent reports of doctors conscientiously investigating various symptoms: but it was not for some time that they began to realise that their own attitudes and their opinions played an important part on what went on between them and sometimes, also, in the development of new symptoms.

Before proceeding I must describe the structure of Balint groups for those who are unfamiliar with them. In the early 1950s groups for general practitioners were arranged in London, first at the Tavistock Clinic and later at University College Hospital. They were led first by Michael Balint and later by others including myself. Groups based on the same ideas and with much the same structure started in the early 1960s in many parts of the world and are still now as they were then, 'research-cum-training' groups. Their aim was then, as it is today, to undertake research into the nature of the doctor/patient relationship as seen in general practice and in other medical settings. Such research was based on on-going discussions of cases which were currently being seen by the doctors who took part in the groups. Each group consisted of about ten to twelve general practitioners and one or two psychoanalyst leaders. The aim of the leaders was to facilitate work, to encourage the general practitioners to think, speculate and test their ideas and observe seemingly unimportant aspects of their patients. It was thought that the group work might lead to the development of different techniques which would be needed by doctors once they gained

a new understanding of their patients and of their relationship with them.

Traditional research with controls is inappropriate in our field and often futile, however well planned and however seriously it is undertaken. We are beginning to develop appropriate new research techniques. The work of Bacal and his colleagues is important in this field.[9, 10]

One thing we must do when we draw inferences from our observations of the social world, is to make a case for the inference — we cannot prove a theory[11]. Our research has been based on this idea. We have, as I have said, encouraged the general practitioners themselves to make observations and to draw their own inferences in a free discussion in a structured setting and then to follow up these cases.

Notions about the aims of our work now often seem to be based on misunderstanding. There are still many people who think that Balint, a physician and psychoanalyst, wanted to teach psychoanalysis to doctors who are not trained to be psychoanalysts, nor wish to practise psychoanalysis or psychotherapy; that he wanted to use his psychoanalytic knowledge and training to this end. The same ideas persist in the 1980s in relation to those who continue his work. Many people still think that we want to use our psychoanalytic knowledge and training, and our ideas about the nature of the unconscious mind and the use of free association to influence the ways in which doctors work with their patients.

This was not our aim at all then, nor is it now. It is certainly true, however, that in so far as our work is based partly on a close study of the doctor's own feelings, it makes use of the psychoanalytic concept of countertransference. There was no need to refer to the theory behind this idea: it became a part of our area of observation. Conditions were created, as they still are, in which the doctor's feelings could be shown as freely as possible in the group's setting. For instance, no paper material is tolerated in the groups and the doctors have to report freely about their experiences with their patients in a way which is indeed reminiscent of 'free association'. It allows all sorts of subjective distortions, omissions, second thoughts, and so on, to appear, and both the second thoughts of the reporter and the criticism and comments of the listening groups are evaluated. The proof of the correctness or incorrectness of the ideas and reconstructions of what has happened between the doctor and his patient that are discussed in the group is the doctor's subsequent interview with his patient.

The leader's ability and experience in watching for, and listening to, this kind of talk is perhaps made possible for him by his training and experiences as a psychoanalyst. However, doctors who have not been so trained can learn it if they spend time enough with a leader in a group, working in the way that I describe. They too begin to notice the ways in which doctors use their personality, their scientific convictions and their habitual reactions. They see how their second thoughts and their ideas add to the total picture. This insight enables the group to make a sounder diagnosis on which to plan more adequate treatment.

Our aim was then, as it is now, to see whether psychoanalysts who are trained to listen and to observe people and their relationships with them in a special setting with an intense scrutinizing curiosity and open-mindedness, were able to observe anything that would be useful in a different setting, anything which would throw light on medical practice as a whole. Light was thrown on many things, for instance, as stated above, on the kind of rules and attitudes that doctors use with their patients, which in itself affect the patient's life and his way of approaching illness and death. This work was done in an atmosphere, not of condemnation, but of caring attention, as it still is.

If it is true that each culture sets the myths and the rituals with which the individual comes to terms, we wished to examine the myths and rituals and see whether they were useful. We asked whether they were the best possible rules to help the doctor with a sick patient, and a sick patient with his doctor. We never forgot or neglected traditional medicine: Balint was a conscientious and strict physician, keeping up-to-date with current medical thinking, respecting traditional medical practice and the research on which it is based. Leaders, apart from myself, are still all medically qualified.

It is strange that Balint's *work* which has influenced medicine so much in many parts of the world is still very little known generally, although the *name* of Michael Balint is known by many. The decade of the 1950s was one of the most difficult periods in Europe for the development of our ideas, because they were the peak years of the belief in the power of technology. New techniques were indeed advancing most successfully in the medical field as elsewhere and the duration of life was significantly extended. However, the belief in the *value* of life and in organised ideas, whether spiritual or political, was collapsing. Technology was all that was left, the only hope for the future or so it then seemed to many.

If, as I think, the changes which have taken place during the past thirty years have contributed to a slight but considerable change in cultural patterns and are thus far-reaching, then there is bound to be a dislike of, and resistance to the recognition of them. And in addition, they are difficult to describe in 'scientific' terms.

We all fear change and like to think that the way we have always lived, the way we conduct our lives, and the way we think, is the only possible way — the only right way for us. We prefer not to know when we have changed and when a new way of thinking, a new language — not a new jargon, has taken the place of our former ways of thinking, is safe and can be used without calamity. This is perhaps particularly true in the medical profession because doctors are responsible for, and continuously in touch with suffering, pain, birth and death. Their responsibility is very heavy they need rules and will use those which they learned both in their medical schools and earlier in their family upbringing. For them, as I will

show, changes involve a change in their status, although it is difficult to describe precisely in what way the changes occur or what they are. The loss of rules is always feared in case no rules, or no coherent rules, are substituted. Bad rules are understandably felt to be better than no rules at all. We all need a map. The medical schools provide a good one, but unfortunately it does not cover the whole territory.

It could be said that one of the changes that have taken place in the medical field during the last thirty years is that the doctor has become nearer to, less remote from his patient, less of a dictator, schoolmaster or law-giver. He is more like an equal who has special skills and knowledge, not, I hope only more information, and a person to whom the patient turns to learn, not only what to do when he is ill, but also perhaps how to live his life and face his death, or what is left of his life. We have encouraged doctors to question their function, which used to be clear-cut, and still is in many aspects of medical practice, and must remain so.

It would be wrong to give the impression that we have tried to teach doctors to behave during their consultations with their patients as if there were no difference between them and their patients, apart from their technical knowledge and skill. They are still the 'leader' when they are with their patients, as the leader of a Balint group is still the leader with his groups, and as is true with groups both large and small in our civilization. But as in other fields in present day society, the role of a leader has changed. In my view, leaders are needed as much as ever, but not distant superior people who think that they have all the answers to all the questions that are put to them. Their status and function have therefore changed. They still have to exercise great authority on many occasions, for instance when treating illness which arises out of what we have called the traditional diagnosis, but this never, or seldom, covers the whole diagnosis of the illness presented to them.

The function of leaders in the 1980s is in itself a subject worthy of a paper. There have been various attempts during the past decade to set up leaderless groups: to experiment with the idea that leaders are not necessary, or that if they are, they will arise spontaneously and when they do so, this in itself makes them more suitable to be leaders than if they are appointed in the more usual ways. In my view this idea has shown itself to be over-optimistic. Instead, as I see it, leaders are needed and have to be appointed in the more usual ways. In my view this idea has shown itself to be over-optimistic. Instead, as I see it, leaders are needed and have to be appointed or elected, but they have to be people who can allow other members of their group, however small or however large, to be forceful and outspoken and articulate — to have ideas of their own. Leaders are needed, but they must allow other members of their groups to be *prima donnas* if they so wish, to have their owns ideas, to be difficult, to be non-conformists and even to go their own way. Leaders are needed to facilitate the spontaneous development of the exceptional individual and also to keep the cohesion of a group because of, or in spite of, the creativity of some of its members. If the leader wants to be the sole creator or the only *prima donna*, then the old style of leadership returns and in the doctor/patient relationship the patient becomes an inferior being with nothing to offer in his relationship with his doctor, except an illness or a symptom.

The same is true in other fields. Perhaps each field influences the other or perhaps they grow spontaneously out of the same needs of the society at any given time. The leader can appear to be 'democratic' and open-minded and not a superior human being, but unless he feels in his heart, knows and can accept the fact, that he is not superior to other members of the group, only different, as each one of us is different from the other, then he will not tolerate the results of the work that the group is doing, ie. the creative work in his group. This is true in any group, whether it is a group which consists of two people or of very many more.

In the medical field, changes in the attitude of the doctors to themselves can reverse a belief in the magic of technology without diminishing the relatistic power of the use of technology; can restore a belief in the power of the indeividual. This way of thinking does not bring any clear-cut solutions and can sometimes bring about intolerable confusion. Yet, perhaps it is worth quoting from the last session of a conference that I attended recently, which had been arranged by the International Institute of Strategic Studies. The subject of the conference was the future of Strategic Nuclear Deterrence. Most of the conference, as you can imagine, dealt with the problems of technology and tried to evaluate technological developments in the strategic nuclear field. All this was well above my head, but throughout the conference the importance of human relationships, of the power or impotence of the strong nation over the weak and so on, was discussed realistically. In his summing up, the organiser of the conference made the following statement which could have been made by any doctor or certainly by anybody who is familiar with working in any deapth with human beings. 'If you are not confused, you cannot understand. If to be confused means to understand then we are going in the right direction'. I hope we are too.

One could say that if we are to remain alive, changes have to occur in our ways of thinking and our rules about living, about our understanding of our relationships with one another, changes which are equivalent to changes in our culture. These changes have started all over the world. Sometimes, unfortunately, the changes first arouse reaction-formations against the main stream and relationships become worse and not better for a time.

It may be that the particular problems which we face are greater in the industrial societies of Europe and in the United States than in other parts of the world, partly as a result of urbanisation. For instance, a greater number of people have lost their roots and connections, large families with their complicated and intimate inter-relationships tend to

disappear, and individuals become more and more solitary, even lonely, although they themselves might deny it. If in trouble, they have hardly anyone to whom to go for advice or consolation, although they might get reassurance from a great number of people. They may not have any real opportunity to find out what is troubling them and very little of how to unburden themselves. We know that in many people, perhaps in all of us, any mental or emotional stress or strain can be accompanied by various bodily sensations. If no-one else is available, in such troubled states, a possible and in fact frequent outlet in the countries which I know best, is to go to the doctor and complain. In such countries psychological problems may be taboo, but physical ailments are acceptable. *What* the complaint is about is perhaps not so important as the visit to the doctor itself, because the patient himself does not really know what is worrying him, except a cough or cold or ache or pain. It was to describe this phase in an illness that we coined the phrase 'unorganised phase in an illness',[3] where the doctor's skill is decisive, and where there is frequently no illness to treat. Later, when the illness becomes organised, there is a pharmacology which will help the doctor. He can diagnose and treat an illness; this however, may still not be quite enough.

Now I would like to describe in detail the kind of thinking, the kind of doctor/patient relationship, which we might expect to find in the 1980s in the countries in which I work. The opening moves of a simple case. Recently a patient in her mid-twenties came to her doctor asking for slimming tablets. The doctor was not willing to give her the tablets, she refused at once, saying that she never prescribed such tablets and wanted to know why the patient wanted them. She said that perhaps it was because she was unhappy. The doctor quite early in the discussion in the group realised that in refusing the patient's request and trying to get her to 'talk' so quickly, she had handled the situation very badly and had not helped the patient at all. She realised that the refusal in itself was not therapeutic. She showed that she was aware of her responses to her patient and wondered why she responded in the way she had. She became thoughtful. She was vulnerable to the remarks of her colleagues in the group, but open to reflect about what was going on when she first saw her patient. She was not so anxious about her own weaknesses as many of our early doctors had been, so she was more able, quite early in her work, to study her own reactions and to wonder why she had reacted as she did when the patient had asked for something which she thought was unreasonable.

Another case, a man of 35 who weighed 36 kilogrammes when he was first seen by a woman doctor who sent him into hospital, but continued to see him regularly both when in hospital and later when he was discharged. The patient told his history in a curiously disassociated way. It included descriptions of journeys to South America, sailing down the Amazon and so on. For most of the time, the patient would stare past the doctor and fix his eyes somewhere on the wall and she would try to bring him back into the consultation. He told about his relationship with his father whom he saw as a very correct man, he supposed that he was rebelling against him. He also spoke of the time when he was four years old, when he had put himself on a diet of bread and water for three weeks in order to punish his mother and frighten her. He was also clearly trying to frighten his doctor, which he succeeded in doing. He did not however stop her wanting to work with him though she tried to get him into treatment with a well-known psychiatrist who is particularly interested in patients with anorexia nervosa. The patient would not go for psychotherapy because it would be too painful. The doctor responded to that by saying, 'If you don't look out, you know what's going to happen, you may kill yourself.' She added that in killing himself he would also be hurting his family.

The group were impressed by how angry the doctor was and the doctor said that she felt the patient needed challenging and she supposed that he would not come back so see her after what she had said. She had been frightened, then angry. Now she was anxious but determined. In fact the patient did come back. The doctor had not been too intrusive or angry. The patient's weight increased rapidly (he put on ten kilos in about six weeks). But he made it quite clear to the doctor that she was not going to cure him and she did not challenge this stand. She thought that it was a case of passive resistance; things washed over the patient and he ignored them and in doing so he was very destructive to people around him.

As time went on the patient continued to put on weight and became pleasant and less withdrawn with the doctor. She was careful to notice when she said something that was an intrusion and knew she must be careful. No question about his private life was acceptable. She was tolerant of the patient going his own way because she realised that in spite of it, he was using his relationship with her. This is a doctor who does not always feel that she must leave it to the patient. She often feels that it is her job to be in control, but she reacted to this patient in this way — with great sensitivity.

I am using this case to illustrate the way that a doctor's feelings and reactions to a patient and her ability to follow her own train of thought as well as that of her patient can help even with a seriously ill patient. I have also chosen it because, although it is more like psychotherapy than most of the cases that are presented at our seminars, the work was done during ordinary surgery hours. It was done by a doctor, who on the whole likes being in control, and is worried sometimes when she thinks her colleagues are not; but who, when necessary, was able very carefully and consciously to let the patient take some control and to be particularly careful not to be intrusive at the wrong time. Steady progress has been reported over a five months period.

I have suggested that one of the major changes in the doctor/patient relationship during the last thirty years has been a change in the attitude of the doctor

to himself as a doctor, to his professional image of himself, which has changed his relationship with his patients. I hope the cases which I have described illustrate this point. Doctors are more willing than they were, to be used by their patients in a way which is appopriate to the patient as well as to themselves, and not only in a way which is appopriate to some ideas they acquired during their training. Doctors also need satisfaction, and cannot possibly be good doctors unless they feel satisfied in their work. In my experience, they can be more satisfied with their work and more at ease with their patients if they are less rigid in their ideas about what patients and doctors should do, and provided (and this must always be repeated) that they do not in any way forget or get out of touch with the knowledge and skills they learned in their medical schools, and which they have to continue to learn throughout their lives, ie. do not get out of touch with what we have called traditional medicine. If they can be leaders without being dictators or *prima donnas;* if they can take responsibility without depriving their patients of responsibility, then they will be of greater help to their patients.

As Professor Loch puts it with admirable clarity, a doctor's aim is to help a suffering patient by understanding him.[12] He thinks that this understanding enables a patient to preserve himself as an active human being who is as free as possible, as independent as possible in his own life and his own activity. At some periods in his life and in some areas of suffering, man has to be understood or to understand himself in order to extend his activity and be free. To effect such a change, somebody is needed to whom a person can talk, who accepts him, and enlarges his capacity to understand himself. Language forms a bridge between two people, but in medicine, language is not the only bridge. The patient also communicates with his body.

To illustrate this point, here is an example from some work in the 1970s.[13,14] A doctor reported a patient, Mr. F., aged 34, a married man and a toolmaker by trade, with a son aged eighteen months. The general practitioner presented the patient at a Balint-group because the patient had been off work for some months and the doctor felt that he was making no headway in getting him back. The patient appeared to be depressed and the doctor was rather angry with the patient's employers for making him do such exacting work. He talked with the patient and prescribed appropriate drugs.

In the discussion in the group, it was thought that the doctor had strong ambitions for the patient. He thought though, that the man should leave his job and take an easier one because he was harassed and overstrained. The patient had not said this, but the doctor had inferred it. He did not know what the patient wanted for himself and what conflicts, if any, he had about his work and what contradictory tendencies. The group gave plentiful advice, as groups are wont to do. After a time someone suggested that the question was not only how to get the patient back to work and to what kind of work, but that perhaps the question was to find out whether he really *liked* work, or preferred being at home with his managing but amiable wife. In short, what were the patient's aspirations and what kind of man was he? A long dicussion followed.

At a follow-up report three months later, the doctor said that the group discussion had been helpful; he, the doctor, had become less active and the patient said he did not want to *leave* his work although he had stayed away for so long; nor did he feel angry with his employers. When the doctor listened again, the patient was able to say *what* he could do and what could be done and what he *wanted*. It seemed that he had not been able to be dominant at work up to now, to 'throw his weight about', but after the interview he had gone back to work and had felt quite well. He had been able to tell people to wait for him so that he could finish his job, instead of feeling rushed and bullied; he was in charge of the situation and did his work in his own way. The patient was able to assert himself at home, too, and also with his doctor.

This patient had to say something and be understood before he himself knew, and could accept, one aspect of himself about which he had been only vaguely aware; he was then able to act upon it. The patient's conflicts and contradictions were not discussed (although they could have been in terms of his wish to be passive and his fear of his own activity), but all that seemed to be necessary at that time for him to find out, by talking, what kind of activity he was capable of, and what he enjoyed. Some patients need more. They may seek psychoanalytic or other forms of treatment; or trained general practitioners may be able to provide the 'more'.

The usual questions in a doctor's mind when he is doing traditional illness-centred medicine (be it physical or psychological) are, where is the illness located?And what caused it? For instance, in psychotherapy, the causation of the illness is usually looked for in the relationship with parents and siblings, or in early childhood. In the kind of technique which arises out of Balint-groups, these questions and the observations which might help to answer them, do not have a privileged position. But as we know, it is very difficult to observe anything in an interview when there is no available theory to explain it; when what is observed apparently makes no sense. If one has a theory, one is limited by the theory; if one has no theory, it is difficult to observe, but it gives freedom to observe. This freedom is useful only if it is coupled with discipline: in our case, the discipline of careful and attentive observations and the ability to know how much of what is observed originates with the patient, or how much the doctor himself contributes.[14]

A brief contact with the doctor, a brief period of understanding, can be of help to the patient if as a result the patient finds himself less alone, more in touch with himself, so that he can make more use of himself and of his environment. The patient's independence and human dignity are not endangered, and he can feel more alive. He feels that he is in control of himself and of his life and can use the

doctor when he wishes within the limits that the doctor's personality, technique and skill allow. This does not mean that our doctors never make links between present problems and early childhood difficulties, as is done in many forms of psychotherapy, but we think that the techniques which are now used, as a result of Balint-group work and the links between childhood and present problems consolidate, but are not in themselves the therapeutic tool. The therapy, we think, lies in the particular relationship between the doctor and the patient, where some fresh understanding is gained in a setting where an on-going contact is possible and both doctor and patient can have something to offer. I want to emphasise that the possibility for an ongoing contact between doctor and patient is a necessary part of the technique. This in my mind is the essence of general practice, where concern for the body and the mind is available in conditions where they are not separate.

Early in this paper, I said that the group-leader's job is to facilitate the work; to help the group to work. I have yet to describe what I mean by work. I mean that each member of the group should be free to think about the doctor and the patient and the illness and ask themselves questions, rather than ask other people questions. It is always tempting to ask the presenter of the case all the questions, in order to avoid thinking. The *work* consists of thinking, observing, trying out solutions, finding them useless, trying others,and so on, about a patient and his illness, with his doctor. We always encourage people (including the leaders) to think for themselves, even if their thoughts seem to them to be rather silly, and so each person has to have what Michael Balint called 'the courage of his own stupidity'. This kind of work in which the imagination as well as the ability to observe and think, and the doctor's skill and knowledge which he gained during his professional training, are all called into play, is focused on the relationship between the doctor and his patient and the presenting illness or complaint, and never on developing theories or ideas about illnesses or doctors.

Each group is a research group; each case has to be seen as unique, and each is a part of a training because in thinking about each case, doctors are trained to think in a new way and have to find ways of using their new understanding. Doctors are already trained when they come to Balint-groups to carry full responsibility for their patient and to my mind this is a basic requirement for our work. Each doctor is responsibile for his patient, even after, or perhaps particularly after, he has discussed the patient in a group.

During the last thirty years doctors have become less frightened to encourage their patients to be themselves. One could say that when we started to work the doctor felt he had to decide how he should be used by his patients, and during our work he has constantly to reassess not only how he thinks he should be used, but how the patient wants to use him. It was never our aim to try to find short cuts in order to avoid long psychotherapeutic interviews or investigations, but to measure, as precisely as possible, the therapeutic potential of the doctor/patient relationship in the general practitioner's everyday setting. From time to time, a general practitioner is able to meet a patient's need in a short interchange. And because in general practice a follow-up is always available — it is rare for a doctor not to see his patient over many years — in our seminars we can follow what happens when a doctor sees a patient and is able to do something that he thinks is relevant in a short time. These short interchanges are not *instead* of traditional investiations or treatment. They are in addition and usually take place while traditional techniques are being used.

At first glance it would seem that what patients need from their doctors is not very difficult, is something very simple in fact. They want their doctors to be not only competent physicians who agree to look after them, but also people who *want* to look after them. However, this is not simple, because the doctor can only do this after he has learned that it is just as worthwhile looking after a patient who has a justifiable reason to ask for his help as when there does not seem to be such a reason. So it is essential for a doctor to continue his training after he has finished and to be prepared to rethink for the rest of his life.

Furthermore, patients only feel that they are being looked after when their doctors show them, perhaps only during a very brief interview, that they, the patients, are more than a name or a diagnosis. Patients do not want us to be father-figures. What they want from their doctors is some respect for themselves as people, just as the doctor needs some respect from his patients for himself as a person. Patients need the respect which is due to a person who feels ill and who is in the presence of someone who is trained to respect people as well as illnesses.

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Balint Weekend at Oxford 26th-28th September, 1980

This was the fourth annual meeting for general practitioners, especially for trainees and trainee-group leaders, to sample a weekend in a Balint-group and discuss the experience. There were 80 doctors present, including 20 'non-Balint' people who are leading trainee-groups.

The programme included a seminar by Enid Balint on Group Leadership, and also a demonstration-group led by her. Everyone was asked to have a case in mind for discussion in small groups, and over the weekend many people had a chance to present their cases. The response seems to have been enthusiastic, and we are already arranging to repeat the meeting next year.

Also, we hope to arrange a Saturday meeting at the Royal College of General Practitioners for non-Balint group-leaders to discuss leadership problems. It is difficult to assess the value of such a weekend, but we hope that some of the younger doctors will be encouraged to form groups of their own later, and we made some valuable contacts with group-leaders, two of whom are running Balint-type groups of their own for established general practitioners. It was a great pleasure to have Dr. Sandy Bourne with us at this meeting, and we hope that this will be the start of closer co-operation with the Tavistock groups.

Cyril Gill

Residential Balint Weekend at Oxford University

From 7 p.m. Friday, September 25th to 1 p.m. Sunday, September 27th, 1981

General practitioners, both principals and trainees, are invited to sample the experience of being in a Balint-group for a weekend. There will be opportunities to discuss the experience, and the problems of learning and teaching in small groups.

The cost of the weekend will be reclaimable under Section 63, together with travelling expenses.

Further details are available from the Secretary:
Dr. Peter Graham,
149 Altmore Avenue,
London. E.6

The Fifth International Balint Conference in Cologne

The Conference of the International Balint Federation was held in Cologne at the end of October 1980. Sadly Dr. Stoppe, the chairman of the German Society had died unexpectedly two weeks before the Conference. Enid Balint's excellent opening address described the gradually changing nature of general practitioners' observations in the group in this country and abroad, as fresh general practitioners joined training groups. Analysts may be used by general practitioners in slightly different ways too, though the basic method of training remains constant, with the doctor's feelings respected and his ideas developed in the group, in the same way that he is encouraged to help his patients to do the same. We must beware of impressive research which may be useless, and of holding on to theoretical concepts which restrict new ideas. The interaction of psychoanalysis and general practice is something very much alive and mutually valuable.

It was rare to hear Enid expounding her ideas, which contrasted strongly with those of Professor

Bastiaans. He gave an excellent description of the progress of a group. As doctors shed their apostolic function, they became anxious, depressed, and dependant, presenting impossible cases. After various flights and fights, aggressive and libidinous tendencies emerge in the cases presented, and hopefully a doctor eventually recognises his own difficulties in a way which helps him to understand his patients. He described the dangers of over-involvement, hysterical transference, and group competitiveness.

The contrast with Enid was in his handling of the group. He shows them slides about children developing (he was unable to show these to us) and at moments of difficulty, he helps the group along with analytic expositions. This paternalistic approach must give an entirely different model to the general practitioner from Enid's sharing of experience. It would be fascinating to know whether, in fact, group-members emerge with such differencies in their behaviour or not. Such questions could not be answered in a Conference where there were many lectures and papers from experts to large audiences, and very little discussion in small groups.

However there were some excellent papers, notably from Professor Knoepfel and the contingent from Argentina headed by Dr. Luchina. The group-demonstrations were also very good. But the form of the Conference did nothing to help the idea that general practitioners have something important to tell their leaders, and the contrast between the speeches of Enid and Professor Bastiaans highlighted the problems unresolved in the Conference.

There were difficulties in translation and we were in a very expensive Conference Centre. Not surprisingly the German Balint Society have suffered a financial loss and no other country would be keen to hold the next Conference in the usual two-year interval. Instead, the Swiss Balint Society will organize the next one in four years' time. We hope they will organize an actual 'Balint experience', with participants discussing cases in small groups containing members who can translate where necessary. Also they might book a college in vacation which would be somewhat cheaper and more appropriate. The National Balint Societies might get together for conferences before the four-year Conference in smaller groups of two or three National Balint Societies at a time.

Cologne was an enjoyable setting and there was clearly a vigorous international body of general practitioners present, although they did not have enough chance to make themselves heard. As usual, contacts between the Conference meetings were also very useful.

Cyril Gill.

Obituary

Dr. DOROTHY ARNING, MA, MSc, MB, ChB.

Dr. Dorothy Arning, who was in general practice in Hampstead for over 40 years, died after a short illness on 30th March, 1980. She was 86.

Dorothy was born in Manchester, and after studying chemistry at Somerville, Oxford, she worked during the first world war as a supervisor in a munitions factory in Coventry. Then, after working as a research chemist in Manchester and for three years at the Royal Free Hospital, she won a scholarship to study medicine. She graduated from Victoria University, Manchester in 1927.

After house-jobs in Manchester and at the Garrett Anderson Hospital and the South London Women's Hospital she started up in general practice in Kilburn, and moved in the early thirties to King's College Road, Hampstead, where she continued in active practice until she retired at the age of 80.

At all times Dorothy was very committed politically and devoted much of her time and her enormous energy to many reform groups which included the Socialist Medical Association, the Society of Cultural Relations with the USSR, the Medical Association for the Prevention of War, as well as the National Council for Civil Liberties and the Abortion Law Reform Group.

Her earliest interest was in gynaecology and birth control and she took an active role in the National Birth Control Association. She was largely responsible for setting up the Willesden Women's Welfare Clinic and became its medical officer. Her prime interest was in people and their welfare, and this became all the more apparent after she joined the first Balint Group at the Tavistock Clinic, and so became one of the 'Old Guard' which was responsible for the work on which Michael Balint based his now classic '*The Doctor, his Patient and the Illness*'.

Outside medicine, Dorothy's main preoccupation was mountaineering. She joined the Ladies Alpine Club in the 1920s, as well as other clubs, and she went week-end climbing whenever possible in the Peak District, and spent many climbing holidays all over Europe, North Africa and Iceland.

Her enthusiastic stories about her adventures were always highly entertaining, especially when she spoke of her tough exploring holiday in the Andes, when she was over 70, and later her account of her riding a mule to the bottom of the Grand Canyon was truly amazing. She was almost 80 when she went on a visit to Russia.

Towards the end of her life she derived much pleasure from her life-long interest in opera, and in her lovely garden.

P.H.

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