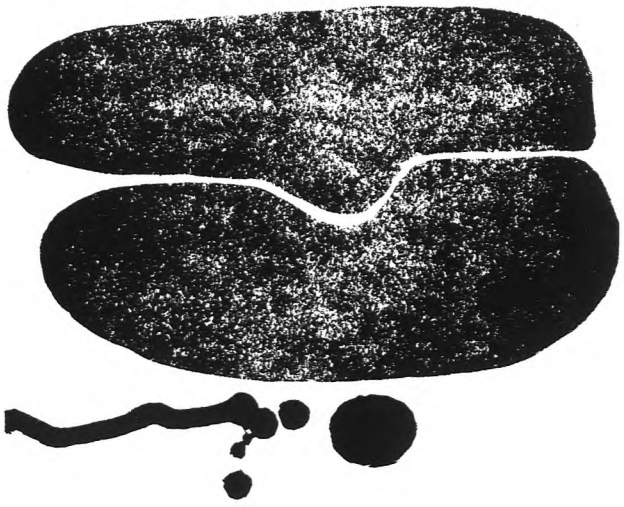
Journal
of the
Balint Society

2004



Vol. 32

JOURNAL OF THE BALINT SOCIETY

Vol. 32, 2004

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Editor: John Salinsky
Editor emeritus: Philip Hopkins

The Balint Society:

The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help general practitioners towards a better understanding of the emotional content of the doctor-patient relationship. The Balint method consists of case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group. Associate membership is available to all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners in London. There is an annual residential weekend at Oxford, and there are occasional weekends and study days for elsewehere in the country.

The Society is always ready to help with the formation of new Balint-groups. The Group Leaders' Workshop provides a forum for all Balint-group leaders including GP Course Organisers to discuss their work.

The Society is affiliated to the International Balint Federation, which co-ordinates Balint activities in many countries and organises an International Balint Congress every two to three years.

The Journal appears annually and is circulated to all members. There is an annual Essay competition with a prize of £500.

THE BALINT SOCIETY WEBSITE

The Balint Society has its own internet website. The address is *www.balint.co.uk.*

Unlike some addresses, this one is very easy to remember and to find.
When you have located it on your computer (if in doubt ask any eight year old child) you will find a whole sheaf of pages providing all sorts of interesting and useful information.

Pages include:

- NEWS of recent events and forthcoming meetings and conferences.
- FAQ (Frequently Asked Questions) about Balint: helpful for newcomers.
- GROUPS: How to start new groups and get help with leader training.
- INTERNATIONAL PAGE: Information about the International Federation and news about the next International Congress. There is now a NEW INTERNATIONAL BALINT FEDERATION WEBSITE at www.balintgesellschaft.de/ibf
- JOURNAL. This page shows the contents of the current issue and the editorial in full.
- BOOKS. A bibliography of the best Balint books in English. Plus a handful of recommended papers.
- LINKS. By clicking on www.balint.co.uk you can easily go to the American, German and Finnish Balint Society websites. More are coming all the time.
- THE BULLETIN BOARD enables you to ask questions about the Balint Society and have discussions with other people who have contacted the site.

Have a look at the Balint Society Website NOW! Tell everyone about it ! Refer anyone who is remotely curious about Balint to www.balint.co.uk

Programme of Meetings of the Balint Society for the Thirty-fifth Session, 2004-2005

Lecture series 2004-2005

All lectures are held at the Royal College of General Practitioners
14 Princes Gate, London SW1 1PU
Time: **8:30 p.m.** (with coffee from 8.00 p.m.)

Dr Sonya Baksi — Tuesday 19 October
'The effects of being in a Balint group whilst a student on the work of a consultant paediatrician

Dr Tessa Dresser, retired GP and appraiser
Tuesday 23 November
'Appraisal: what are we discovering?'

Dr Peter Shoenberg, consultant psychiatrist in psychotherapy — Tuesday 15 February
'A psychosomatic approach for medical students'

Dr Robert Hale, consultant psychotherapist, Tavistock Clinic — Tuesday 15 March
'Sick doctors'

The 16th Michael Balint Memorial Lecture will be given by
Dr Paul Sackin, GP, Course Organiser,
Ex-president of the Balint Society
Co-author of 'What are you feeling, doctor?' — **on Tuesday 19 April 2005**

The Group Leaders Workshop will meet at the Tavistock Clinic, Belsize Lane. London NW3 at 8.30 pm on:

12 October 2004
24 February 2005
14 June 2005

The Chester Balint Weekend 2005 will be held from 13-15 May.

The **Annual Dinner** will be held on Tuesday 28 June 2005 at The Royal Society of Medicine

Further information from the Hon. Sec. Dr. David Watt

Editorial

How would you like your Balint?

There are many different varieties of Balint group, perhaps as many as there are Balint group leaders. But even that allowance of diversity would exclude groups where the leader has a minimal role confined to organisation. Are some groups more authentic than others? Are some that claim the title not really Balint groups at all? Would the founder recognise them? Does it matter?

Let us start with the kind of group that is probably most familiar to readers of this Journal. We think of it as 'the Balint Society model'[1] and it can be experienced every September at the Society's Oxford weekend. In this version, the two group leaders are likely to be general practitioners. They keep the discussion focused on the agreed subject of the emotional content of the doctor-patient relationship. They don't use technical terms or make interpretations. They discourage too much questioning of the presenter and they protect the group members from 'intrusive' speculation about their personal histories. They do encourage members to imagine how the patient may be feeling and to reflect on their own spontaneous feelings about the presenter's story.

This is subtly but significantly different from the model developed at the Tavistock clinic and also found in other groups led by psychoanalysts and psychoanalytic psychotherapists. In these groups, the leader may be silent for long periods, making no attempt to guide or intervene. Then she will gather up the threads of the discussion and offer a psychodynamic account of what has been going on in the patient's life, in the doctor-patient relationship and possibly in the parallel process of the group. This interpretation may be taken up by the group immediately or at a later stage. Alternatively it may be ignored. Those of us who prefer the Balint Society model may argue that this style of leadership makes the group too dependent on the leader and her specialist knowledge and less willing to think for themselves. Advocates of the 'Tavistock' style might reply that the group members need access to the leader's psycho-analytic insights if they are to understand their patients and themselves at a deeper level.

Looking further afield we may find some much more exotic variations which would certainly have made Michael Balint sit up and take notice. At last year's International Congress in Berlin[2] there were demonstrations of Prismatic Balint Groups, Balint Psychodrama Groups and 'Balint groups with active and guided imagination'. These groups all employ techniques first developed for use in therapy groups for patients. They have in common the aim of encouraging group members to cultivate an intense awareness of the emotions and fantasies induced in them by the case presentation they have just heard. This may be facilitated by lying down on the floor with eyes closed or by a role-play or a 'sculpting' of group members into a symbolic tableau representing the presented patient's relational network. In all these European Balint variants, group members find themselves experiencing overwhelmingly powerful feelings. Tears are not infrequent and there seems to be a general feeling of emotional release and catharsis after a successful session. British Balinteers may find all this a bit much. After all, on this island of ours, we don't like to let ourselves go and weep all over the place like our continental cousins. In our groups, there is little or no self-disclosure and emotions are carefully held back. I am exaggerating a little of course, because there are occasions when self-control is allowed to slip and a few tears are shed. I remember an occasion at Oxford when a mature woman group member passed a Kleenex to a tearful young man with the comment: 'a mother always has a hankie'. All the same, these events are rare and dry eyes are the rule. It occurs to me that Michael and Enid Balint may have designed this kind of restrained Balint group especially for us British, knowing that we would never be able to cope with anything else.

What sort of groups are we most likely to find in the United Kingdom today? Oxford flowers only once a year, the Tavistock struggles to maintain a single ongoing group and we know of only a handful of groups elsewhere in the country for established family doctors. Some groups are being started for students and for hospital doctors and this is most encouraging. But the great majority of UK groups nestle within Vocational Training Schemes for GP registrars and senior house officers.

Small group work is regarded as supremely important by those who guide and plan GP education and course organisers are more or less expected to include it. The groups are a popular part of the half-day release course – but how many of them are Balint groups? Most of them do not use the name and some course organisers would vigorously repudiate the connection. Many group leaders prefer to use a case presentation only as a starting point for a general discussion on a clinical topic. Nevertheless, the groups discuss patients and they provide a safe space for young doctors to express their feelings and concerns.

How feasible is it to run a traditional Balint group in this context? Even leaders, trained in and committed to the Balint method find it difficult. Our young doctors in training greatly appreciate the opportunities the small group provides for a free and lively interchange of ideas and feelings. But they also want to widen the frame and may feel restricted by the Balint leader's interpersonal relationship centred

agenda. Ruth Pinder's ethnographic study of a London VTS Balint group[3,4,5] shows clearly that the group members have all sorts of other things on their minds that they want and need to bring into the group. These include the difficulties of reconciling their scientific hospital training with the human uncertainties of general practice; the cultural, racial and sexual differences which influence the attitudes of patients and doctors; the degree to which doctors can and should feel responsibility for the huge social and personal problems that they encounter every day.

Those of us who try to do 'proper Balint' with our Vocational Training groups are well aware that we have to relax the rules and allow in all sorts of discussions that would not be on the agenda in Oxford or Berlin. Need this be a cause for regret? Perhaps, as Ruth Pinder et al[3] suggest, Balint needs to evolve and develop as the world changes if it is to maintain its usefulness to young doctors. The needs of group members seem to differ in different times as well as in different cultures. We need to be flexible but we also need to preserve our most important core values. The report concludes: 'The continuing ability of Balint to speak to new generations may lie in its ability to conserve the best of a well respected approach and adapt to new conditions. Getting just "the right" amount of difference means distinguishing between what Balint cannot afford to lose and what it cannot afford to keep.'

Or should we aim to be the guardians of the original Balint method, keeping the sacred tradition alive for anyone who might want to come and consult us about it?

How would you like your Balint?

JOHN SALINSKY

References:

1. Sackin P. What is a Balint group? *Journal of the Balint Society* 1994;22:36-37.
2. Salinsky J and Otten H. *The Doctor, the Patient and their well-being – world wide: proceedings of the thirteenth International Balint Congress,* Berlin: H. Ruckdruck Celle, 2003.
3. Pinder R, McKee A, Sackin P, Salinsky J, Samuel O and Suckling H. *Just the 'right' amount of difference: narrative research into Balint and other small groups for general practice training.* A report prepared for the Royal College of General Practitioners and the Balint Society (awaiting publication).
4. Salinsky J. A new kind of Balint research? *Journal of the Balint Society* 2004; 35-37.
5. Pinder, R. A case study from the research report. *Journal of the Balint Society* 2004; 38-40.

An interview with Michael Courtenay

Michael Courtenay was talking to John Salinsky on April 18th 2004

JS: May I take you back to your first meeting with Michael Balint. How did that come about?

MC: I had written to him after first reading *The Doctor, his Patient and the Illness* and said I was interested in joining a group, so he wrote back with an appointment to go and see him at the Tavi. It was the most searching interview I've ever experienced. He seemed to penetrate one. He said 'how many children have you got?' (We had four at the time) and he said: 'four children!'. But he didn't seem to be very focused on what we were going to do. It seemed to me very personal; he was shining a searchlight on me as a person.

JS: You'd been in practice a few years by then?

MC: I'd been five years in practice then.

JS: And were you aware of some frustration with the way patients presented?

MC: I was aware of having no training that seemed to have any application on what I was supposed to be doing. The emotional side of ill-health certainly made itself known to me. I attempted to meet this by reading funny little books about 'anxiety' etc. But at least I knew that the deficiency was what went on in people but I couldn't find an answer.

JS: Did you have some background interest in psychiatry? Were you aware that there would be a lot of emotional stuff in general practice?

MC: No. Not at all, really. I had no idea what I was going into.

JS: So the book really spoke to you –

MC: Yes. I thought: this man knows the problems. And he indicates possible ways of approaching them. And I need this because otherwise I'm going to be thrashing about wildly as I've done for five years.

JS: So you arrived at your first group. Can you remember what that was like?

MC: I do indeed. It actually took place in the drawing room on the first floor of 7, Park Square West. This turned out to be improper later on and the Tavistock Clinic rapped him over the knuckles and said we had to meet in the Tavi itself. But we met at Park Square West for a whole year, about eight of us. It was a beautiful room with some wonderful artefacts on the walls. It was an L-shaped room with one photograph of Balint as a young man on which someone had put on devil's horns! But we were, to start with, a totally ill-assorted crew. There was a Pole, who never spoke a word for the first three months – and then left. There was a lovely GP from Malvern who used to drive up. He was very go-ahead, he actually had a radio in his boot. He was simpatico and then there was Erica, who has since become a great friend. And there was another chap who had done some psychiatry, which was not the right approach, apparently. But there seemed to be no explanation, it was quite amazing. Apart from presenting cases, and – that was the thing – if you didn't have a case to present every week, you stood in awe of great wrath. Not that you heard eight cases but you had to have one ready.

JS: But he didn't pick on anybody to present a case…

MC: No, he'd just say 'Who's got a case?' and people would raise a hand - or not - but there weren't great silences. Because he made it terribly clear at the first meeting that you would have to have a case. And of course we pulled out notes and that was utterly forbidden. Put those away. Enid was the co-leader…

JS: So she was there from the beginning?

MC: Yes. And when he was at his fiercest, she used to protect the chicks a little bit. We were always terribly pleased with her interventions in our defence.

JS: What sort of fierce things did he say?

MC: He would be quite critical. Sort of: 'Why did you do that?' and 'What did you expect to gain from saying that?' It was pretty direct and pretty strong but very rarely too strong. If he became too hectoring then Enid would sort of put up a shield for us.

JS: Were the sessions a similar length to nowadays?

MC: Yes, it was pretty strict. They were an hour and three quarters and at the end we just departed. In my case there wasn't a moment to lose because I had to go straight to surgery.

JS: Two cases in a session?

MC: Two cases pretty well always. If there were follow ups – he would sometimes say: 'we'll do some follow ups next week'. So we might get three or four follow ups.

JS: And was it expected that you would have done a long session with a patient before presenting him?

MC: Yes. He would definitely presume that any presented case would have had a long interview. He never said, but everyone agreed that this took at least three quarters of an hour. Subsequent consultations were not so long but more than the average consultation time. Which was at that stage, you know '57, '58, pretty short.

JS: What sort of problems did people present on the whole?

MC: Quite a lot of them were what would have been termed psychosomatic. Questions as to why someone who was asthmatic was having more attacks and this would be

viewed from the point of view of it having a large emotional component. But the main thing really was whenever you got stuck with a patient and you didn't really know what was happening; if you found you were referring the patient repeatedly to different people or there was some obvious no progress sign. There was a wide spectrum of possibilities.

JS: And were the patients that were presented usually someone whom the doctor felt they really wanted to help? Because these days, especially with registrar groups, the patient presented is often someone the doctor feels fed up with or annoyed with or bruised by, rather than someone he really wants to engage with.

MC: No, I think the boot was on the other foot. I think the feeling was that we, the doctors, were not meeting that patient's need and that we were sore because we felt we were professional failures, and not able to see which way to go. There were a few in which the doctor felt he had been rubbed up the wrong way, but they were rare. That was not the main focus.

JS: So it was very much 'how could I be doing this better'?

MC: Definitely. Here's a patient whose complaints don't make sense to me, I'm struggling to make sense of them and I need help there.

JS: Reading the book, *The Doctor, his Patient and the Illness,* although it's fascinating and you can see the way his ideas were developing, you don't really get a sense of what it was like to be in the group. Would you agree?

MC: I would. Actually, returning to the book, I found that even after a few years it was strangely old fashioned to read. It seemed to be quite different from the atmosphere of my first working group.

JS: Things had moved on, presumably.

MC: They had. It had been going seven years before I started which meant that it had probably run through a couple of groups. It was very sticky for the first three months, and then it got easier; it started to flow. The poor Pole disappeared and the rest of us had become more friendly. Perhaps the chap who had done psychiatry was not one's most close colleague, but it was treating emotional illness from a specialist's position which we didn't really feel. We still felt that we needed more time but there was a consensus from all but two that we were on the same train. Then we moved to the Tavi and we had two new members. For those who had been at Park Square West it was distinctly a sad move. And then in the third year we moved into the Tavistock Institute. That was actually better.

JS: Did you get a feeling that you were being trained to be GP psychotherapists?

MC: That was certainly the feeling. Quite early on, before the end of the three years, there was a sort of hint of rebellion from some of us about that. Partly because, well, speaking for myself, I was aware that I was giving time to a tithe of the patients who really stood in need, and it was actually one of the most painful things that I hadn't got time to give because I suppose I did long interviews on four nights a week. But four patients a week and you had to see them for some time. And as one became more aware of the problems, the more of the damn problems were visible. So it became increasingly agonising.

JS: How would a group in those days compare with a group at Oxford today?

MC: There's a great deal more freedom in the Oxford ones. You have to remember that that group finished in 1960 and we moved on to another group. But it was rather old fashioned. Christian names were not used.

JS: Christian names were not used in our group (1974-78) you may remember until about half way through.

MC: That's true. Perhaps that was part of the old tradition continuing. We were just doing as we had done before. I must say I find that quite horrifying. I totally accept that it's true. So it was much more formal. Having said that, the nature of the work soon broke down the formality so that after a year the group was behaving much more like an Oxford group. The Oxford group seems to start de novo in a weekend. I can't see that happening in those days.

JS: Was it more difficult in those days for GPs to be open with each other and trust one another with this kind of material?

MC: No, oddly enough, I don't think so. That was the reason, because we were all guilt laden and everybody admitted – with one notable exception – that we were a pretty hopeless lot. And we were all floundering about on the same floor.

JS: The kind of way of leading a group that my contemporaries learned from you and Mary Hare - I'm curious about where that came from; whether that was present in the original groups or whether it was more due to Enid's influence. I am thinking of the sort of thing where we would deflect a question back to the questioner.

MC: That was always present but Michael Balint would be given to passages of didactic teaching on a particular problem – which was very useful – but you wouldn't actually find in many groups now. The other thing is he seemed to be quite directive. I think the main thing is that the reflected question wasn't as common. He would make some remark about the presentation which would not be a spot diagnosis but a direction in which to pursue the discussion at your next interview. But it was an interesting duet

between Michael and Enid. She would often disagree with him. She would definitely challenge him and they would have a semi-private argument and in a way that was a great learning experience. Because there was a dialogue between people who presumably knew what they were talking about. It also was teaching you that you didn't have to take the directive statements if you didn't want to. It was when there a was a good deal of cross discussion between group members about something and Michael would bring that to an end by some sort of rather bold didactic statement and Enid would then say Well, I'm not sure that's how I would see it! And what about – another way? So there was in fact the model that there was always more than one way to see anything.

JS: I think pairs of leaders nowadays are very afraid of disagreeing with each other.

MC: I think you are right. The group that you were in which was led by Mary and myself was post the so-called Tuesday Group, the one that produced *Six Minutes for the Patient.* That was a major shift in technique. Michael and Enid's idea was to change the culture. I see that as the watershed. Because he then no longer was training us to be psychotherapists, he was no longer insisting that we spend 45 minutes with a patient… it was a sea change.

JS: What brought that about ?

MC: I think he came to realise that a lot of us were probably not competent to be psychotherapists! I mean he didn't actually say that, but having that long interview requirement meant that a lot of patients were being neglected. And he also realised that so many 'ordinary' general practice consultations which have a strong somatic element might be just as important. I remember one of his things was: 'Can't somebody present a case with a cough?' Poor Aaron Lask was the sacrificial lamb: he produced a case. Balint appeared to be extremely angry and was really rather cruel. We all bled with poor Aaron. Michael said 'I'm fed up with these long cases which get nowhere! What about the ordinary case, the real, the case you see every day, lots of them, what about them? So that was the crunch. Then, we'd been invited to Aberdeen for a weekend. The professor of psychiatry in Aberdeen at that time was Colin McCance. So we all went up on the night train, drinking whisky and then we had this amazing weekend. In which the idea of a short case really was cemented. It had happened before. The week before, Jack Norell had presented a woman with acne and that was the first ordinary case. It was amazing. It was like peeling off layers of opaque material. In Aberdeen we had a whole spate of these cases, they weren't all acne but they were all ordinary. This was in the mid 1960s. And the group absolutely changed. Then we knew we didn't have to spend 45 minutes with all the patients we then presented. I think Christian names came in then. I think it was moving

JS: Well, you'd been together a long time by then, hadn't you?

MC: We had. We'd been together four years. But that was the great change in my opinion. And he became far less didactic. He was still piercingly acute – he would say something that you had never remotely thought about that. But it was a different thing. There was much less teaching, much more encouragement to be bold.

JS: What about the emphasis on the doctor's own feelings? Was that there from the beginning?

MC: Not in my first group at all. It was about the doctor-patient relationship, but not the doctor's feelings, standing alone.

JS: Well, even the doctor's feelings as induced by the patient?

MC: Yes, that was there. You know, curiously enough, it wasn't such a democratic feeling of exchange as it became later on. It was a question of an invitation to say what was going on between A and B – rather than what A feels or B feels. It was a little bit more distant.

JS: Because when we are leading groups we quite often say to somebody, how would you feel if this was your patient?

MC: Yes. I don't ever remember that in the first group. Although it just so happened that at the end of three years the person appointed to lead the group couldn't do it and Bob Gosling stood in. I presented a long and impossible case, a 'pregnant nun'. He sort of looked at me and said: ' I know you have had quite a lot of experience but why have you presented this pregnant nun? And he was absolutely right. If only I'd remembered that at Oxford when that Italian doctor presented: if only I had done a Bob Gosling with him; that's what I should have done. Then we had a young leader who was very warm and simpatico, who had quite a different technique. That was leading on to a much less charged atmosphere in the group. With Bob there was a bit of a Spartan feeling. He was very good, but it wasn't comfortable.

JS: Like being with a classical psychoanalyst?

MC: Absolutely! That's right. You've hit the nail on the head. But the other chap was more avant-garde, more relaxed. I think his name was Harding. He was a protégé of the Balints and he worked at the Tavi, I think he was a senior registrar. There were people from two other groups welded on to our group of whom at least 50% remained, which was rather odd. And we definitely had to negotiate for a few months.

JS: Another thing leaders do today is to represent the patient: to say, if I was this patient I would be feeling so-and-so...Which can often get the group going again.

MC: Yes, Michael would have said: Now, the patient is in the room. The doctor is the patient. So he would invite the rest of the group, saying: you heard the story, but that's only part of the story. He is presenting the patient as a person. That would be his centre of gravity.

JS: So how did these subtle changes come about, do you think?

MC: Michael Balint had been wooed by the Family Planning Association with whom he started these psychosexual seminars. And that I think made him apply less rigidly the pure psychoanalytic approach. I joined in the second wave of those. But we were actually more psychotherapeutic in that. He felt that was reasonable because we didn't have to choose between patients. We had relatively long interviews in the marital difficulties clinic. He was interested in testing the possibilities of focal therapy. But when it came to the FPA wanting more leaders, he was prepared for GPs like myself to go and be leaders of that group because that was limited scope and we probably wouldn't be dangerous!

JS: How did the move to the presentation of shorter consultations begin?

MC: Well, those seminars made him think because a lot of the non-consummation papers had come out of quite short interviews, twenty minutes or so, in someone coming for contraceptive advice. And that's why he started off in the Tuesday group wanting to hear about ordinary length GP consultations and we all resisted it, we were all set in our ways. But he broke us down, courtesy of Aaron and Jack. But the amazing thing was, once that was broken down, the flood gates opened and we were all producing lots of cases and he didn't seem to be inhibited at all about the different level.

JS: What would he think today, if he were to come back?

MC: I think he would have approved of what we do. He was never satisfied with where we'd got to. I think he would have been very disappointed if we hadn't moved. The hardest thing to swallow would be his feeling about the qualifications for leaders. But the fact that he changed that for the FPA groups makes me feel that even that - he would have been rigorous as to selection, but Tom Main was perfectly agreeable to GPs as long as he knew who they were and what they were doing.

JS: I remember something he said at the second London International Conference that was printed in Philip Hopkins' book *The Human Face of Medicine,* Tom Main's line was you have to do what you have to do. And if you haven't got any analysts then you have to use GPs –

MC: Absolutely. He was pragmatic. I mean you've got to get the best you can. Better to have second best than none at all. Because otherwise the work can't go on. But I think Michael would have been pleased that the group that Enid led, the one that you were in when she became ill – I think he would have been very pleased with that group [the group that produced the book *While I'm here, doctor*] and I think he would have been pleased with our last group [*What are you Feeling, Doctor?*]. He would have been critical, but constructively critical. Perhaps he would have said, we ought to have looked at the defences in a more psychological way. But I think he would be 'chuffed' that the work still goes on. Very much so.

JS: And what would he think of the fact that there are so few analysts involved in this country, compared with say, France or Germany?

MC: I can see him shrugging his shoulders. I mean there wasn't any difference in his day. Psychoanalysis has not taken well to British soil, let's face it. With some notable, notable, exceptions. But I don't think that would have bugged him. He had sort of learned to live with it. These damn Brits! Although he was more British than the British, in some ways. I think he would have been sad, but not surprised.

JS: What was the attitude to Balint work and Balint doctors among GPs in general when you were doing it in the late fifties and sixties?

MC: Pretty negative. I used to go out and give talks and that sort of thing. By and large, a wall of rather cold semi-hostility towards these people looking at their own navels. I think Michael would be very pleased with the involvement of GP training. He would think that was a major positive outcome of his work. But I've had some pretty chilling experiences, talking to non-Balint doctors over the years.

JS: So we get more respect nowadays?

MC: We definitely do. I think after a rather chilly downturn, I think there has been a resurgence. The fact that we have had citations, I think we are taken seriously. Maybe disagreed with, but that's fine.

JS: They may not want to join us –

MC: No but we are seen as genuine research workers. It's a point of view with which you can agree or disagree, but you are not damned. The great joy of my own in Balint work now is that you can be utterly free with colleagues or patients. The openness of communication in medicine, which was not there when I entered it in 1952.

Lessons of the Masters

by Michael Courtenay

This is the title of a recent book by George Steiner based on his Charles Eliot Norton Lectures of 2001-2002. My introduction to his thinking was reading his *Grammars of Creation* a few years ago, which led me, among other things, to read Proust. He suggests that, pivotal in the unfolding of Western culture, stand Socrates and Jesus, who were charismatic masters who left no written teachings and who founded no schools. In the efforts of their disciples and the passion narratives inspired by their deaths, Steiner sees the beginnings of the inward vocabulary, the encoded recognitions of much of our moral, philosophical, and theological idiom. He goes on to consider a diverse array of traditions and disciplines, recurring throughout to three underlying themes: the master's power to exploit his student's dependence and vulnerability; the complementary threat of subversion and betrayal of the mentor by his pupil; and the reciprocal exchange of trust and love, of learning and instruction between teacher and disciple.

I found his theme fascinating and prompted me to read a number of books to which he had referred, but finally led me to wonder how Michael Balint might fit into his thesis. It seems to me that Michael might be someone special, the exception that proves the rule, a Master who strived to liberate his disciples from dependency. Not that he escaped rebellion, even if it falls short of betrayal. I recall listening to a paper read at the second Balint congress in Budapest which suggested Michael was not the initiator of what we now call Balint-work, but ascribed that role to a named other. I was astonished that the author of the paper should choose a Balint conference to air this view, rather than by the nature of the assertion that Michael was not the prime mover. The fact that I cannot remember either name of the author of the paper or the name postulated as the true genius can, of course, be construed as evidence that I have repressed both as a consequence of dependence on my part of 'the master'. Again, at the memorial meeting for Enid Balint arranged by the British Psychoanalytical Society I heard Bob Gosling suggest that Enid's calm demeanour had been a key element in modulating Michael's wildness. David Malan, who had attempted a rigorous scientific approach to evaluating brief psychotherapy published in *A Study of Brief Psychotherapy*, once remarked that when Michael Balint came through the door, science went out of the window. Did these critical views suggest that, although Michael was convinced that his whole work was based on psychoanalytic principles, other analysts were aware that he was in some sense a maverick, basing his approach somewhere between scientific medicine and psychoanalysis? He certainly did not think that being a practising psychoanalyst was in itself sufficient to qualify for being a Balint group leader, even though he considered undergoing analysis essential. This is illustrated by the case of an analyst who was in the position of associate co-leader to Enid in a GP trainee (registrar) group, whom she had invited to learn the necessary skills, but proved to be unable to apply psychoanalytic expertise in a way appropriate to a leading a Balint group. What, then, was the latent factor necessary? Having a thorough understanding of the nature of the work of a GP (or specialist if that is the focus of the group work) was certainly a vital requirement – I always had an uncomfortable feeling that Michael could conduct a surgery in my practice better than I could. But it is not only that. In my own case I was astonished that Tom Main considered that I could lead a Balint group which was then seeking a leader. I was even more astonished when Sandy Bourne, at a group leader conference held in Bern, Switzerland, made the remark that I had reached the country inhabited by analytic leaders by an alternative route. If these encouraging noises mean anything then it must mean that both analysts and non-analysts must make a journey into a 'Balint space' of special expertise. Not that I am smug, let me assure you. One member of my last (research) group expressed disappointment in not having had an analyst leader of the group. While remembering that Michael always forbade the overt use of analytic terms, especially transference, he never changed his view that all group leaders should be analysts, though he did sanction the members of the groups who were doing research on psycho-sexual matters to lead groups set up under the auspices of the Family Planning Association. Whether this meant he thought that restricting the area of pathology made this a safe procedure or that whether he was really changing his mind we shall never know. My first GP group was co-led with Mary Hare, so I had a feeling of safety in her analytic insights, while she relied on my firsthand experience of general practice. This was a happy and, judging by the current position of several of the group members, a mutually enriching one. Mary's long battle with depressive tendencies was won after we attended a conference in Japan, at which we presented a paper, when she confided that she now realised, at last, the worth of her own professional work. What is clear to me now is that though I fell under the spell of Michael, there was nothing he enjoyed more than being stood up to, so to speak. I well remember Rosa Taylor saying, during a group meeting, that he was like Henry Ford who didn't mind what colour the car was as long as it was black. He laughed his head off!

The greatest personal rewards for me have been events that have mirrored things the Balints spoke of: how something learned by a 'student' has changed his/her professional aims, or how a colleague feels their work was

understood even beyond their own understanding. But this satisfaction is not achieved by feeling the recipient is in thrall to the 'master' but rather that one has opened the door of the cage and let the bird fly free. So I believe that Balint-work makes us all free, even though this echoes the dreadful, cynical, words that surmounted the gate of Auschwitz. Perhaps that very echo means that Jewish genius transcends even a holocaust and may lead us to understand what is the essence of the process which we have shared in Balint-work training. This somehow combines the insights of psychoanalysis and traditional medicine, and sets a completely new standard for teaching and learning. Can this help the International Balint Federation in its quest to define the necessary qualities of future Balint leaders?

Reference:

Steiner G. Lessons of the Masters. London: Harvard University Press, 2003.

The widening scope of Balint work comments on "What are you feeling, Doctor?"

by Henry Jablonski, psychoanalyst, Stockholm, Sweden
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These comments are based on an introduction to a seminar on the above-mentioned book which was held in Stockholm on April 27, 2002 in connection with a Council Meeting of the International Balint Federation.

To highlight the situation of a GP and a psychoanalyst for that matter too I would like to quote a Talmudic passage: 'If you cannot carry your own burdens, how can you expect others to do it for you?' I believe the more precise British-English translation would be: 'Carry on, be a good sport, and keep a stiff upper lip.' Now we know that this recommendation – not to burden your fellow human beings with your worries and sorrows and to be a self-composed person – has not reached our realms, and will not until Redemption Day. Our job, it seems, is to cope with this inherent 'demand-for-dependency' setting. In Sweden the aim of medical practice is to exert it 'in accordance to science and proven clinical experience'. But to the humanistic and Balint-educated doctors this is only half the truth. Experience teaches us this is not a sufficient framework for seeing and treating your patient in an adequate way. There is something missing. And here Michael Balint's perspective and the elaboration in *What are you feeling, Doctor?* really adds to the perspective on clinical work. Because 'in accordance to science and proven clinical experience' does not say anything about the meeting between the two persons in the consulting room. Some doctors are prone to use 'in accordance to science and proven clinical experience' as a fundamentalist prescription of how things should be. I mean that it is expected that the patient should behave in a rationalistic way so that the doctor be allowed to exert his skills and medical techniques accordingly.

Except for the complaints about medical problems in a restricted sense, body and mind problems are often interwoven, and the sorting out requires a broad and simultaneous awareness and knowledge on the part the GP. How many tons of human problems a day can a doctor endure? It can be perceived as a bombardment, and I think the article by the psychoanalyst Tom Main in the appendix to the book where he uses the imagery of soldiers at the front, is really very good. A Balint leader colleague, the psychoanalyst Peter Molin, has suggested that a doctor only has a limited daily energy quota for his patients. He measures it in Freud units: 'How many Freuds do I have at my disposal today?'

In *What are you feeling, Doctor?* there are many examples of the different varieties of demands or hidden requests of the patients and the reactions of doctors which I think many doctors immediately will recognise from their own consulting rooms. What is interesting is how the members of the Balint research group discuss how these reactions in the doctor – which we as psychoanalysts put under the heading of transference and counter-transference reactions – could be used in the professional GP work in a more systematic way. The book demonstrates Balint work as a way of integrating: how the doctor can develop his being and way of seeing things, rather than adopting these ideas merely intellectually. The authors demonstrate that when the doctor is 'in touch' he works in more of a flow and with an ability to adapt spontaneously and specifically to the particular meeting – analysts would say pre-consciously. What are the demands? Is it possible to address them – for the patient and for the doctor? What are the options, given the setting that I am working in?

The book illustrates in a very living way many aspects of the training in developing that skill. And still you have to have the experience yourself of good Balint group work to truly know how much it may improve your clinical adaptation to the patients and your own ability to reflect on and evaluate what you are doing professionally. Dr Salinsky has used the metaphor of the doctor as a landlord, the surgery as an inn and the patient as a guest. Here in this book the cases in the words of the presenting doctor are told. Then follows a lively abstract of the discussions taking place in the group. Some case examples are very moving and all of them will be vividly recognised by the clinically experienced reader. What is strikingly hopeful about this book is that it demonstrates how many seemingly hopeless relations could be turned into something good and became part of the solution of the problem for the patient.

Balint work aims at clarifying, improving the clinical work by making the doctor less defensive. The group of doctors in this book explores the various styles, 'coping' strategies, and defensive systems when the doctor is far from his best. And still – to live up to professional ideals – the doctor has to come through such a day too and be able to look at himself in the mirror.

How personally revealing about the doctor can Balint work be and still be Balint work? Does bringing the doctor's personal neurotic hang-ups into the group work make it not a 'proper' Balint group? To me the answer is distinctly no! I think this comes naturally after a few years in good enough groups with open-minded and experienced members. In my experience, if group members trust and respect each other, if leaders are felt to protect the work

against abuse (that might occur in the heat of work), then the personal aspects will evolve more outspokenly as work proceeds. I do think however, that the work becomes group psychotherapy when the emphasis too rapidly is shifted onto the doctor's personal life and conflicts without sufficiently working through the various aspects of what the patient brings into the consulting room.

As I am reading *What are you feeling, Doctor?* my impression grows stronger that the group and its leaders started using a previously (by Michael Balint) forbidden tool (actually therapeutic in essence) which they were eager to try out on each other. (I come to think of the Sorcerer's Apprentice and the forbidden use of the magic broomstick.) And the group dynamics certainly correspond – to suggest just some motives – to an inner personal longing to be seen, to be confirmed, not to be alone with one's disappointments, to continue some work from one's own personal therapy. We take care of our patients. We also eventually recognise our own longing to be taken care of. Maybe one of our more or less unconscious motives might have been through our profession to repair, to restore a primary love object-relation, by turning a passive need into an active striving and thus achieve good mastery. But we cannot disregard the need of the doctor for aggressive control of the object. Paraphrasing the title of a psychoanalytical article by Leo Stone published in the USA in 1950s, one could say that this book in one way is about 'the widening scope of Balint work'.

Although it is impossible to ignore the impact of Michael Balint's personality and creative mind, I believe it is important not to define Balint group work by the leadership style of Michael Balint himself but by the scope and setting of the group work. Let me turn to one example in the book: the case of the woman with an HIV infection. Here I felt the group shifted too easily to the personal issues of the group member. Maybe that is what she needed and invited the group into – or were people too eager? In spite of what was evoked of betrayal on a personal level, to my mind there were issues in the doctor-patient relation that remained not discussed. Those were: the initial demand of the patient to involve the doctor in a legal procedure, and in a power struggle with her ex-partner; to corrupt the integrity of the doctor, to infect the integrity by drawing her into a discussion on a legal matter where the physical findings did not correspond to her own account. There was a very intricate interplay about deceiving and being deceived and being the partner in a deception against a third person.

It is not clear how the group elaborated on that. But I was impressed by the stamina of that doctor as she still felt her attitude towards the patient could not be changed! Here I felt the group spoke to and wanted to support the little girl and the betrayed woman in the doctor, but deceived the professional person by not chiselling out the complexity and trickiness of the demands made on her by the patient. But then again, that might not have been what this doctor needed from the group. Maybe what helped her was bringing the personal issue forth. Then she could do the rest by herself.

Doctors need personal psychotherapy too – particularly when their upper lips stiffen too much. You may ask: 'OK, so what if we do some personal psychotherapy in the Balint group?' And I would answer: 'I have no absolute objections, but I think the group leader has to protect the group of professionals from developing too much intimacy so that work does not become skewed in the end. If you have no agreement on going into the private lives of members you risk a wild therapeutic situation. Also if the atmosphere is too intimate the introduction of new members into the group gets complicated. And many Balint groups are "half-open" with a slow circulation of members, though this was not the case with your group. But it is still a delicate balance to keep.'

The fact that the paper by Tom Main, a British independent psychoanalyst, inspired the research work presented in this book shows that Balint work also after Michael Balint is taking place at the junction of clinical medicine and psychoanalytical psychology, and how mutually rewarding such a meeting can be.

Reference:

Salinsky, J and Sackin, P. *What are you Feeling, Doctor? Identifying and avoiding defensive patterns in the consultation.* Oxford: Radcliffe Medical Press Ltd, 2000.
Swedish translation: *Hur känns det,doktorn?* Ulrika Jacobssen. Lund: Studentlitteratur, 2004

Compassion Fatigue and Burnout in Balint Groups – a Personal Perspective

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Our Balint group has been together for nearly five years. Over that time the composition of the group has changed but the majority of us have been there for the whole period. We are all General Practitioners (Family Physicians) most of whom do more counselling than usual, and therefore need some extra peer support.

Recently I was struck by how the group had changed over the years as some of us are moving away from counselling while others are moving towards doing more counselling. I was particularly taken aback by my own reaction when I presented a very difficult patient who I'd been seeing for about 15 years. She told me that she had made up most of her story. I didn't care! My question was: 'Is this a bad thing or not? Am I suffering from Compassion Fatigue or Burnout, is it that I have developed better boundaries over the years and, if so, is this a healthier approach, or is there something else going on that I need to address?'

Let me digress for a moment to discuss the differences between Burnout, Compassion Fatigue and Vicarious Traumatisation. The National Centre for PTSD[2] has a 'Fact Sheet' that defines Burnout using Figley's definition of 'physical, emotional and mental exhaustion' caused by long-term involvement in emotionally demanding situations. I'm sure we can all relate to some extent with problems such as 'professional isolation, emotional drain, difficult client population, long hours with few resources, ambiguous success, unreciprocated giving and attentiveness and failure to live up to one's own expectations for ensuring positive change'. The symptoms are depression, cynicism, boredom, loss of compassion and discouragement. Burnout can be pervasive and recovery can be difficult.

Compassion Fatigue, as opposed to Burnout, can be of sudden onset and is a natural consequence of working with people who have experienced stressful events. It develops as a result of the doctor's exposure to their patients' experiences combined with their empathy for their patients.[7] Symptoms include helplessness, confusion, isolation, exhaustion and dysfunction. There is usually a feeling of being overwhelmed by work and of being incapable of effecting successful patient outcomes. If addressed in the early stages there can be complete and rapid recovery.

Vicarious Traumatisation (Secondary traumatic stress disorder) is a type of Post Traumatic Stress Disorder that is unique to those who work with traumatised patients. It involves a 'transformation in the therapist's inner experience resulting from empathic engagement with clients' trauma material.'[10] It is much more difficult to recover from and can be cumulative and permanent.

Compassion Satisfaction describes the sense of strength, self-knowledge, confidence, meaning, spiritual connection and respect for human resilience that keeps us doing this work.[2] I found a 'Compassion Satisfaction and Fatigue Test'[11] and assessed myself. I was somewhat surprised to discover that I had 'good potential' for Compassion Satisfaction, 'moderate risk' for Burnout and an 'extremely high risk' for Compassion Fatigue.

Does a Balint group help?

My question then is whether belonging to a Balint group protects us from Burnout and Compassion Fatigue and increases our potential for Compassion Satisfaction?

The idea of a Balint group is that we discuss those patients that are causing a reaction in our own lives (countertransference). Thus we can become better practitioners because we are freer to deal with the patients' problems without our own reactions 'muddying the water'. Secondary benefits, however, are the development of insight into our own vulnerabilities, peer support, positive non-judgemental input and debriefing. As Frank Dornfest says, 'The physician learns to be more therapeutic in his or her relationship with patients while, equally importantly, learns a framework within which to view patients and practice that leads to less frustration, dissatisfaction with practice, and Burnout.'[12]

Few enter the medical profession thinking that they might pay dearly for their care of others.[4] We have usually come with strong beliefs in such ideals as the goodness of people, the ability to create a better world, the conviction that justice will prevail and our own power to make a difference.[5] As beliefs become eroded we may be overwhelmed with a sense of disappointment, failure, hopelessness and responsibility. The support of our peers may help us address these idealised expectations and build a more balanced and realistic sense of meaning and purpose for ourselves and our work. Our ability to deal effectively with the risk of Burnout is partly dependent on our emotional and intellectual understanding of why we entered the helping profession, as well as an increased awareness of our adaptive resources and coping mechanisms.[3]

Empathy versus detachment

One issue that has come up many times is the tension between empathy and detachment. Gerald Egan, reviewing the work of Carl Rogers, describes empathy as a 'way of being where the helper, without judgement, enters the private world of the client to understand the feelings and

personal meanings that the patient is experiencing'. Egan describes a 'deeper level of empathy, where the helper gains an insight beyond that of the client, into the client's own story.'[8] We know that we need empathy and compassion to maintain an effective therapeutic alliance with our patients and to deliver effective and high-quality care. Often we may feel that there is an even deeper, ethical obligation to sacrifice our own needs for the needs of our patients. We also know that it is those who have enormous capacity for feeling and expressing empathy who tend to be more at risk of Compassion Fatigue. Those most vulnerable to a progression to Burnout are those who take their empathy to the extreme of viewing themselves as rescuers.[10] Such a sense of 'omnipotence' and perfectionism can hamper insight into the early signs of dysfunction by justifying personal behaviour as necessary for the benefit of the patient.

On the other hand it has been shown that doctors who seek detachment from, rather than emotional engagement with, their more difficult and demanding patients have more protection from Burnout, improved concentration, rationing of time, maintenance of impartiality and so on.[8] We need integrity, sacrifice and compassion, but we also need self-awareness to engage empathically with patients more effectively and to gain insights into our own responses to our patients' stories.[8] We need to learn to recognise our reactions by developing awareness of our own signals of distress. As we take part in self-analysis activities in a Balint Group, we can internalise what we learn about ourselves from our interaction with the other participants. With the development of such an 'observer ego' of our own we can see and understand what is happening between ourselves and our patients and hence be appropriately detached and able to act in their best interests.[1]

Alone we may be unable to identify our own responses. Our work culture as medical practitioners values self-sufficiency, stoicism and repression of personal emotional reactions.[5] Thus an exaggerated sense of personal control, fear and denial causes many doctors to avoid dealing with personal vulnerability until significant damage has occurred.[4] We know that as General Practitioners our morale, divorce rates, alcohol abuse and so on are worse than those in most other sectors of the community. However we also know that our strongest assessment tool is our own ability to reflect on our experience and to hear what important 'others' in our lives tell us about our functioning.[10] In an environment such as a Balint group we can debrief, 'normalise' emotional reactions, reduce stress by sharing experiences, reinforce the value of our work and reformulate our boundaries.

A comparison with Palliative Care

The Palliative Care literature says such things as:

> *We need to understand our strengths and weaknesses in order to be able to work effectively with people who are struggling with challenging and difficult emotions as well as life's changes and losses. Palliative Care Counsellors have a responsibility to themselves and their clients to maintain their own effectiveness, resilience and ability to help clients. They are expected to monitor their own personal functioning and to seek help and/or withdraw from counselling, whether temporarily or permanently, when their personal resources are sufficiently depleted to require this.*[6]

Health professionals who work in such fields as Palliative Care tend to have better support networks than General Practitioners. However, we know that the same principles apply. Compassion Fatigue can similarly challenge a doctor's ability to render effective services and maintain personal or professional relationships.[7] We see a full range of difficult patients – the acutely mentally unwell, the traumatised, the dying, those with chronic pain or chronic illness, the 'heart-sink' patient and the socially disadvantaged. They depend on us for their health care and it is part of our responsibility to them and to our other patients, our staff, our families and our friends to keep ourselves as balanced and healthy as possible.

Management and prevention

The management and prevention of Compassion Fatigue and Burnout can be divided into personal, professional and organisational categories.[9]

Helpful activities in the personal arena include humour, relaxation, exercise, good nutrition, sharing of emotions, hobbies and other activities in which you can excel, respecting your own limits, maintaining time for self-care activities and spiritual connections (meaning and purpose, faith in the future or in a higher power).[5] Our medical training has encouraged characteristics such as obsessionality, narcissism and omnipotence. As we move into middle age we tend to move away from these and our capacity for empathy, insight, self-awareness and self-protection improves. On discussion with our group, we realised that it is characteristics like a strong sense of cohesion, openness, humour and respect for each other's strengths as clinicians that had kept us together so long. During our sessions, criticism was not about being 'better than each other' and even if it were misplaced we did not tend to take it personally.

Participation in a Balint group will be included in any list of helpful professional activities, along with maintenance of a balance of variety and nature of work, pacing of work and sufficient release time. Professional boundary keeping such as overtime limits, not taking work home, understanding self-disclosure boundaries and realistic expectations are best explored with our peers. For those who work in particularly

traumatic areas, limiting exposure to trauma material (e.g. news items) and the development of boundary rituals may also be helpful.

For many General Practitioners the organisational issues are complex and extremely frustrating. The chronic shortage of General Practitioners, inadequate rebates, increased paperwork, professional isolation, limited resources, time pressures, fear of litigation and societal attitudes, to name a few, are mostly beyond our control. Some of us have dealt with this by reducing our time in Private General Practice and moving into alternate activities such as teaching, research or medical politics.

So, back to the original question. Do Balint groups protect us from Compassion Fatigue and Burnout? I think the answer has to be yes, no and I don't know. I know that my peers in my Balint group have helped me have better insight into my own 'schemas', the deep, often unconscious, level that has often been exposed as I struggle with my more difficult patients. I know they have taught me 'not to be a toilet' for my 'heart-sink' patients and to draw better boundaries for myself. I know that I have often debriefed with them and that they have encouraged me and given me positive feedback about patients who have left me feeling vulnerable and insecure. I know that, with them, I have challenged many of the beliefs about myself as a doctor that have been idealistic and inappropriate. I know that my potential for Compassion Satisfaction is probably higher, partly because the group helps me continue to enjoy the real meaning and purpose for my work. I think that I have a lesser risk of Burnout because they help me keep my perspective and support me. Paradoxically however, I think that I have a higher risk for Compassion Fatigue because I have had the courage to go into more and more difficult areas of Medicine. They have given me permission to be myself; they have brought out a 'risk-taking' side of me, which has not been content to remain with an unchallenged status quo.

Acknowledgement

I would like to take this opportunity to thank the members of my Balint group for all they have done for me in the last five years and for their willingness to constructively critique the content of this article.

About the group

We started the group because one of the General Practitioners thought that she needed to have some peer support for her increasing exposure to difficult patients who needed counselling. She spoke to a psychiatrist and they asked for expressions of interest from other GPs as to whether they would like to come to a Balint Group. We set up two groups, each overseen by a psychiatrist who had an interest in helping GPs but not necessarily with formal analytical training.

We meet once a month, have wine and nibbles, review the previous month's case and then the designated person presents a patient. The psychiatrist approaches the group with an analytical style but we have often discussed therapeutic options etc as well. It is a very interactive group and we all augment what is said by the psychiatrist as we discuss the doctor and patient in question. At the beginning of each year we review what a Balint group is all about, reassess our aims, discuss how we have changed over the previous year and make any new plans for the year ahead. Our group has about half of the original members still coming. We mostly have about eight members.

I have started to work with suicidal adolescents, with refugees and with Aboriginal people, one doctor now spends half her time doing menopause medicine, one has just about given up general practice altogether and does surgical assisting, two are now only doing counselling and the rest do a combination of counselling and regular general practice.

References

1. Victorian Foundation for Survivors of Torture Inc. *Rebuilding Shattered Lives*, 1998.
2. National Center for PTSD. Working with Trauma Survivors. www.ncptsd.org/facts/disasters/fs_working_disaster.html (accessed 4th August 2003).
3. Stebnicki, Mark A. Stress and Grief Reactions Among Rehabilitation Professionals: Dealing Effectively with Empathy Fatigue, *Journal of Rehabilitation* Jan-March 2000.
4. Mitchell, Jeffrey T. Surviving Trauma Treatment, *Contemporary Psychology*, Vol 41 No. 9, 1996.
5. National Organization for Victim Assistance *Community Crisis Response Team Training Manual*, Second Edition, 1998. Chapter 18: 'Stress Reaction of Caregivers'.
6. The Flinders University of South Australia and International Institute of Hospice Studies, *Calming the Storm – Bereavement Education for Palliative Care Workers*, 1996.
7. Rudolph, J.M., Stamm B.H. and Stamm H.E., *Compassion Fatigue A Concern For Mental Health Policy, Providers and Administration.* Poster at the 13th annual meeting of the International Society for Traumatic Stress Studies, Montreal, PQ, Canada, November 1997.
8. Huggard, P Compassion fatigue: how much can I give? *Medical Education* 2003; 37:163-164.
9. Saakvitne, K.W. and Pearlman, L.A. *Transforming the Pain: a Workbook on Vicarious Traumatization.* London: W.W. Norton & Co. Ltd, 1996.
10. Figley Charles .R. (Ed) *Coping with Traumatic Stress Disorder in Those Who Treat the Traumatized.* New York: Brunner/Mazel, 1995.
11. Stamm, B. H. & Figley, C. R. (1996). Compassion Satisfaction and Fatigue Test. www.response-kit.com/csftest.htm (accessed 4th August 2003).
12. Dornfest, Frank. The American Balint Society. *Balint Training. A 'how to' manual in development.* http://familymed.musc.edu/balint/bits/howtomanual.pdf (accessed 9th November 2003).

A Pilot Registrar Balint Group in Melbourne

Dr Marion Lustig, Melbourne, Australia

Introduction

A pilot registrar Balint group was offered in Melbourne by the South-East Region during the second half of 2003.

Aims

The aim of the group was to give the registrars an introduction to Balint work. They would start to learn how the doctor-patient relationship could be explored, understood and skillfully utilized and how valuable this can be in general practice. They would be encouraged both to continue with the group during their training, and to consider participating in a group after their training once they were in an ongoing general practice situation.

Methods

Recruitment:

The registrars were invited to attend by Bambi Ward, the South-East Regional Co-ordinator for VMA. She emailed them with a brief description of the nature of Balint work. I attended a VMA dinner for all registrars at which I introduced myself and Balint work and invited participation. Medical educator Steve Wilkinson encouraged the registrars to attend.

Duration and frequency:

The group was set up as a pilot group commencing in September 2003 and continuing until the end of the year, with the registrars being asked whether they preferred a weekly or fortnightly group and what times would be possible.

Place:

Dr Lustig's rooms in Caulfield were offered as a location.

Funding:

Dr Lustig was paid by the South-East Region.

Nature of activity:

The group was offered as an opportunity for the registrars to discuss any of their general practice patients, particularly those where strong feelings had been elicited, and those patients the registrars had experienced as difficult. The aim was to discuss two new patients in each session, with time for follow-up of patients previously discussed. The focus would be on the psychological aspects of general practice with a particular focus on the doctor-patient relationship.

Evaluation:

The registrars were asked at the outset to describe their own personal and professional learning objectives and the attributes they felt were necessary within the activity in order to fulfil these learning objectives. At the completion of the activity, they were asked to evaluate it in terms of their own objectives as stated at the outset and to answer a series of questions.

Results

Practical aspects:

Initial interest was shown by six registrars. However, of these only four actually attended, with one attending only the second last session as the sole participant. There was initially a consensus that an evening time was preferable as this fitted in better with the registrars' varying work commitments. In an attempt to recruit more registrars, two sessions were held in the late afternoon immediately following the day education sessions at the same locations (one at Box Hill and one at East Bentleigh). This approach was not successful in attracting more registrars. There were eight sessions in total, six of these being held in the evening at Dr Lustig's rooms in Caulfield. Light refreshments were made available and participants were invited to arrive half an hour prior to the activity commencement time. The registrars strongly preferred fortnightly rather than weekly sessions, and this was the pattern adopted. Attendance and punctuality by the three registrars commencing the activity was very good. These three registrars all completed pre and post activity evaluations and these are described below. The invitation to participate in the activity was extended beyond basic term registrars to all general practice registrars, but no participants in advanced terms were recruited.

Activity process and content:

I felt that the participants were keen to learn about the psychological aspects of general practice and prepared to be very open and honest with the group about their difficult experiences with patients. Generally two patients were presented during each session. There were few opportunities to follow up patients previously presented because of the short duration of the activity.

Because of the small numbers, I decided to take a much more active role in the discussion than is usual in Balint group leadership. In addition to the usual leadership roles of taking care of the group framework and boundaries, facilitating focus on the doctor-patient relationship, and encouraging participation by all group members, I felt that some "participant-like" contribution was required in order for there to be sufficient discussion, to reduce the otherwise unacceptable levels of group anxiety and to model the qualities of speculation, thoughtfulness and openness which the Balint process encourages in participants.

Here are some examples of the patients presented (the participants gave explicit permission for these de-identified examples to be used for promotion of the activity):

1. Heroin addict, bizarre physical symptom, requesting benzodiazepines.
2. 15 year old girl, sexually active with two men, possible STD symptoms, seeking contraception, not wanting mother informed.
3. Chronic pain syndrome patient on work cover, getting worse.
4. Patient's husband requesting extended time off work for wife for work-related stress, not allowing wife to speak during the consultation.
5. Young tradesman with history of anxiety and depression, multiple physical symptoms being investigated for one year, tests normal.
6. Young woman pregnant, comes for abortion which husband wants. She wants the baby, marital difficulties.
7. Young man being accused of harassing others at work, psychosomatic symptoms, seems to want doctor to take his side against employer.
8. 14 year old girl, left home, on sickness benefits, heavy marijuana use, depressed, refuses referral for counselling.

Participants' evaluation:
Attached are evaluation questions for both pre-activity and after the pilot period.

In their pre-activity evaluation, learning objectives stated by participants were:
- to gain a greater understanding of psychological issues in patients, both overt and covert;
- to gain a better idea of how to deal with patients' psychological issues;
- to understand more about the psychological aspects of general practice;
- to learn how to deal with "problem patients";
- to develop an understanding of complex psycho-social situations complicating medical issues;
- to obtain help in addressing psycho-social issues with patients presenting with somatic complaints;
- to gain skills in dealing with complex psycho-social issues;
- to enable patients to see that psychological factors may be relevant;
- to learn how to be objective, non-judgmental and yet supportive;
- to deal with manipulative and demanding patients;
- to deal with patients eliciting anger or antipathy;
- to feel comfortable with being able to make little difference to patients with underlying social issues;
- to improve counselling skills.

The attributes participants felt would be necessary within the activity in order to fulfil their learning objectives were:
- discussion ;
- clinical examples;
- reading material;
- being able to discuss issues openly;
- a supportive group;
- being able to talk in a small group;
- willingness of participants;
- trust of group with leader.

The post-activity evaluations were carried out both in writing with the three regular participants and with a discussion with the two participants attending the final group session. All participants felt the group had been a good experience.

In terms of the practical arrangements, they felt that unless the group was part of the education program, the evening time slot was best. They all believed that participants had felt safe, that there was an atmosphere of trust and openness in the group and that participants had been willing to share their experiences with patients honestly; and that the group had been very supportive. They valued confidentiality within in the group. All felt that it would have been better to have greater numbers in the group. Their suggestions made about possible reasons for the small numbers of participants were firstly that the registrars already have a heavy workload and were not willing to undertake an additional, optional activity; and secondly that registrars tended to be most anxious about and focused on organic medical aspects of general practice. All four participants were interested in participating in further Balint group experience, and the two participants who were asked said they would be prepared to pay for the cost of further Balint group work if it were not otherwise funded.

Participants found the cases presented by others were invariably similar to cases they, too had found difficult. Comments made about what had been learned included:
- understanding more about the psychological aspects of general practice;
- being more aware of own feelings and emotions in the consultation;
- feeling more confident in dealing with patients;
- feeling more open to developing an understanding of psycho-social issues;
- being more likely to identify psychological issues or more comfortable exploring them and discussing them with the patient ;
- becoming less anxious in dealing with psycho-social issues;
- becoming more open to the possibility of psychological rather than just organic causes;
- gaining better insight into why certain patients were difficult;
- delving into own perceptions and expectations of patients;
- attempting to understand the patient's perceptions and expectations;
- reflecting especially about poor interactions with patients;
- being more confident in dealing with confrontational patients;

Limitations on what had been learned that were mentioned included:

- perhaps they would still struggle to deal with psycho-social issues;
- difficulty in identifying how much increased confidence and reduced anxiety was through experience in general practice and how much through group experience.

The specific questions asked as part of the post-activity evaluation were all answered in the affirmative. These involved a variety of aspects of the learning experience I had aimed for, plus an interest in continuing with the group during their training and joining a Balint group once they were in an established practice.

Discussion

I felt this had been a very successful activity on all counts other than numbers of participants. Participants were very positive about the group qualities of trust, openness, willingness to participate in discussion and feeling supported by the group. They all felt they had learned more about psychological aspects of general practice and the doctor-patient relationship and felt more confident in being able to deal with psychosocial issues and with difficult doctor-patient interactions. There was a greater awareness in the post-activity evaluations of their own reactions to patients, together with a greater awareness of and openness to exploring psychological issues with patients. The opportunity to discuss their own cases in detail, and their individual struggles to deal with difficult interactions, was welcomed. My impression was that participants had had little opportunity previously to obtain help with some of the difficult situations they were encountering in their work. The interest by all participants in further Balint work in my view reflects both their recognition of the value of this work and of the limitations of the short pilot period. Balint training does involve the facilitation of a personal developmental process in participants and this requires more time, often around 2-3 years of participation.

In terms of the aims of the pilot, I feel that the activity gave the registrars a fairly good introduction to Balint work, in that they felt they had learnt something about how the doctor-patient relationship could be explored, understood and utilized and how valuable this can be in general practice. Many of the comments they made reflected a greater awareness of both their own emotional responses to patients and of the patient's experience of the consultation, two key aspects of the doctor-patient relationship. However, their experience of Balint work was greatly restricted by the small numbers of participants. They did not experience the richness of discussion and diversity of viewpoints that a larger group can provide. The aims of encouraging them to continue with the group during their training and to consider joining a Balint group once they were in established practice were completely achieved, as all participants wished to continue with the group.

There appear to be several ways in which registrars may be involved in Balint work:

1. *Optional participation in a registrars' group.* With the current structure of registrar training, this would probably have to be during the evening so as to cater for registrars' varying work commitments during the day. Ideally this would continue for the duration of general practice training, with participation whenever practicable. Allowance would have to be made for absences during rural rotations. The pilot has demonstrated serious difficulty in attracting sufficient participants with this approach.

2. *A registrars' group as part of the compulsory education component of general practice training.* This approach is the one most commonly adopted overseas. In the U.K. and the U.S.A., for example, registrars' groups where offered are invariably as I understand it an integral part of the training program. This approach has a number of advantages:

- registrars can participate in a group without feeling unduly pressured in their already busy schedule;
- including the group as part of the education program makes a powerful statement to the registrars about the importance for general practice of interpersonal skills and psychological issues;
- registrars have the opportunity to discover by personal experience the value of such a group, which they may not otherwise understand;
- such a group provides support and promotes confidence as well as facilitating learning about psychological issues in general practice.

3. Another alternative is inviting registrars to participate in existing groups for practicing GPs. This has the advantages of:

- helping to boost group numbers for both the registrars and the practicing GPs;
- giving the registrars opportunities to experience role models for both general practice and Balint group participation.

It has the disadvantage that registrars and practicing GPs are usually very different in their stages of professional development.

A Balint Group for Medical Students at Royal Free and University College School of Medicine

Peter Shoenberg: consultant psychiatrist in psychotherapy and
Heather Suckling: retired general practitioner and part-time tutor

Abstract:
This is a descriptive paper about an experimental Balint group for first year clinical medical students at the Royal Free and University College School of Medicine, London.

It describes how this group originated, its aims and objectives and what happened in the group, including an account of some of the material presented by the students.

Background:
The medical school has a long history of teaching about the doctor-patient relationship. Balint himself ran a group for medical students there from 1962 to 1969[1] and teaching in communication skills was introduced by general practitioners in the early 1960s. Since 1958 the Department of Psychological Medicine and Psychotherapy has offered first year clinical medical students the opportunity to see a carefully selected patient for once-weekly psychotherapy for a year, with weekly supervision, as a way of helping them to learn about the doctor-patient relationship.[2,3,4] It has remained a successful and popular option for students, and has been copied by other UK and European and North American medical schools, but is only available to a very small proportion of the annual clinical intake. This year ninety students (out of a newly expanded clinical intake of 360) asked to be considered for the scheme. Fifty attended an assessment interview, but as there were only fourteen places it was decided to offer an alternative weekly Balint group for a period of three months to some of the remaining students, who could not be placed on the student psychotherapy scheme. Eleven students were selected and offered the chance of joining one of two groups, one to be run by Peter Shoenberg (PS), and the other by an accredited Balint leader and GP, Heather Suckling (HS).

HS was already working part-time at the medical school as a tutor to first and second year (pre-clinical) students for the Professional Development Spine. This course was developed in line with the recommendations of *Tomorrow's Doctors*[5] and includes ethics and law, clinical skills, evaluation of evidence, health promotion, community orientated medicine and communication skills. The whole course emphasises the importance of patient-centred medicine. The community orientated medicine course includes introducing a group of students to patients and encouraging them to elicit a history from a patient, but the communication skills' teaching is behavioural rather than reflective; so for example there is emphasis on the value of the use of open and closed questions, eye contact and body language. Although this is an invaluable part of the course HS was concerned that that students could make this a somewhat mechanistic process, rather than one which allows the patients to tell their own stories. She was aware of the success of introducing medical students to Balint groups in Germany[6] and Poland[7] and was already considering approaching the medical school about the possibility of running a Balint group for students, at a later stage in their training, when they were seeing patients regularly.

Consent was obtained from the medical school authorities to run a pilot project for three months. A small amount of funding was secured to pay HS a nominal fee and PS led the group as part of his teaching commitment. It was planned that the students were to come to the group in their own time.

What happened
Ten of the eleven students invited attended a preliminary meeting, at which the ground rules were agreed, the aims and objectives were discussed (see Table 1) and a preliminary evaluation questionnaire distributed. One student dropped out after this meeting, but the remaining nine students remained throughout the thirteen weeks. The first case discussion groups were on 6th January 2004.

Table 1

BALINT GROUP for MEDICAL STUDENTS

AIMS AND OBJECTIVES:

Aims of the Group Sessions:

1. To provide the students with an opportunity to explore the emotional aspects of their work in a safe environment
2. To increase the students understanding of their patients' communication
3. To provide support and supervision* for the students
4. To encourage the students to reflect on their work

Objectives:

After the course the students will:

1. Be able to consider their clinical encounters in a new light

2. Become aware of the significance of the relationship between the doctor/student and the patient

3. Be able to recognise the feelings which are evoked by the interaction with the patient and be able to use these for the benefit of the patient

4. Become aware of the emotional meanings of patients' physical symptoms

5. Be able to use the group to express and process anxieties and frustrations about their work

6. Recognise the inherent value of the consultation itself

7. Become aware of their own limitations

8. Value their own humanity and personality and the effects of these on the patient

*supervision in the psychotherapeutic sense

For the first four weeks PS and HS each took a group as arranged, but subsequently, with the agreement of the students, the groups merged and ran with the two leaders. The students were invited to discuss encounters with patients who continued to occupy their minds. As in a traditional Balint group, the emphasis was on the relationship between the patient and the student and the emotional, rather than the clinical aspects of the consultations. Follow-up reports were encouraged and helped to provide continuity. Initially, as the students began to get to know and trust each other, there were general but important discussions about how difficult it was for the students to meet with patients, to develop their roles and to confront illness and death. Later, the discussions were on a deeper level, and explored the emotions and personalities of the individual patients and their effect on their illnesses and the interaction with the students. Likewise the students recognised the effects on their own emotions and how these and their personalities affected the consultations and the outcomes for the patients.

A total of fifty cases were discussed in the seventeen group sessions. Initially several cases were discussed briefly at each session and there was more time spent on general issues, but as students became more confident they were able to discuss individual cases in much more depth. A list of themes of the cases presented was kept, but as a total of 64 themes were identified, they will not be discussed in detail here. At the end of the three-month period the students were asked to complete a second evaluation questionnaire.

We were impressed by the honesty and openness of the students, their ability to reflect on their work, their powers of observation and their intuitive acceptance of a holistic, patient centred approach. However, not all their experiences demonstrated the positive effects of being 'patient-centred', particularly in relation to medical students. In the present climate of efficiency and limited resources in the NHS, patients rarely stay in hospital for more than a few days and so it is sometimes difficult for students to find patients to interview. Some patients are very ill, others are fed up with being interviewed and others want to demonstrate their right to refuse to be seen by students. One student described how he had been walking towards a patient, trying to look pleasant and encouraging, about to ask her permission to interview her when she glared at him and said:

'No! I said "no" to the students yesterday, say "no" today and will say "no" tomorrow! You cannot talk to me!' Several of the students had come across this particular patient, but they all found it upsetting although they laughed in the group, relieved to find that they were not alone. Other examples were brought where the patients gave remarkably different stories to different students or even to the same student on different days. Whereas experienced doctors are familiar with this, it is clearly very distressing for students.

Even in the early smaller groups, the students were able to share feelings with each other. One of the students talked about seeing a poor wizened old man in his eighties with severe peripheral arterial disease. She said he had been so wasted that she could see his ribs and his emaciated abdomen as he lay on the bed: he was hardly able to talk and looked like a bag of bones, with one leg amputated. She expressed how shocking it had been when his remaining leg had moved. It had all been so upsetting that she had burst into tears afterwards when she spoke to her mother on the phone. This led to a discussion about the relationship between what you see, and what you feel, and the fear that this man had aroused in her of growing old herself. This was followed by a discussion about the fear of touching patients. Another student described a patient who had come to the Accident Department and was so badly burned, from being in a fire that one could not tell the colour of his skin; all one could see was ash covering his body and how his hair was charred. The student had got ash on her skin from examining the man. It had all been very threatening and frightening. She said she had wanted to cry and realised it would be good to cry. The group expressed the view that one should be objective if one wanted to become competent.

The student who had told us the previous story now told us another one, about taking the history of a man on a cardiology ward. He had kept on interrupting her to talk about the loss of his wife, as she tried to persist with the medical history. He said, 'I'm sorry, but I want to talk about Kate.' By his bedside was a picture of Kate. Apparently he had been looking after his

wife who had Parkinson's disease and who during this time had lost four stones in weight. The group wondered what the student should do, because the patient had refused to have counselling, yet he so obviously wanted to talk. Someone suggested that this student should return to him later, but what would happen if he began to talk about something the students could not handle? Another student suggested that it was best when somebody talked about something that was difficult, just to say nothing and listen. PS commented that this case showed how important the patient's emotions were, and how the student needed to have real emotions themselves, in order to be empathetic.

Later, after the groups merged and when there were two leaders, the students were able to consider deeper issues. One student described her first experience of seeing a patient dying in the Casualty Department. He had died of a third heart attack: she described her surprise at the very peaceful expression on his face, which contrasted with the heart-rending screams of the relatives in the corridor and the anxieties of the Casualty doctors that they might have missed a high serum potassium. The group discussed how this first experience of seeing a death had affected the student. She denied that it had been upsetting, yet her eyes were filled with tears.

In this larger group our discussions explored the histories of patients who did not fit into the hospital system. One student described a very demanding and abusive young homeless drug addict who had wanted her to make the phone call to a homeless persons unit, which she had done. But when she had demanded that she fetched some orange juice for her, the student had refused to do this, as she did not consider it to be her role. Another student presented an angry, rather litigious patient, who was convinced that the ENT surgeons, who had put grommets in her ears, had caused her to develop tinnitus subsequently. She described how the two consultants had patiently listened to this demanding and aggressive patient, yet she still had not been satisfied, even when they had offered to take the grommets out. The students talked about why people were angry, why they were hypochondriacal: one student suggested that it might be to do with a private unhappiness with perhaps a broken marriage in the background.

Another student described a case of a woman who came to an incontinence clinic complaining that she became incontinent of urine only when she passed a certain building. We all agreed that this might be a psychosomatic case, where one had to take into account the patient's personality as well as their illness.

In another session, a student described the story of a man who had already had a coronary by-pass, who was now presenting with unstable angina pectoris. In the doctor's notes, the social history only recorded 'lives with wife', but the student had allowed him to tell his story. The patient had told her that his wife was becoming increasingly frail. He had wanted to move from their house, which he felt was much too big, but the wife had not wanted to move. On the day of his admission to hospital the weather had been very cold, he had been busy all day, and then he had had a very heavy meal, after which he had to do the washing-up on his own. It was then that his angina had come on. He had ignored it for one and a half hours before feeling able to call for help. The student commented that the doctors had seemed only to be interested in the medical problems, when in this case it was clear that this man's social and personal circumstances were so relevant. Another student said that in the Care of the Elderly department, the psychosocial situation of the patient was always considered carefully and another said that general practitioners also tend to consider the whole patient more than hospital doctors, and are aware that they need to consider the patient's beliefs and expectations.

The ensuing groups included discussions of patients with dementia and facial disfigurement, and how doctors dealt with these frightening and painful situations. Other groups focused on patients who were difficult historians, or who were devious with the student. The students wondered if it was because they *were* only students, after all. In one group, a student described a young patient with ulcerative colitis who said he preferred to talk to her, rather than the doctors, because she was nearer his age. She had found the closeness in age a challenge. Two students said they preferred to be with younger people, but another student said he preferred older patients with whom he felt safer.

A recurring theme was the problem the students had in finding patients with whom they could spend enough time to listen to their personal story, as well as obtaining a systematic medical history. Often there were so few patients that they interviewed patients in pairs. Often they would say that they were 'only students' who 'were in the way' and sometimes considered a nuisance by both patients and staff. Inevitably this feeling reduced their confidence.

After thirteen weeks the group came to an end. The students said how much they had appreciated being given time to talk about their work with patients, to hear other people's views, and that this had given them a fresh outlook and helped them to see things in a new light. They said it had been a revelation to realise that they, as students, could be useful to patients, and that it had stopped them feeling so alone with difficult problems. They also said that it had emphasised the need for them to listen to the patients' stories and had increased their confidence, so they did not feel obliged to constantly bring the patient back to the purely medical problem

Conclusion

In contemporary medical culture remarkable scientific discoveries have radically improved the treatment of many life-threatening diseases, so that everyone's expectations are much higher.

The failure to cure is too easily seen to be the fault of the doctor, and the obsession with health targets and reduction of waiting times for patients to be seen has often been at the expense of time spent in listening to the patient. The culture of large teaching hospitals has also changed, with a greater emphasis on rapid through-put of patients and increasing specialization of units which may be so large that they have little to do with each other. The divorce of mental health trusts from the main medical hospital trusts has had many complex consequences, not least a new kind of splitting of psychological from somatic care.

How are we to help medical students to negotiate this brave new world in such a way that they can hold on to and enhance their natural emotional sensitivity and become competent but also caring doctors? Students go into medicine with many important ideals which may be too easily lost along the way. Whilst the teaching of professional attitudes, including learning basic communication skills is very much to be praised as a development, students also need time and support to reflect on their new experiences in relating to patients if they are ever to achieve an emotional maturity as doctors. We have found this experience of running a voluntary Balint group for these students deeply rewarding as a way of trying to reach this goal, and believe it may offer a way forward for the many rather than the few in this new era of expanding medical schools.

Reference List

1. Balint M, Ball D and Hare M Training medical students in patient-centred medicine. *Comprehensive Psychiatry* 1969; 10: 249-258
2. Ball DH, Wolff HH An experiment in the teaching of psychotherapy to medical students. *Lancet1963;* 1: 214-217.
3. Shoenberg P The student psychotherapy scheme at the University College and Middlesex School of Medicine: its role in helping medical students to learn about the doctor-patient relationship. *Journal of the Balint Society* 1992; 20: 10-14.
4. Bloomfield I. Student psychotherapy and its role in helping medical students to learn about the doctor-patient relationship. *Journal of the Balint Society* 1992; 26: 15-18.
5. General Medical Council *Tomorrow's Doctors: recommendations on undergraduate medical education.* London: General Medical Council,2002.
6. Otten H. Balint work in Germany. *Journal of the Balint Society* 1998; 26: 16-19.
7. Jugowar B and Skommer M. The effectiveness of Balint training for medical students. In: Salinsky J and Otten H (eds). *The Doctor, the Patient and their well-being – world wide.Proceedings of the 13th International Balint Congress* 104-108. Berlin:Ruckzuckdruck,2003.

Does the imposition of Government directives threaten the potency of the drug 'doctor'?

James Willis

Address given to the Balint Society on 28 November 2003

It is a great honour to be asked to speak to this society. When I started in general practice, medicine was very much more hierarchical than it is today. Doctors who attended Balint groups were definitely *up there*: a kind of dusty, distant intelligentsia, clever people who I found both intriguing and daunting. I never came close to being one of them myself, although I suppose things might have been different if I had started my practice in London and met different people. I had found a series of group sessions led by the psychotherapist Heinz Wolffe perhaps the greatest highlight of my undergraduate training at the Middlesex. And there were elements of the same desperately-missed human approach to medicine in the sessions we had with the GP Harry Levitt (in that same panelled room, as I remember) which attracted me so strongly to general practice.

Apprenticeships

In full flight from the aseptic, calculating, *inhumanity* of hospital medicine, I found myself drawn, not just to general practice but to *rural* practice, and thence to Tony Danby of Lyndhurst. In those days first-choice GP recruits like me were in extremely short supply, and we were able to choose between training practices and especially between trainers. I had a large field to choose from, the whole of the British mainland, and I made a wonderful choice. The best GP I have ever known: my model ever since. He knew and loved his patients in a way which was so completely natural and so uncontrived that to have mentioned it, or heaven forbid, analysed it, would have seemed obscene. He was simply a master of the craft of general practice. And I was his apprentice, learning so many things that cannot be taught, or that you don't even know you are learning. As a result of this experience, and to a lesser extent other experiences throughout my career, I am utterly convinced that *apprenticeship* is *the* indispensable component of proper medical education.

I mentioned this to an ex-special needs headmaster during the tour of Ancient Greece my wife and I were on last week and he whistled in mock horror, which was really astonished approval, "You ARE a reactionary!" "Yes, I'm a reactionary *with gizmos*!" said I, indicating my state-of-the-art digital camera and palmtop computer on the taverna tabletop, which I had been using conspicuously throughout the trip, and demonstrating to anyone who was interested. Which they all were.

A reactionary with gizmos

'A reactionary with gizmos'. In other words a pretty mixed-up kid. Tony Danby, as I have indicated, wasn't much into Balint. And I too was instinctively suspicious of something which seemed to drift dangerously close to the mystical. I had been hugely influenced by my father, who although a considerable polymath, well read, writing in beautifully correct English and studying several foreign languages as an amateur, was above all a *scientist*. He worked in Atomic Energy research, represented our country as an attaché in our Embassy in the United States, and at the time I am talking about nothing less than the Secretary of the British Association for the Advancement of Science. (He was Magnus Pike's immediate predecessor.)

So I saw myself as a scientific doctor. I saw science as the thing, which had brought medicine out from the dark ages, replacing tawdry hocus-pocus and charlatanism (which revolted me) with the beauty and clarity of accumulated scientific truth. None of these attitudes have I changed since. My prejudices were reinforced by the antics of certain colleagues, many of whom involved in GP training in the 70s (a time when I was not involved in training myself), who seemed to be plunging themselves and the young doctors in their charge into a cult of patronising, self-indulgent introspection. Always one to react against fashions I was deeply disinclined to 'Let it all hang out'. I remember first coming across the word 'psychobabble' and writing it down because it provided such a neat and necessary name for a new phenomenon. I used to get a lot of refugees from the style of practice which involved asking penetrating questions about sex at every consultation. Quite a lot of patients obviously enjoyed this manifestation of seventies sexual liberation as much as their doctors, but others didn't. And then it was a game with the dice loaded against them. The more they protested, the more knowingly did the doctor diagnose their 'self-deception' and their 'denial'. And if they made the mistake of showing actual indignation at the whole performance they found themselves on the receiving end of that wonderfully-unanswerable put-down, "I'm *interested* in your anger." And yet, I found an instant and enduring enthusiasm for everything I learned about Michael Balint. *The Doctor, his Patient, and the Illness* was one of the books which were so often alluded to in those days that you felt you knew what it said without having to read it. I used to tell people that you could get anything you wrote published so long as you

mentioned Balint. But I did read it, and it did have a profound effect on me. For example, I recognised the *collusion of anonymity* as another important phenomenon in need of a name. And when I read about the *drug doctor* I thought of Tony Danby.

Conflict – splits – lines in the sand

So this is the theme of this address – it is about *conflict*. And the *resolution* of conflict. Mixed up kids. Mixed up doctors. Mixed up society. A matter of ambivalence. A matter of paradox. And what on earth we are going to do about it. Edward de Bono once said that all science is a matter of *lumping and splitting*. I think we are looking for a new split here, perhaps something as simple as a new name, but I don't think it's going to be as easy as that. Because general practice needs elements of art and of science; elements of logic and of mystery; elements of individual freedom and of centrally-imposed control. And somehow at the moment we have got the split-point wrong, because we can't speak out *for* science without seeming to be *against* art (or *vice versa*), and we can't speak out against 'psychobabble' without seeming to be against the putting of the subtleties of human values at the forefront of medical practice. And we can't speak out against the abuse of power (which I increasingly recognise as the link between many of the things I feel passionately about), without seeming to be against power itself. And we can't speak out against the abuse of technology without seeming to be against *progress*.

The particular split I want to consider this evening is where we are to draw the line between professional freedom and central control. Because I believe a fundamental problem today is that we have got this split-point wrong – through fundamental misunderstandings of the issues involved. The sad thing for me is that a lot of this misunderstanding has arisen through the abuse of my beloved science. In fact we are a society that is so besotted with a naïvely mistaken notion of science that it thinks it is on the point of solving *everything*. This means that any things that still go wrong (and some still do go wrong!) ought to have been avoidable and are therefore *somebody's fault*. Inherent in this belief is the assumption that we have finally passed beyond the era in which personal qualities were paramount in human fields such as medicine. Now we are expected to accept that the system knows best, and that it has superseded the professional freedom which was previously recognised as necessary. The fact that this freedom happened to provide a particularly satisfying life for practitioners is deemed to be irrelevant; mediaeval scribes no doubt found their work satisfying too. Now 'working to rule' is no longer a synonym for striking – we are all to be made to do it all the time, in the name of progress. The difference is that the rules are now going to be so refined that they are going to work in every situation. And there will be no dissent permitted: 'we have the technology' to make sure everybody complies.

Mark Twain said, "It ain't what you don't know that makes you foolish, it's what you *do* know that *ain't so*." I have spent a great deal of my career thinking and writing about things we think we know about general practice which I have noticed *ain't so*. And things we think we know about the workings of the human mind which I have also found *ain't so*. The problem is that the arguments that have to be employed to demonstrate these truths won't fit into the kind of sound-bite which is all-but essential for discourse today.

Our visitor
from Africa
in her flowing robes
could not be squeezed
into tiny tick-boxes *

The arguments we need must be wide and long and deep. That is why it is natural for the case to be advanced from general practice. General practice is *concerned* with the wide and the long and the deep. Indeed, one of general practice's most distinctive features is that it is concerned with *wholes* rather than the parts upon which contemporary science so characteristically focuses its gaze. As I wrote in my book, *The Paradox of Progress*, our narrow conception of science (and I am including the whole of logic and reason when I say science), is automatically excluding the very class of arguments which *must* be used in order to demonstrate these phenomena. This is how I put it then, just over ten years ago, when the dangers I was so worried about were almost entirely in the future, and I thought that I would only have to point them out and everyone would rush to avert them:

> *The current trend towards external review of everything is fundamentally flawed. The idea that regulation is a good thing per se is an illusion. Regulation destroys humanity. It undervalues the individual human being, his mind, his motivation and his integrity. Unfortunately general practitioners have to some extent colluded in the process of reducing their practice to a lot of sterile formulae. They have done this because they have shared in the illusion that this is what is necessary for progress. This means that general practice, the last great bastion of professional generalism and common sense, is being judged by the wrong criteria. It has lost its self-respect because it is trying to express itself in a language which denies its very nature.*

Other people have said similar things. Robert M Pirsig in his wonderful book, *Zen and the Art of Motorcycle Maintenance*: '...the crisis is being caused by the inadequacy of existing forms of thought to cope with the situation. It can't be solved by rational means because the rationality itself is the source of the problem.'

Yann Martel in his celebrated 2000 Booker Prize winner, *Life of Pi*, '...reason, that fool's gold for the bright...' Common wisdom also accepts it as self-evident that there is more to life than, 'Targets... Tasks... Attainment... Outcomes... Monitoring...' This is the list of buzz-words which our friend Judith Hepper (who with her husband Edward was also on our trip to Ancient Greece last week) compiled in the idle moments of a recent school governors' Performance Management Training Day, during which she privately composed the haiku which illuminated this talk:

PERFORMANCE MANAGEMENT
columns of cold figures –
Outside, Autumn glows. *

But common wisdom, Judith's or anyone else's, doesn't count in the Brave New World. It never did 'count', of course, but in the Old World (which was Brave enough in its way) we did value things that can't be counted. By the way, that is the responsible objection to Evidence Based Medicine, on the face of it a wonderful and powerful idea for which I was an early enthusiast and advocate, but an idea that that is now being terribly abused by people who do not understand the relationship between models (of whatever kind) and the reality they represent, people who think that the world, the universe, and everything really can be encapsulated in the formulae of rigid science.

The 'house of our minds'

I am convinced that there is a great truth hidden in this common wisdom which is *permanently beyond direct articulation:* that the wonderful tools of science and logic and language we have invented merely give us the front door to the house of our minds. A house whose elaborately furnished rooms hold a representation of reality whose richness and detail is of a magnitude infinitely greater than we can *ever consciously conceive*. It has to be so, surely, or would any of us, especially us GPs, survive for a single moment without being overwhelmed by the weight which must be in our minds. And fortunately not *on* our minds! So we can bring things out to the front door of the house to show people, as I am doing now. But that is all. We can never invite anyone inside. More than this, and this really *is* the crux, we cannot go inside *ourselves*! I mean we can't consciously go inside and look around. And that is the way it is always going to be. The vital thing is that we should recognise this fact and give back to our inner minds the respect they deserve. And recognise that allowing sufficient rein for the exercise of the unfathomable ability hidden inside is the only way the practical world can be made to work. I have taken this argument one stage further: I believe that the representation of reality in our minds – the model created in the 'house' I have just described – is different in *kind* from any representation or model we can artificially create. In particular, and my main argument has sufficient force if you don't accept this speculative extension, I believe that the model in our minds incorporates a bizarre property of reality, in that reality consists of many, perhaps an infinity, of *incompatible truths*. Life is not, in other words, a simultaneous equation.

I believe that this fact has been revealed clearly for the first time in human history by our generation's attempt to model human experience in mathematical terms at the gigantic scale made possible by microcomputer technology. I believe that GPs, because of the nature of their work and the way in which computers are being applied to that work (in the UK more than anywhere else), are seeing this effect *first*. We have ring-side seats in an historic attempt to solve a huge simultaneous equation. In fact we are not in the ringside seats, we are in the ring, unlike the ring-leaders, that is, who are somewhere else entirely looking at their screens. And we can see *more clearly than anyone else* that the result isn't coming out. All around us we see central control trying to create Utopia, and actually creating chaos.

"It ain't what you don't know that makes you foolish – it's what you do know that ain't so". That is just what we are seeing; in our worst moments the control of the British NHS seems to have been taken over by arrogant fools.

Where to strike the balance?

So back to the split-point that we have to define somewhere between the two poles of freedom and regulation, which is currently so wrongly placed in our society with respect to the professions. And in an advanced, democratic society that is the kind of thing which ultimately has to be defined by popular consensus (unlike the question of whether we go to war, apparently). In other words, in defining this balance point between freedom and regulation the perception that people in general have of what is reasonable is the utterly crucial thing. But it is all very confusing: Some people for example might argue that while people should be free to choose *when* to brush their teeth, they should not be free to chose *whether* to brush their teeth. Similarly, it is established in our society that it is reasonable to compel motorcyclists to wear crash helmets, but judging from our observations last week in Greece, this perception is not shared there. All but a tiny minority of motorcyclists in this fellow-member of the EC were bare-headed, and children were to be seen travelling standing up in the backs of pick-up vans. On the other hand, we were warned that in Greece jaywalkers can be prosecuted relentlessly by armed policemen and even extradited from Britain to stand trial. We Brits have not chosen to compel bicyclists to wear crash helmets, but the Australians and New Zealanders regard this as elementary common sense. With the news that chestnut trees in Norwich came under the axe last year because of the threat their conkers caused to children, the possibilities for parody are exhausted. I can see

no logical line which will prevent tennis players from being prosecuted for not having enough tread on their tennis shoes. And should that day come (possibly hastened by my raising the issue tonight) experience tells me that the received wisdom will then change and everyone (except a few die-hard reactionaries) will swing round to a point of view that regards this measure as entirely reasonable and opposition to it as barbarous. 'It had to come…' everyone will say. Once the problem of the previously-uncounted injuries caused by ill-shod would-be Henmans has been revealed something will have to be done to make sure it can never happen again. 'You can't be too careful…' everyone (except a few of us) will say.

Afternoon shadows creep across the lawn
The day's notes are penned
Guidelines have been straightened
Role-play endured
Tasks completed
Outcomes secured
'Evaluation and Depart: 3.30.'
We escape
To find
The children. *

Tackling the problem

You *can* be too careful! My books and my website contain my attempts to express my own multifaceted attempt to draw this split-line, which aims to avoid the traps of anti-science and pseudo-science on the one hand and what I call scientific fundamentalism (the error of thinking that science provides certainty) on the other. These were the Scylla and Charybdis of my 'Sea Monster and the Whirlpool' keynote address to the 50th anniversary Spring Meeting of the College, which is on my website, www.friendsinlowplaces.co.uk, as is the full text of The Paradox of Progress.

The relative/absolute divide

You can be too careful! Risk is not an absolute! The relationship between absolutes and relatives is one of the things which are so problematic in our contemporary thinking. This evening we are tempted to look for an absolute split, for something which will enable us to distinguish logically, clearly and finally between the things which are reasonable for society to impose and the things which are not. But unfortunately it can't be done; all these questions are relative, fluid, flexible. In all sorts of ways our society longs for it to be otherwise. Doctors at the moment are finding it extremely difficult to argue for the importance of clinical freedom and independence from political control without appearing to be irresponsible. This is the very last thing they want to appear, because professionalism is *all about* responsibility. Football matches are absolute things. Today there is a fashion for calling people who are seriously involved in the activities of life 'players'. And you can see the attraction of this approach: games are so wonderfully simple. They have nice, clear rules. They have two opposing teams. And you are either *for* one side, or you are *for* the other. The team you are not *for*, you are *against*. The score is measured in nice, simple units. If '*we*', get one more unit than '*them*' – '*we*' win.

How delightfully easy it is to 'play' games! Money is like that. The objectives and performance of a business can be defined absolutely in terms of money. No wonder managers want to believe general practice can be run like that. But general practice is *not* like that. It is about life, and life is not like that!

EXTERNAL ADVISER
Straightened tie,
Sharp patter,
Acetate sheets,
Bullet points.
'I've never actually been a teacher' *

Life is *different*. General practice is *different*. In general practice we do not aim to 'win'. 'Winning' is a concept which can at most be described as fuzzy. People who have actually been GPs know this, however foreign the idea may be to those who have not. Everything in life is relative, multifaceted. You can be against something in life without being *for* its opposite. In life we have to make balanced judgements over issues of such subtlety and complexity that rational analysis is literally inapplicable. But our society has fallen for the grand illusion that we have now grown beyond that kind of fuzziness and that we are now in a position to define systems of rules which will cover every eventuality in its every detail. Douglas Adams saw the point uncannily early in his radio play, *The Hitchhiker's Guide to the Galaxy*. Progress seems to be leading us inexorably towards a final ANSWER, to the world, the Universe, and EVERYTHING. And, in his most brilliant insight, he realised that that answer will be a NUMBER, 42. Ask a silly question…Upon how many measurable parameters are general practitioners going to be evaluated under the new contract? Isn't every one of those a silly question? And where was the opposition?

The answer

I have told you that I always held Balint doctors in a kind of awe. That was why I felt it a particular honour to be invited to a meeting of this society by Jack Norell in 1985 because he liked a little verse of mine which I had submitted (with the utmost misgivings) to the Journal of the Royal College of General Practitioners in response to something he said in his William Pickles lecture. He read it for me at the time, out of kindness but slightly to my disappointment, and I wonder if you would indulge me by allowing me to read it myself now. I won't sing it, although I could certainly do that too:

THE MODEL MEMBER'S SONG
Verse 1
Model Member
I am a model member of the Royal College of GPs.

I'm lacking no accomplishment to rid my patients of disease.
I did the OK house-jobs in a range of specialities
(I'm good with a retractor and I've done a few appendices).
I've even sat an MEQ on Oath of Hippocratica,
Systemic Lupus Erythematosus and Sciatica.
My practice is a business and efficiency is everything.
I ridicule the fossils who persist in chronic visiting
ALL:
He ridicules the fossils who persist in chronic visiting.

M.M.
I analyse my patients on a scale from one to forty-two,
They're broken down by age and sex
And height and weight and size of shoe.
I tape my consultations to admire communication skills.
Oh yes, I am the very thing the patients need for all their ills!
ALL:
In short he thinks he's marvellous and who are we to disagree –
He is a very typical example of the new GP!

Verse II
MM. (*thoughtfully*):

In fact I sometimes wonder if my training was vocational
It had a sort of relevance, but nothing too sensational.
My teachers taught me arrogance but now I need the common touch –
My practised pompous strutting and carnation haven't helped me much.
I find myself let down by all those bright ideas that we were taught,
The customers refuse to need the sort of help we thought they ought!
I fill my time with courses and in meetings with the health care team.
Do patients feel they are the mote? – and that I only see the beam?

ALL:
Do patients feel... *etc.*

M.M.
In fact when I'm available as freely as I ought to be
When I can understand the reasons patients really come to me,
And when the things I know and those I don't know I begin to see…
You'll say a better general practitioner could never be!

ALL:
Ah yes, these simple qualities are what we'd really like to see
We'd say a better member of The College there could never be.

So you see my preoccupations go a long way back. And I believe that history has vindicated my fear that this College, which I have always regarded as indispensable in the development of general practice, was leading us in a fundamentally wrong direction. Indeed, it has been largely responsible for the current catastrophe of regulation driving out professionalism and compromising the potency of the drug doctor. This is because the college was dominated for many years by a particular kind of doctor. (This has changed now, thank God.) Suffice it to say that that kind of doctor was not like Tony Danby. And I don't think he was like Michael Balint, but you will be able to tell me that. I wonder in fact what Michael Balint would have had to say about the plethora of agencies that now exist to spy on doctors and on their confidential records, to interfere with their management of their patients, and to force them to comply, before they do anything else, with a complex array of politically-inspired priorities. I am sure I know what Tony Danby would have had to say.

If the college had joined with the BMA in 1990 and led the profession in a principled stand in defence of professionalism I believe we would have been as successful as the lawyers were, and with far more justification. In view of the assumption today that some form of professional re-accreditation was 'overdue' and 'bound to come' following the series of medical scandals that marked the end of the last millennium, it is salutary to remember that in spite of the fact that the MDU council had been told that they would *have* to introduce such a scheme if they were to avoid having one *imposed* by the government, one third of the members still voted against the principle. Ordinary members of the profession, the Tony Danbys and the 'me's, were even more worried that the changes would do more harm than good. And today there is almost universal agreement that the measures introduced at unknown but certainly gigantic financial and human cost are no rational response to the problems they were supposed to be addressing.

An overlooked example of the irrationality underlying this explosion of untested regulation is the extraordinary injustice of the slur on single-handed doctors in the aftermath of the Shipman affair. Dame Janet Smith's report of July 2002 makes it clear that Shipman committed the first 72 of his *known murders whilst he was a member of a large group* practice. If he had been apprehended by the authorities at that time, when he *ought* to have been apprehended, it would have been large group practices (if any particular kind) which should have come under scrutiny. And yet this government, which seeks to shackle individual doctors into doing and saying only those things which have been scientifically proven, fell into this profound error of logic. No one has ever apologised to the class of exceptionally devoted, effective and appreciated doctors who were thus so mortally wounded.

Resolving the conflict?

I believe the only thing we can do to readjust this crucial balance is to have the courage of our convictions and talk about the problem in order to re-adjust the general perception of what level of control is reasonable. We have to win the argument that general practice is *different*. It *isn't* like being an airline pilot, and we have got to say this instead of, as we see outspoken doctors so often doing, colluding with the fiction that it is. There is an enormous amount of instinctive popular support for what I am saying. People know that it is basically true. We all know that it is basically true. But in talking about the problem we have to avoid the pitfalls I have mentioned ...the Scylla and Charybdis of my analogy in Birmingham last year. We cannot abandon rationality, as the Observer newspaper has abandoned it in sanctioning the ludicrous mumbo-jumbo assertions of its 'Barefoot Doctor' columnist. But we do have to show that rationality has limitations, which must be carefully explored. We have to show how essential it is to put unquantifiable feelings and values back into our balance of judgements about vital issues such as the amount of structure it is reasonable for our society to impose on professional freedom. And we have to acknowledge that the human mind has mysterious qualities which are deeply hidden, so automatic that we take them for granted, but immensely powerful and subtle. And utterly essential if we are to make activities like medicine work at the human level. In short, we have to restore respect to individual people as the paramount priority of our civilisation.

So there we are, this talk has not been as coherent as I would have liked, nor even as scientific, but I know that the more I would have appeared to have made my case clearly and simply, the greater would have been my failure to reflect the real feeling that I am trying to express. (I think of this a sort of 'Catch 23') I have brought some laboriously chosen, if not *well* chosen, items to the doorstep of my house, and we have considered them for a while together. But it is what is inside the house that really matters. And I can only hint at that.

The best final hint I can think of is this, the last of the nine free-form haiku Judith wrote during her day of School Governors' Performance Management Training. It is very short. This picture of her, with her lifetime of experience, writing quietly for herself while the sharp-suited young man (who has never actually been a teacher) enumerates his bullet-points, somehow encapsulates for me the nature of the gulf I have been talking about. Not a difference of degree, but one of kind.

Who will monitor
The magic? *

The potency of the drug doctor is founded on magic.

* My thanks to Judith Hepper for allowing me to use these examples from the numerous irregular Haiku she wrote during the course of a recent School Governors Performance Management Training Day.

Are you a doctor? Experiences with ChildLine

A talk given to the Balint Society by Dr Sheila Cross

Introduction

When I was a young consultant paediatrician I would from time to time hear murmurs about Balint groups from colleagues and friends but could never quite understand what they were, nor how one gained admission to this mysterious exclusive society. More particularly, I wondered vaguely why I was excluded. I thought little more about it until I met and worked with Heather Suckling and Chris Donovan and began to understand what Balint was about, and now I am somewhat amazed and very pleased to be invited to join you, at least for one evening. I have been glad of this renewed interest in Michael Balint and his work. I have been lent his book *The Doctor, His Patient and the Illness* by a friend who was part of an early group. I found it enthralling, and found much in it of relevance to our work in ChildLine and in the training of new volunteers. I am also grateful for the opportunity to talk to you about ChildLine.

Although it is now unusual to be asked 'What is ChildLine?' there are still misapprehensions about us. I want to quote what Barbara Kahan said in 1997. Barbara Kahan was chair of the National Children's Bureau, she chaired the Pin Down enquiry, and was special adviser to the government when the Children Act was being prepared.

> *Few people in 1997 will recall the scepticism even hostility with which the concept of ChildLine was greeted when it first began work 1986. Before ChildLine there were many large and powerful agencies seeking to offer, as they still do, help of many kinds local authorities, national voluntary organisations, the NSPCC. ChildLine added something different.*
>
> *It enabled distressed children and young people, from the anonymity if a phone box to speak to a voice without a face and to tell their sorrows their fears their needs while they held the power to decide when to stop whether or not to give their name how much to tell a very different position from the traditional procedures however well intentioned.*
>
> *Ten years on ChildLine has done far more than provide an outlet for individual children though they, and adults who themselves were once children who needed help, have telephoned in their hundreds of thousands. What ChildLine has done in addition is to open up a way in which the voices of the children, not the services speaking for them, can now speak for themselves clearly and powerfully.*

I hope this evening to let the voices of young people who have rung ChildLine about health issues speak to you, and although you will only hear brief quotations, I think you will indeed find them clear and powerful. I hope also to increase your understanding of ChildLine and how we work

I am not going to swamp you with numbers but you need to contemplate for a moment the numbers we deal with at ChildLine. We do not question callers for demographic detail although we value all that comes our way. When I was new, and realised the immense amount of information we had about young people and children, I complained to one of the senior staff about the lack of basic data – age and race for example – we take for granted in the Health Service. He replied, 'But we do know what an awful lot of children say'. In a year about 140,000 calls give rise to written records. This means that there has been a meaningful counselling exchange, however brief. Of that 140,000, about 9,000 are about health problems – mental and physical. It is some of the physical health problems of young people and those close to them that concern us tonight. I am not going to talk about the thousands of calls about mental issues, although the body and the mind are, as you are well aware, not easily separated.

My interest in these calls was quickened by a call I took one evening from a young boy who was in care. He was unusually cheerful about his prospects, he liked his social worker, was just moving to a new foster home and thought that looked like being a success. He was anxious to please them. I wondered why he had rung. Then he said, 'I know you're not a doctor but can I ask you about my asthma'. I did not of course question his assumption. He said he'd had asthma for a while and I could hear a bit of a wheeze. His social worker had taken him to see his new doctor and his treatment had been fully discussed and explained to his new foster mother. Then he said, 'The thing is there's another inhaler they don't know about' It was a steroid inhaler. I felt concerned that his doctor didn't know about it, and asked why he was keeping it a secret. 'I just don't want them to know everything about me....'I was startled and moved. I wondered how many of my patients in the past were holding on to relevant information because they didn't want me to know everything. I wondered what other insights would be found in the records of calls about health. I began to think these insights into could be important for me and possibly for others.

At ChildLine the written call records are summarised and entered into the computer. These 'snapshots' form the basis of retrospective research. Identifying detail is excluded or changed but the content of the call and the

quotations are as they were recorded at the end of the call. I looked at 700 snapshots when I was writing the report *I know you're not a doctor but...* in 1998 and have since looked at several hundred more to see whether they have changed over the years. Rereading, the calls seem to me to have lost none of their immediacy.

I want to tell you about and perhaps appeal to you this evening for four groups in particular:

Callers probably mostly healthy, who cannot or dare not get their worries heard

Children with concerns about other people's health

Children at risk after bereavement

Children who are enuretic

Then I shall give you some of their views on the vexed issue of confidentiality, and end with some of their thoughts about doctors.

First the 'worried well'. Of course a counsellor cannot know that a caller is well, nor can I, but as I read the records I can make a good guess in many cases. They are boys and girls but, as always at ChildLine, most are girls. They fear serious diseases. Often they can only get glib reassurance without any proper explanation, and often their anxiety is dismissed or laughed at. No doubt it is well meant, but laughter does not reassure. Many of the symptoms are those of early puberty. Little girls find a breast lump and think they have breast cancer. Cancer and AIDS are major scares and, just as for adults, the fear of cancer commonly follows the death or diagnosis of another member of the family. Sometimes after trivial playground events or after sexual experiment, they fear HIV infection and then of course it is very hard to tell anyone they know.

Grandma died of breast cancer, I can feel a lump is it cancer?

I read an article about breast cancer, I can feel two lumps could it be cancer?

Mum told me not to be silly but I'm frightened.

My hair's falling out I think it's cancer. [a relative with cancer had lost her hair after chemotherapy]

I've had a lump for a year. I'm too scared to ask.

They are often miserable, and may have hung on to their fears for months or longer because they fear the diagnosis, not so different from many adults. Although it is possible that some of them are ringing NHS Direct these days, ChildLine still gets these calls. We offer a safe place to put fears into words, talk about what is normal and discuss the next step.

Counsellors may nowadays suggest NHS Direct. Often after discussion a caller may find that they can talk with their doctor, or, my favourite source of help, the school nurse. With help they may realise that it would be possible to raise a difficult subject with a parent. A quite young boy who said he had 'a willy problem' he couldn't tell anyone about, thought after talking for a while that yes he could talk to his Dad adding 'He's a doctor.'!

Callers who have anxieties about other people's health

It's good to have the opportunity to appeal to an audience of GPs for these young people. It seems from their calls that they are very easily left out of discussion about the health of other family members. I must confess I remember very few occasions when I talked to my patients' siblings about what was happening. There was always a feeling that was the parents' business, and I suppose often the parents needed all the attention they could get.

It is not just that young people are worried about what will happen to their sick relative; there are associated problems. There is guilt of course.

My brother bullied me so I ran away Dad had a heart attack because I ran away.

Mum had a stroke when my sister was born. I think it was my fault.

I've been bunking off school I talked to my mother now I'm worried it will send her blood pressure up.

My mother needs an operation she doesn't want to have it and Dad says that's my fault

Dad has blood pressure. Mum says I'm killing him when I'm naughty.

Reading or listening between the lines of these calls we can often hear that this guilt which may sit very heavily, has possibly been laid on the caller by an adult either deliberately or in anger or perhaps inadvertently and of course guilt may come from their own perception. It causes much unhappiness.

It is not hard to understand that because they are losing the very person who was there for them when they had a problem, the child may feel very alone with their anxiety. This is made worse by other people being caught up in their own distress, and perhaps wanting to spare the child. As so often, there are children trying to carry responsibility in a way that would probably surprise those around them, and young people left very isolated, hurt, frightened about what might happen.

I heard my mother tell Granddad she's got cancer. I thought we got on all right but she didn't tell me.

My mother's going to die soon; I can't manage without her. [This caller had made careful preparations to kill herself after her mother's death.]

Mum is going to die soon and we are very worried about Dad he doesn't seem to be coping.

I'm worried about a man who follows us after school. Mum has angina, I don't want to make it worse by telling her.

Mum has kidney problems. Can you tell me how to donate one of mine?

Reading records such as these or listening to the young people, one can sometimes sense a concerned parent who may be trying to keep their child safe from bad news, and who would be dismayed to realise what a burden their youngster was carrying.

There were not many young carers in my samples; perhaps their case is now heard, perhaps not answered but at least heard. But there are children in situations that surprise and affront us. I answered the phone to a school nurse about four or five years ago. She asked me to talk with a ten-year-old who had been in obvious distress at school. This little girl lived alone with her mother. Her mother was ill. This is the story the little girl told me in a very calm small voice during our conversation.

My Mum is ill...She has had cancer... She stays in bed... I take her food but she doesn't eat it...She drinks a bit but she sicks it up... She's a kind of yellow colour... She's says she'll be all right and I'm not allowed to call the doctor... I'm worried.

Some one must have known that woman was ill, someone must have known she was a single parent. It is not easy for such a caller to understand why Mum may have given this instruction, where loyalty lies, what responsibility is appropriate, and that loving and caring for Mum may mean setting aside impossible requests. We all take many calls about a variety of subjects, where the issue is 'Who is taking care of whom?' Often helping young people to realise that their need to help or protect their parent may be better served by allowing that parent to hear their worries, even though that may be painful for both. Remembering always that the caller knows their parents better than we do.

Now I am going to plead that you be alert to the possibility of abuse where one parent or carer is ill or has died. There was some media anger when the ChildLine report about bereaved children highlighted the risk of abuse. There are obvious factors that make it a risk. The distress of the well or surviving parent, the loneliness, the search for comfort, the analgesia of drink, and in some cases the absence of the parent who provided a restraint.

My mother is dying, Bob is her boyfriend, and he makes passes at me when he is feeling low.

Mum's got liver disease, she's in hospital. Dad beats me when he is drunk. If Mum dies no one will stop him.

Dad came to my bed this morning. He said it wouldn't hurt. Mum died and I miss her.

Mum beats my little brother. She won't listen to me she didn't drink until my step dad died.

There is also evidence of children suffering serious neglect, which seems to go unnoticed, or could it be that it is easier not to see these things? I didn't take these two calls myself, but the record rings loud and clear when read in the child's own words. I cannot forget them.

Mum died. We're worried about Dad – he doesn't wash, he's always in the pub. I try to wash and iron like Mum. I do a paper round so we've got some money for food. It would be nice to have some one we love look after us.

Please can you tell me a home I can walk to. Mum died last week. Dad wants me to go to a home.

I could have quoted more. We can sense the distress of the parent left to cope with their own grief and quite unable to carry the child's burden too. It is hard to intrude or 'meddle' in a grieving family but understanding is not the same as condoning. Nor does the child's forgiveness and understanding make it all right. In some instances quite simple measures could make a world of difference. Perhaps listening for hints from the child could help give a picture of life in the turmoil. Direct or closed questions are unlikely to be helpful but casual enquiry from the child may give clues. 'Who does the cooking?' 'What's it like going to school alone?' Who is better placed than the doctor to suggest that a home help could be provided? Or that a

neighbour help get children to school? If necessary we must deal with the fact that, whatever the cause and however much sympathy lies with the parent, a child is being abused or neglected. Child Protection is everybody's business. At ChildLine we regularly refer abused children to social services or other agencies, but we have the privilege of talking with the caller about it, discussing the procedure and the possible outcomes, and now thanks to new technology we are often able to have a three way conversation and stay with the caller until he or she feels confident to trust the social worker alone.

Enuresis

Bedwetting is a common problem. 15% of 5 year olds wet the bed regularly and 3% of 15 year olds wet their beds occasionally. I was dismayed to read the calls from children in a wide range of ages about bedwetting. Some endured abusive punishment, some were given reassurance and loving support, but in both circumstances there were young people talking about ruined lives and deep shame. They may put themselves through desperate measures and even talk of suicide.

I have a bedwetting problem. It happens every night. Mum has begun shouting at me and I am not allowed drinks after six at night. I went to the GP but he said he couldn't do anything. 15 yrs.

I need a help line for bed-wetting. I try not to drink or sleep to stop it happening. It has always happened, I'm frightened of wetting the bed at boarding school. 15 yrs

I'm bad. It's my fault. They made me spend the day in the bath to wash away what I'd done.

I've wet the bed for the past year. Dad's married again. I wash my own sheets and I've bought myself a plastic sheet.

I wet the bed sometimes; I manage to hide it from them... I know they would hit me.

None spoke of using a buzzer, and of course we will not hear from those who have received effective help, but one girl told us she had doubled her dose of tablets so that they would work faster.

How had they fared at the surgery?

My doctor says I must control myself.

The doctor says I'm lazy.

The doctor wasn't interested.

Occasionally I read a story with clear clinical implications and there was one among the records of bed wetters.

I can't stop wetting the bed. They make me wash my own sheets. I drink a lot; I'm thirsty all the time; sometimes I need to go to the toilet on the way home. If I don't make it, I wet myself.

I suspect that in many places this problem gets a low priority, yet in terms of quality of life effective management is amply justified.

Confidentiality

I know I do not need to tell you how worried young people are about confidentiality. It is not simply a matter of 'Will the doctor tell my parents?'. There are many calls which illustrate the variety of ways in which this is difficult for them. I am also aware that it is difficult for doctors.

I can't tell the doctor, he plays golf with my father every week.

I can't go to the doctor, the receptionist is my mother's best friend.

The doctor told social services, I like the social worker very much but he should have told me.

The doctor rang the school...

The doctor told my Dad I'd been, now Dad thinks I blamed him and is furious. I didn't blame him but he won't believe me.

For young people in rural areas life can be very difficult. It may be impossible to get to a clinic or to a different doctor without the family knowing. The nearest A and E Department may be miles away and impossible to reach without explanations. I was taken aback one evening talking to a young woman. She had a discharge, or a problem with her periods, she was scared of seeing her doctor, didn't want to see a man, didn't really want to see anyone. I asked was there not a woman in the practice? 'Yes', she said, 'My mother'.

Perhaps this is the place to say a word about confidentiality at ChildLine. We maintain confidentiality unless a caller is at risk of serious harm. We can only work by gaining the caller's confidence to the point that they are willing to let us get help. This may take more than one call. Where there is the threat of suicide we may have less time. We have the advantage of knowing that the caller has rung us because at some level they want help. Children ask us whether we trace

calls. On very rare occasions we ask the police to trace calls. It is not always helpful in finding a caller.

Lastly, what do young people say about doctors? I was slightly mortified to find that they don't say very much at all. On the whole they are forgiving, expect very little and show great understanding.

> *I think it is hard for them when they have bad news.*
>
> *I don't think they know what to say.*
>
> *Perhaps they don't always know.*

A young woman with a chronic illness rang to talk about her hopes and fears for the future. Her counsellor suggested she could talk about these with the consultant whom she had known for many years. 'Do you think so?' she replied, 'I've never done that.'

Many of their comments will ring all too true.

> *I don't know what's the matter; he looked at my x-ray and said, 'Interesting'.*
>
> *I've had an operation. It didn't do any good. Every doctor has a different idea about what's wrong.*
>
> *I see a different doctor every time I go there.*

ChildLine offers a safe place to express anger, this can be a little uncomfortable at the receiving end but I think it can be a useful safety valve. I liked this simple statement:

> *The doctor is a bastard and a swine.*

I want to end on an up beat note. This was a call from a young boy at about ten o'clock one morning. He lived with an uncle and aunt, and the uncle beat him regularly. On this occasion he had run out of the house. He knew his uncle was out looking for him in the village; he was very frightened. The counsellor asked whether he knew a safe place he could run to. He thought for a moment then said he could go to his doctor's surgery. At ChildLine we have to accept that we rarely hear the end of the story but in this happy true story we did. The 'surgery' – which I expect means the receptionist – rang to tell us that he had reached them safely. He had been comforted and given a cup of tea, the doctor had called social services and someone was coming. I think that's a team that should feel really pleased with themselves. It would be good to think that one day all children will see their local surgery as a safe place.

A New Approach to Balint research?

by John Salinsky

The first part of a presentation given at 'Chairs in a Circle', the joint Balint Society and London Deanery Conference on small groups held at the Royal College of General Practitioners on 13 May 2004

I would like to give you a brief account of the new and exciting research that our group in the Balint Society has been engaged on in the last three years. The idea for the project started with a feeling that we ought to be trying to evaluate Balint work as it exists today in the country of its birth.

The temptation in Balint research has always been to imitate the random controlled trial; to find a way to compare Balint with non-Balint, preferably with Balint coming out tops. Researchers have asked questions like: does Balint produce more effective, more caring, more insightful doctors? Does it teach them something that other doctors fail to learn? Do they prescribe fewer expensive antidepressants and avoid unnecessary referrals? Because of all the confounding factors and the small numbers, this is incredibly difficult. You can measure people's scores on a variety of scales (mainly rated by themselves) but in the end you are left wondering whether you have discovered anything worth bothering about. The internal complexity of Balint makes it difficult to compare and contrast in any but simple ways.

The other problem we faced was the scarcity of ongoing Balint groups in Britain today. The only area of continuity and growth seems to be in the GP Vocational Training (VTS) groups so we decided to concentrate our gaze there.

As we all know, most VTS courses do small group work of some kind. If the course organisers are Balint enthusiasts then the group will be a Balint group. Or something like one. But does the presence of Balint make a difference? And if so how can it usefully be detected and assessed?

We decided to forget about controlled trials and to go instead for a mainly qualitative approach. The difference between quantitative and qualitative methods has been well illustrated[1] by a metaphor about investigating the effects of having jelly for tea. The intervention here would be providing jelly in addition to bread and butter cakes and so on.

The quantitative research question is:

'Does the jelly (and only the jelly) make a significant difference to the tea?' while the qualitative researcher wants to know: 'what does the jelly taste like?' So our questions about Balint work were along the lines of:

- What seems to be going on in a Balint group?
- What do the people involved feel about their experiences? What does it taste like?
- What do they think they have learned?
- And what conclusions can we draw about the significance and value of the Balint group?

Our first task was to check whether we had a valid means of identifying a VTS Balint group and distinguishing it from a non Balint group. We wrote to the course organisers of all the VTS courses covered by the London Deanery and sent them a questionnaire about the nature of their small group work.[2] We eventually achieved a response rate of 100%. By analysing the results we were able to classify the groups as Balint groups, managed groups with a particular agenda, and others which seemed to have no particular agenda. Without going into detail, Balint activity was defined as discussing cases in some depth with a focus on the doctor-patient relationship and the feelings of both parties. So a group that used a brief account of a case as a peg on which to hang a more general clinical discussion would count as a managed group but not a Balint group. We then arranged to visit four Balint groups and four managed groups. One of us visited each group and observed a session, mainly to see if our personal impressions confirmed the results of the questionnaire. Which they did. At that stage, in our ignorance, we assumed that qualitative research would involve a straight comparison of a Balint and a non-Balint group. But things turned out rather differently as we shall see.

The qualitative study

This is where our qualitative researchers come on the scene. Anne McKee was our adviser. Ruth Pinder carried out the observations and wrote the qualitative part of the report. You are going to hear from Ruth herself when I have finished.

To our surprise, Ruth and Anne advised us that it would be more productive for Ruth to spend nearly all her time looking at a single Balint group in depth. The reason for this became clear when we had learned a bit more about the ethnographic approach.

Now, Ruth would describe herself as an ethnographer. That means someone who studies the customs and culture of a particular society. Originally, ethnographers studied so-called primitive tribes whose lives were geographically and culturally remote from 'civilised' societies. The first ethnographers did this by very bravely by going to live with the people they were studying for an extended period. You know the sort of thing: living in mud huts in the jungle and eating the local food. Now it wasn't actually necessary to live in a mud hut to study the Balint tribe. Fieldwork is not generally so hazardous for today's ethnographers. But they do remain committed to trying to understand things from the

insiders' point of view – and then to think about what that might mean.

Before she started this research, Ruth knew nothing whatever about Balint. I don't think she had even heard the name. But she did know plenty about doctors and patients and, of course, ethnography. So you have to imagine Ruth as a complete stranger, being given permission to live among the Balint tribe; to watch and listen to what goes on; to ask questions and make notes. Is she an entirely objective observer? Well, ethnographers, like quantum physicists, will tell you that there is no such thing as an unbiased, objective observer. The investigator's own feelings and preconceptions are bound to influence her. So are the ways in which she interacts with her hosts. This is not only inevitable, it is to be welcomed. The ethnographer's own contribution adds to the depth and richness of the observations. However the process of looking for meaning remains a rigorous one, but the approach is one that tries to combine discipline with imagination. If things seem a little too comfortable, the ethnographer goes looking for trouble: she goes and talks to someone else who might have a different angle. And each new understanding feeds into the next interview, so that the object of inquiry becomes constituted differently.

At first I thought that a study of this kind was completely new in Balint research. Then it occurred to me that when Michael Balint began to work with a group of GPs in the 1950s he knew nothing at all about the world of British General Practice. He saw himself at least partly as an outsider part of whose job was to learn about the world of general practice from the inside. He even called his seminars: 'research cum training' with the research coming first. Naturally, he brought some of his own preconceptions with him: he was Hungarian and he was a psychoanalyst. Now, 50 years later, we are asking an independent researcher to examine the culture that he and they created.

The study

We chose one Balint group as being as authentic as we could find for Ruth to spend time with and study. The leaders, who are also the course organisers, are both very experienced and committed Balint Society members. I should add that they are both GPs. Most of Ruth's observations were with this group; she watched them in action in six three-hour sessions and she had one-to-one interviews with several group members and the leaders. She also spent two shorter sessions with a non-Balint group and interviewed their leader and one of their members. This one-off experience with a non-Balint VTS group (different but also similar) enabled her to view the Balint group 'through another lens'. Finally, she spent time with the Balint people at some of their traditional ceremonial and religious occasions: the Oxford weekend, the annual dinner and the group leaders' workshop. She also did lots of reading about Balint and had talks with some tribal elders. In the gaps between her interactions with Balint she was able to reflect on the meaning of what she had experienced, to formulate new questions and to take them back to the next group session or interview. In this way, her understanding of what she was seeing was able to grow and develop.

Results

After all this immersion in Balint, what did Ruth have to tell the world when she finally emerged? The best way to find out is to hear her story in her own words and that you will be able to do very shortly. The full report will definitely be published one way or another and we are currently exploring the possibilities. We hope that it will lead to further work along similar lines. Meanwhile I will try to give you an idea of the sort of impressions, thoughts, and conclusions she came up with. If you are a devoted Balinteer, I should warn you that some of this material may be a little unsettling. But it's also very thought-provoking and at least some of your cherished beliefs will be upheld. Those of a nervous disposition should definitely stay.

What did Ruth observe?

Let us start with the some of the things that the Balint Society would expect and want to hear about a Balint group: the things that we Balint people treasure. She noted that the doctors were given the opportunity to talk about patients who were bothering them; they were allowed to talk about their feelings; they were encouraged to take their time; their stories were received sympathetically and non-judgementally (on the whole). They felt supported by a group to which they felt they belonged. They were encouraged to see their patients as people who had a life and relationships outside the surgery. It was helpful to realise that other people in the group had been in the same boat; it was also useful to be able to hear so many different ideas and points of view. It made them think.

Many of the doctors in the Balint group were still at the SHO stage. They were painfully aware of the tension between the hospital quick-fix approach which had driven most of their training so far, and the slower, more reflective style of investigation in the Balint group. They were aware that the Balint approach had an advantage in dealing with the uncertainties of general practice: the lack of diagnostic precision, the ethical dilemmas, the alarming closeness of the patient as a person, the shifting boundaries between the professional and the personal. On the other hand, they also missed the more reassuring didactic style of teaching in which there is a solution for every problem. Sometimes they complained that there was too much woolly speculation in the group and not enough medical facts.

These doctors on the threshold of a career in general practice were struggling to find out

what sort of doctor – what sort of person – a GP is supposed to be. How much should you let yourself be affected by your feelings for a patient? Does it matter if you become more emotionally involved with someone of your own ethnic background? What is the proper balance between hard science and soft humanity? Balint was only one of a number of learning arenas in which their attitudes to work and life were changing. Sometimes it was difficult to remember what you had learned where.

Everyone interviewed said that they enjoyed the Balint group and had a sense of belonging that they valued. However, some ambivalent or even critical feelings surfaced in the interviews as well. Somebody said: 'quite a few people in the group don't like Balint, actually'. It could be boring. What was the point? There were no conclusions and no way forward. Some people felt uneasy about being too intrusive on their patients' feelings. What right have we to psychoanalyse them, they wondered. Someone else thought there wasn't enough theory; she was disappointed not to find more talk of transference and counter-transference. Even more equivocally, someone suspected that Balint groups were not all the same: a friend in another Balint group had reported very different goings on.

Ruth's report[3] is very rich and detailed and, before very long, you will all be able to read it and reflect on it for yourselves. She says that the case studies were a kind of anchor attaching her firmly to our world. And as soon as you start reading them you will find yourself in familiar Balint group territory. I can't possibly give you a comprehensive summing up of her conclusions. I can offer you a sample of some of the thoughts, which she has to offer us at the end of her study. Inevitably, what I tell you will be coloured by my own thoughts and feelings and experiences. But that is a perfectly acceptable feature of any qualitative research enquiry. So here we go.

Conclusions

The Balint group offers young doctors a valuable opportunity to voice their feelings about their work. At this stage, on the threshold of a career in general practice they are becoming aware that medicine is not just about disease recognition and the prescription of treatment. There are other dimensions, social, cultural, psychological and interpersonal which are new and exciting, but also disturbing.

In the group, the doctors can tell their stories to a receptive and sympathetic audience. They can collect a variety of opinions from everyone else, which helps them to get the problems into perspective. In this respect Balint style VTS groups and those we have called managed groups are not very different. Learning opportunities are offered, especially psychological ones, with the help of the group leaders. Balint leaders, as we know, are chiefly concerned with the individual doctor-patient relationship. However, because the leaders are guided by this 'Balint agenda' it may well be that some other learning opportunities are closed off. There seem to be some subjects that are difficult to raise in a Balint group, such as race and culture. Does Balint go down less well with people from Asian cultures? It is very much about the needs of individuals, doctors and patients. Are we limited by a very Western notion of the importance of the self?

The doctors have a certain amount of freedom to do what they like with the group experience. They can accept at least part of the Balint philosophy and make use of it. They may also transform it and use it in a different way. They can disagree with it and contest it, take in some and perhaps put the rest away to think about another time.

These observations led Ruth to wonder in what ways Balint itself was (inevitably) being transformed by its interaction with a new generation of doctors. The needs of our VTS trainees are very different from those of Michael Balint's mature GPs in the 1950s. If Balint is changing, how is it changing? To what extent is it flexible enough to accommodate change?

My own view is that Balint groups for registrars and SHOs are already different from those for established GPs (of which sadly there are so few in this country) and from the kind of groups that can be experienced at weekend meetings. Sometimes I wish my VTS Balint group were more like one of these more committed groups. I wish there was more focus on the doctor-patient relationship and less of a tendency to get engrossed in other urgent matters. But perhaps I should be more prepared to go with the flow and let my group members have even more freedom to shape the group to their own needs than they already have. I will leave you with what I think are two important questions, which Ruth asks at the end of her report. They are:

> Can Balint continue to speak to new generations of doctors and other health workers?
>
> And if so, how can we preserve the best while being flexible enough to adapt to the world we live in today?

References:

1. Pawson R and Tilley N. *Realistic Evaluation.* London: Sage Publications, 1997.
2. Samuel O, Sackin P, Salinsky J, Suckling H, McKee A and Pinder R. *Work Based Learning in Primary Care.* 2004; 2:36-47.
3. Pinder R. et al (awaiting publication) *Just the 'right' amount of difference: narrative research into Balint and other small groups for general practice training.*

A case study from the research report

Ruth Pinder PhD

The second part of the presentation given at the 'Chairs in a Circle' conference at the Royal College of General Practitioners on 13 May 2004

I'd like to put some empirical flesh on John's reflections, and present a case study of one of the doctors, one of seven in the research. It is based on observation of Balint work in the main VTS group studied, and a subsequent interview. The case – let's call him Dr. L – is chosen because:

(a) in interviews with Balint practitioners I had been told that *"doctors from different ethnic communities"* sometimes found the Balint teaching approach difficult to assimilate, and wondered why. When Balint was not intended to be 'about' structures such as ethnicity or gender, why did blackness or brownness apparently pinpoint the problem of take-up?

(b) it reflects how intentions are re-shaped in practice, with unintentional and unpredictable side effects as well as the hoped for benefits.

(c) it illustrates the research's main theme: the key importance of grounding the individual learning process that is the cornerstone of Balint teaching in a broader context.

The Case Study:
"I found I had less and less to say"

The interview had been progressing along conventional grooves for about ten minutes when Dr. L. mentioned his interest in quantum mechanics and the philosophy of science. He caught the gleam of interest in my face, and the interview suddenly took off, becoming one of those magical conversations where the whole world can be discussed with a stranger.

Caught up in the sweep of events, Dr. L. had come to the UK as a refugee and the difficulties of integrating here continued to mark his life. Unusual too was his interest in weaving together ideas from the philosophy of science, quantum physics and Tancretic Buddhism. Balint groups on his training course at Highville provided a fruitful arena in which to do so.

The patient he described at the group had a complex psychiatric history, and her parting words on their last encounter "Goodbye, thank you and take care" had alarmed him. As he listened to the complex story unfolding in the consultation, a dispiriting trail of care homes, abuse from a father (or brother – or both?), he felt increasingly at a loss: anything he had to say was almost redundant. His anxieties about the farewell greeting were not misplaced. A week later he told me the patient had phoned him after slashing her wrists: *"a profoundly symbolic gesture"* he thought. He was pleased with the group's response to his case: *"It's amazing all these different ideas"*.

Thinking more generally about the group experience he commented: *"We put up with it and then we actually get into it. We moan and we groan, and then we get into it. The groan initially is that we have to change pace"*.

Other registrars too had mentioned how trying the apparent slowness of things was at first. I wondered what effect Balint teaching had on his day-to-day practice. Effects were less tangible. *"Certainly yes, it's like a thin lining of butter on your toast. You can't quite pin it down. But it definitely does make a difference. It makes you more reflective and more able to face your own shortcomings."* A little later he mused contrary-wise, *"The process of opening your mouth and talking doesn't actually give you too much of an insight into what's happening behind the screen as it were. Life's like that. A mask is what we all wear"*. Meanings were elusive.

The more academically oriented nature of Balint work in his psychiatry attachment had given him food for thought too, but the individualistic model of the self which he felt underpinned all psychodynamic models didn't always fit comfortably with his other thinking. *"Balint is obviously Eurocentric, particularly as I am Vietnamese. It is a construct basically. It's quite sanitised the theory, that's what I find. What is this process where doctors sit around? It must be very privileged. How does it affect us? Well of course it does, you know that. But how does it affect refugees? How does it translate into their life world? How can I translate that to the refugee who gets beaten up and shot in the leg?"*

At stake were urgent issues about social justice and practical help. His questions had a sharp edge as another case in the group that afternoon had focused on the 'inappropriate' consulting behaviour of a Somali refugee patient, a situation which had 'annoyed' the presenting doctor who found her repertoire of tools had little to offer. *"I wonder how much of that is Dr. P's conditioning without her being aware of it? She's the gate-keeper, the shaman, the magic-maker, the totem-bearer growing up in an individualistic society where hello, everyone's for themselves! The Western model, self-determination, blah, blah, blah, blah. Of course there are two worlds there, two minds"*.

He thought of himself as reticent in the group. Not particularly because of any fear of criticism, he noted, but *"no one would understand what I'm talking about – the Buddhist fascination with all things running from the mind. The mind as mover as it were. Jung taps that element too. Most of the time I hesitate to say anything because I'd just have to explain, and the group would have had to have thought about it"*.

It was simpler not to complicate his relationships with others.

Chary of end-points, learning was a continuous process for Dr. L. Balint *"was not about thinking in boxes"*. He explained: *"We've only learnt what is quantified, we've not thought about the impulses of our minds. Because at the subtle level, our mind is like quantum mechanics, particles moving about almost randomly. If we don't have insight into that process, which Balint wonderfully explores"*... He trailed off – a half-formulated thought perhaps. Then resumed *"I believe that Balint is a dynamic, evolving spontaneous process, not something that should be pigeon-holed."* In his excitement, the words tumbled out. *"It should evolve in terms of initiating a process which will let go of the pinning down, without any end-points. If you think in terms of end points, it means you have to define start points. Often things are vague, they're sort of quantum things"*. There were no easily definable compartments to learning, and conventional outcome measures were likely to mislead.

For the future? *"Whoooooaah! Balint plus. Away from models of illness and models of psychoanalysis, to allow the development of a dialogue rather than just Balint and that's it. – talking with people like yourself"*.

Flattery perhaps. Yet something more significant was at stake: the need to transcend the limitations of particular disciplines and ways of thinking – to keep alive the ability to engage with difference.

Like everything else, case studies are always on the move. When I visited a group later, it was evident that in the cut and thrust of everyday practice, Dr. L. had difficulty putting the ideas he had so engagingly described at interview to work. Someone had commented back at the practice, and clearer boundaries were needed between himself and the patient he had presented. The group seemed to agree, and I felt a pang of disappointment. Open-ness wasn't a once-and-for-all accomplishment.

When I returned the case study for him to comment on, he said *"It's lovely"*. A compliment I've decided to take at face value – for the moment.

Some reflections

'The trouble with narrative – telling stories, making histories – is that it is so easy, but thinking about it is so hard' [1]

This is a powerful example of what Balint training can offer, illustrating the way medical culture is 'caught' rather than merely 'taught'. Like all tacit learning, Dr. L's responses were complex and contradictory, uncertain of outcome. These were tentative gropings, half formed thoughts and possibilities for extending his understanding of what it is to practise medicine, and how he might do.

The case study challenges the reductionism of much contemporary educational research. These were not understandings that could be clamped to a satisfaction scale or simple before-and-after impact measure. Both Dr. L. and his experience of a Balint group break down convenient generalisations about the process and utility of it. Through him we see both the strengths and limitations of Balint approaches, that the conventional experimental approach to researching groupwork would have ignored.

It also questions a compartmentalised 'stages' model of thinking, that can too often slip into recipes for learning. Dr. L's ruminations were a series of conversations- within-conversations, de-stabilising assumptions about the linear nature of traditional models of reflection. Insights are always chameleon-like, stealing up on us unawares.

Further, the case study unsettles the notion that doctors digest teaching approaches as discrete wholes. We translate cultural products into our own idiom, as Dr. L's pre-occupation with how to put into practice what he'd learnt to caring for the refugee patients in his charge illustrates. Meanings cannot be legislated for.

The Eurocentrism of Balint and other psychoanalytical work referred to hints at the underlying racial tensions in the group. Where issues concerning gender and race are now pressing social concerns, the case points to the gap between the public acceptance of diversity within medicine, and the private distancing from it. Balint training couldn't not be 'about' ethnicity (or gender) in the doctor-patient relationship at some level, although not, of course in any simple or invariant way. It was not simply an individual matter. But Dr. L. could not be reduced to a category, separated out from the continuity of experience.

Crucially the case study points to the need to engage with diversity. It is the dialogue with difference rather than the comfortable task of confirming what we already know which is the nub of the matter. We learn most from those who are different to us, if we have the ears to hear.

Such findings certainly pose difficulties for medical educators who wish to assure a rightful place for Balint training on the medical education policy agenda. Process scores low marks when it comes to reliance on league tables and performance indicators to prove 'effectiveness'. However, the research shows that process IS an outcome of what doctors continue to do throughout their lives, to gropingly discover what they need to know. As Zygmunt Bauman[2], one of the most influential social theorists and critics of our age notes, the best learning is: "an open-ended process concerned more with remaining open-ended than with any specific product, and fearing all premature closure more than it shuns the prospect of staying forever inconclusive".

The question the research posed most tellingly for me is: what is the potential of Balint

training to speak to the moral, social and political issues of our age, (of which the so-called 'clash of civilisations' is but one example), through an understanding of the patient-doctor relationship, and a fuller understanding of ourselves? I don't think I'm ready to answer that yet.

References:

Dening, G. Performances. Chicago: University of Chicago Press, 1996.
Bauman, Z. The Individualised Society. Cambridge: Polity Press, 2001.

Reflections On Vulnerability Within the Doctor-Patient Relationship

The Balint Society Prize Essay 2004

by John R. Freedy, MD, PhD, Department of Family Medicine
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The Case

My goal in this essay is to invite an examination of how we are socialized as physicians. My question is this: What effect does our socialization before, during, and after medical school and residency have on our capacity to be a physician while still maintaining our most essential human qualities?

It is customary to start each Balint group with a case that provides a collective focus. I will honor that tradition in this essay. I invite readers to imagine themselves as the presenter of this case. Likewise, the author and readers collectively should become "the group" considering this case. Herein, we will consider the thoughts, feelings, and behaviors stirred by the case. We will catch a glimpse of both conscious and unconscious motives at work. Our task is a mutual one and I trust that as with any effective Balint group, we will all benefit from the experience (Balint, 1957).

The case involves viewing one's own reflection in the mirror. Please imagine that the reflection is not literal, but rather what we see is a view of the unconscious. Using the terms of the Balint group, our reflection suggests both the personal and professional self. We are able to see our defenses, their development, and protective function clearly, without self-deception. We also regard how and where our defenses get in our way. We see where our deepest insecurities lead us to avoid something or someone too painful, too emotionally threatening to bear. Ultimately, we see the emptiness of our self-deception. We begin to understand the possibility of becoming more fully ourself. We wish to bear the risk inherent in being more honest with ourself and towards others. As with a young child, all things seem possible. Our fears have not yet crept in to rob us of an ability to honestly know and express our most basic needs. We become increasingly able to be with other people without pretense or the press of overwhelming expectation. We accept our limitations and in so doing are more fully human, more fully alive.

Of course our case is only hypothetical and as such it is unrealistic. It is impossible in a brief moment to clearly comprehend one's entire psychological make-up and to apply this understanding towards the end of more effective interactions with our patients. Like all human beings, physicians spend a lifetime being socialized to think, feel, and behave in a customary fashion. However, our case opens the door to exploring the impact of social forces on a physician's capacity to maintain his or her most essential human traits.

The Socialization of a Physician

Medical education is a rigorous process. The process of becoming a physician is intellectually, emotionally, and physically demanding. The degree of self-sacrifice required can be monumental, if not legendary. It is not unusual to hear a physician say that from an early age they could think of nothing other than becoming a physician. To me, such expressions seem to be the product of a bit of self-deception, a bit of selective memory in action. I don't believe that physicians are born. Rather, it seems to me that we are socialized to follow a certain path. A young aspirant towards the medical sciences may very well receive a good deal of attention and praise for expressing the aspiration of becoming a physician, a healer. In a sense, the personal self grows in esteem as the child is praised for their "goals". "You are a good boy! You are a good girl!" "I approve of your aspirations..." "You are important..." The child's intellectual pursuits and emotional well-being become intertwined with emotional well-being becoming too much of a function of intellectual goals and accomplishments.

I don't mean to be overly simplistic. Obviously there is more than one pathway that people choose to follow in becoming a physician. Some of us developed an interest early as in my hypothetical example. Other people develop an interest in medicine somewhat later in their lives. Regardless of the pathway followed, I have noticed certain universal traits that are common to the nature of those of us who have pursued the physician's life. These common traits include: a keen intellect, curiosity, interest in science, interest in people, compulsivity, hopefulness, idealism, and a need for control among other traits. Any prolonged journey requires a steady supply of emotional nurturance to fuel the confidence necessary to tolerate the price to be paid in taking the journey. It is necessary to receive the encouragement, support, and approval of other people in order to achieve our dreams. It feels good to receive approval from other people. It is as if being called "doctor" provides us an echo of that long-ago praise of "you are a good boy...you are a good girl". It is a nice feeling, this validation of self. Nevertheless, most physicians are somewhat naïve when it comes to understanding the costs of the process by which physicians become socialized.

Society looks up to physicians. Consider any social survey that presents a list of the most highly respected professions. Physicians are always at the top of the list. As a group, physicians are put on a pedestal; we are even deified to some degree. An illusion is created. A bargain is struck. At a subconscious level our patients believe: "You will carry my sickness, my pain, my vulnerability. You will keep my secrets. You will heal me; keep me well. You will tell me that I am not vulnerable, or at least convince me that I am less vulnerable than I am. If you cannot cure me, you at least will not leave me alone in my suffering, my humanity. In exchange, I will elevate you to a highly respected status. I will pay you well. I will praise your intellect. I will feed your ego. You are a good boy. You are a good girl. If you help me believe that I am not vulnerable, I will help you believe the same for yourself." It is all a pleasant, rainbow colored dream.

As a medical student and a resident physician I have felt uneasy with this subliminal bargain between physicians and patients. Michael Balint spoke of a pathophysiologic, mechanistic, "illness-centered medicine" that focused on an objective means to fix what was broken within the patient. Along such lines, medical students and resident physicians are encouraged to take a history, examine the patient, run a test, prescribe a medication, do a procedure, and if all else fails refer the patient to a subspecialist. In fractionating patient care, we are more likely to ignore one of the most important aspects of being human, our capacity to relate to another human being in a basic and honest manner. Instead, we feel the compulsive need to "do something". As an alternative Michael Balint suggested a "patient-centered medicine" that sought to understand and address the needs of the patient as an individual. Emotional intimacy with the patient was something to be understood and titrated as appropriate to produce the desired healing effect (Balint, 1970). However, there is a great emotional risk to breaking the tacit doctor-patient agreement to maintain a mutual sense of invulnerability. Balint training is essential in the socialization of physicians because it offers an alternative to the myth of mutual invulnerability

The assumptions underlying Balint training are a radical departure from traditional medical training. From the perspective of Balint groups, we learn that both patients and their physicians are vulnerable. Patients re-enact their vulnerabilities, their conflicts in the context of the primary care consultation. Likewise, physicians are prone to reenact their own conflicts and defenses towards their patients. Balint training offers the opportunity to seek to understand our personal self so that we become free to think, feel, and act differently in the context of the doctor-patient relationship (Balint-Edmonds, 1984; Salinsky & Sackin, 2000). The myth of mutual invulnerability is challenged and in the process healthy changes become a possibility. The physician becomes free to question their prior socialization, free to develop our personal and professional self. Where unconscious forces previously ruled, we become consciously able to negotiate a new way of relating to our patients.

Experiential Learning

I came to the process of medical education later than most. I am currently 41 years old, married, and have two young children. I am a second year Family Medicine Resident in Charleston, South Carolina. Prior to medical school I completed a PhD in clinical psychology and practiced as a clinical psychologist for nearly a decade before starting my medical education. To my surprise, I found medical education to be more emotionally stifling than intellectually difficult (although it was definitely an intellectual challenge). Earlier in my medical training I was unable to articulate why I found the emotional environment of medical training so oppressive. Most fellow students and resident physicians were so busy trying to survive that there was little interest in acknowledging the pressure to emotional conformity under which we labored. Most alarming to me, I had the sense that too many faculty members didn't notice the emotional avoidance that was intrinsic to the daily practice of medicine. McWhinney (1998) spoke about "...the affect-denying clinical method that dominates our medical schools" and called for "...medicine to become a self-reflective and comptemplative discipline...for medicine to be a moral as well as a technical education."

To my relief, a few faculty members did see the social process between doctor and patient requiring denial and repression to maintain the myth of mutual invulnerability. My experience was that these faculty members were most often found in either family medicine or psychiatry. I was introduced to Balint groups as part of a year family medicine clerkship. This clerkship Balint group allowed for weekly participation, which I found to be very comforting. As a second year family medicine resident I have been able to continue Balint training. This group provides an oasis of self-examination in a desert of anxious avoidance. I am learning that one can become a physician who is unafraid of his or her psychological shadow. A healer who seeks to understand the personal and professional self. Someone who is respectful of both patient and self, without an irrational fear of exposing patient or personal vulnerability.

It is relatively easy for me to express the words on these pages. However, the reader should not be deceived. It took a hard fought personal experience to crystallize these insights and to be able to express these thoughts clearly. Prior to the current year I had been in good health. This past autumn, I experienced a spontaneous bout of atrial fibrillation. This episode led to my hospitalization with typical tests being run (EKG, telemetry monitoring, cardiac enzymes, thyroid panel, echocardiogram, etc). It turned out that

dehydration and excessive caffeine were the proximate causes of my misfortune. My unconscious urged me: "...avoid caffeine, stay hydrated, and take a beta blocker and all should remain well...you are still invulnerable . . . untouchable . . . " Unfortunately, my situation did not turn out that simply. Unexpectedly, an ascending aortic aneurysm was discovered. I was stunned, devastated, overwhelmed. Primed by participation in a weekly Balint group I had a flash of insight: "this is what it feels like to be a patient . . . stripped down . . . naked . . . vulnerable . . . scared . . . what I am experiencing is preverbal, unconscious, primitive, but real . . .". It also occurred to me: "it is much easier to be a doctor than it is to be a patient". As a patient I no longer had the option of denying the obvious. In my current Balint group, we are often asked "What kind of doctor does this patient need?" I now had a new perspective on this question. "What kind of doctor do I need as a patient?" By extension I began to ask, "What do my patients need from me as their doctor?"

Experiential Unlearning

At the age of 41, I had to unlearn what had taken me a lifetime to learn. This process took months and is still ongoing. All of my socialization into the medical profession had not prepared me to be the vulnerable one. Despite all of my intellect, all of my advanced degrees, all of my emotional insights, all of the hard won battle scars of my life, nothing had prepared me for the shock of being completely vulnerable. It was as if I was a toddler again. Clearly an illness can bring a patient (and their family) to their knees. What is even more telling to me, is the fact that my health problems have a good outcome. My atrial fibrillation is unlikely to recur as I keep hydrated, avoid caffeine, rest well, and take a beta blocker. My aortic aneursym was found to be related to a congenital bicuspid aortic valve. With annual imaging studies and medication to reduce blood pressure, my aneurysm is most likely to remain stable and expand only very slowly. I may never need corrective surgery and if I do require surgery the likely success rate is very good. More than one person has reminded me: "you are lucky...damn lucky...your atrial fibrillation probably saved your life."

It is a funny thing though, for many months I did not feel lucky at all. Initially, I wanted my former life back. I wanted my invulnerability, my immortality back. It was necessary for me to grieve for my lost sense of invulnerability. It took me months to let go of that false sense of self that had been groomed through socialization from an early age. I came to realize that I am forever changed, but for the better. For the first time, I knew, I really knew experientially what I hadn't quite been able to articulate at an earlier point in my socialization into the role of being a physician.

Here is what I came to understand. We are all vulnerable, physicians and patients alike. Patients come to physicians for healing. In part, healing involves the body. Traditional medical education is best (most comfortable) in teaching about the body. But healing also, and as importantly, involves the mind, the emotions, and the spirit (or soul if you prefer). With my newly discovered self I not only needed, I demanded a physician who understood that I needed attention directed towards my body, mind, emotions, and spirit. Anything less was not addressing my real needs. Anything less is not addressing my patients' needs either. It seems to me that the major benefit of Balint group participation is that it provides a safe environment within which physicians experience the conditions that provide an opportunity to become just this type of healer. A physician who is unapologetic in their capacity to address the full range of patient needs.

I learned something else of importance in my capacity as a patient. I have often heard it said that addressing the fullest needs of our patients takes too much time and effort. Counter to this (defensive) notion, I have found that I require very little time from my physician for such issues. I mainly need a physician who is aware that these issues exist for me and that these issues are central to my care. The physician must have the emotional maturity and presence of mind to acknowledge these issues in my presence. My own physician mentions these issues simply and briefly each time that we meet. A typical comment from my doctor would be: "I know that it's hard for you to turn lose of this worry right now, so I will not ask you to do so until you are able. " Several months after these words were exchanged, I found it possible to invest my trust in my physician and to focus on living my life. I am indeed a lucky man.

My Balint Group

As a second year family medicine resident, I participate in a weekly hour-long Balint seminar with fellow residents and two faculty co-facilitators. This Balint group provides an opportunity for experiential learning within the context of peer support. The faculty co-facilitators provide a model of openness towards the psychological dynamics of patient and physician experiences (Johnson, Nease, Milberg, & Addison, 2004). During the groups, we learn to not stifle or block our feelings. While the avoidance and repression of affect was encouraged in becoming a physician, in the context of the Balint group the affect denying clinical method is no longer the basis of personal or professional self-esteem (McWhinney, 1998). Rather, the model for professional development becomes openness, patience with self and others, tolerance of ambiguity, depth of self-exploration, and the application of such knowledge to ongoing clinical cases (Salinsky & Sackin, 2000). You learn an immeasurable amount from your own clinical case presentations. Likewise, you learn a lot from the case presentations of your fellow Balint group participants.

My current Balint group has been immensely valuable to me as I have struggled with my own sense of vulnerability. I noticed that I had presented the same case on several occasions; a man with whom I felt anxious and annoyed. I initially believed that the patient was only superficially like me (e.g., male, over 40 years old, married, two children). His problem was chronic low back pain and his agenda was to obtain narcotic medications from me. During one consultation he described how his back injury had changed his life: "Doc, it was just like the World Trade Center…the twin towers… when those two planes slammed into the buildings, it was total destruction, it was all over…that's just how life has been for my wife and me since my back problems got bad and she got sick too." These words made no sense to me when presented in the consultation. During my second Balint group presentation, the real issue came into focus. It occurred to me that on September 11th, the civilized world was betrayed from within as our technology and openness was used against us. Perhaps my patient felt betrayed from within by his body or by a medical system that had failed him. I was feeling a similar betrayal by my body and the medical system that I expected to give me only good news. I believed I was much too young to have a serious health problem.

My negative feelings towards my patient were, in part, a function of the inadequacy of my own defenses to protect me from the intensely personal sense of vulnerability that was stirred within me by this case. This transforming insight has allowed me to develop a more therapeutic role to replace the previously antagonistic and avoidant role that I had taken with this patient (Brock & Johnson, 1999).

The exquisite beauty of the Balint group process lies in the fact that it provides a private, supportive, and consistent environment within which to loosen the shackles of our personal and professional socialization. We become emboldened to acknowledge our own fear of morbidity, mortality, loss, and emotional pain. We address our own vulnerabilities and the vulnerabilities of our patients with the earnestness and care of a thoughtful parent towards a vulnerable child. We relearn what it really means to be fully human. Yes, we are all vulnerable to illness, physical and emotional pain, suffering, and loss. However, healing involves the opportunity to have a doctor sufficiently free of personal and professional fear (anxiety) to be with you in your struggle. A sort of re-birth occurs and it is all very liberating. The only thing worse than being ill, is the experience of being alone in your illness. I can think of nothing more meaningful than sharing a time with a fellow human being when your presence really matters.

References

Balint-Edmonds, E. (1984). The history of training and research in Balint-groups. Journal of Balint Society, 12, 3-6.

Balint, M. (1970). Repeat prescription patients: Are they an identifiable group?
Psychiatry in Medicine, 1(1), 3-14.

Balint, M. (1957). The Doctor, His patient and the Illness. New York: International Universities Press.

Brock, C.D & Johnson, A.H. (1999). Balint group observations: The White knight and other heroic physician roles. Family Medicine, 31(6), 404-408.

Johnson, A.H., Nease, D.E., Milberg, L.C., & Addison, R.B. (2004). Essential characteristics of effective Balint group leadership. Family Medicine, 36(4), 253-259.

McWhinney, I.R. (1998). The physician as healer: The Legacy of Michael Balint. In Salinsky, J. (Ed.). Proceedings of the Eleventh International Balint Congress. (pp.63-69). Southport: Limited Edition Press.

Salinsky, J. & Sackin, P. (2000). What are you feeling doctor: Identifying and avoiding defensive patterns in the consultation. Abingdon, Oxon: Radcliffe Medical Press.

A student patient relationship in therapeutic setting

By Caroline Hulsker,
medical student, University College/Royal Free Hospital School of Medicine

As a medical student studying at University College London, I have had the unique opportunity to join the Student Psychotherapy Scheme, which aims to give the medical student insight into the doctor-patient relationship, in a therapeutic setting. This scheme allows up to 15 students, who have finished the first three years of their medical training and are starting the clinical part of medicine that year, to join the teaching hospital's Psychotherapy Department and to be assigned a carefully selected patient, who is seen by that student for individual once weekly psychodynamically oriented psychotherapy. By the time the student finishes the programme, they are midway through their second clinical year. After each session with the patient, the student has to write up a report and discuss this with one of the senior psychotherapists in the department who acts as their supervisor. The scheme is thus a unique opportunity for a student to get a close insight, not only into the life of one patient they come in contact with, but also into the importance of the doctor-patient relationship, which in turn has a bearing on the contact of the patient with the medical profession as a whole.

The patient whom I saw for a year was a young person, suffering from an atypical grief reaction. During the year of therapy, the patient and I built up a close relationship of trust. This allowed the patient to open up and confide in me. It also meant I became their strongest attachment figure. As a result, as a student therapist, I have learnt about the responsibility of taking on a certain role in the life of a patient. The student-patient relationship has motivated me to pursue a certain depth in the relationship with my future patients, however long or short the contact with those patients will be. I know this will undoubtedly help in their healing process, or at least the quality of the doctor-patient relationship.

Furthermore, this process has been a learning experience that I feel cannot be obtained in any other part of clinical medical training. The Student Psychotherapy Scheme is a very well designed programme in which students are closely supervised and are able to have an experience, the impact of which can change the outlook on their career. It is a unique opportunity to practice communication skills outside a fictitious setting (as is done at most universities). Not only is weekly communication with the patient of paramount importance, but communicating difficulties and needs with the different members of the patient's network of care is also required.

Also, students are forced to recognise their limits with respect to patient care as they take on the responsibility of a therapist. In my experience, this has been the only setting in which I was responsible for a patient, and where I had to indicate when I had reached my limits, and where I needed help from other members of the patient's network of care. Being part of a team, responsibility was shared, and tasks too difficult for me were handed over to other team members such as the supervising psychiatrist, or the secretary of the psychotherapy department. As a student, there have been no other opportunities to experience this. I found it extremely motivating to get to know what it is like to handle and share responsibility, and this learning experience has been an enormous advantage for me.

I hope that this brief account of my experience of a student-patient relationship will stimulate other universities to set up similar schemes for their students, as it will benefit not only them, but their future patients as well.

Caroline Hulsker won joint first prize in the Ascona International Awards for Medical Students competition, which is sponsored by the Swiss Psychosomatic Society and the Swiss Red Cross.

Caring for patients – caring for doctors: the patient-doctor relationship

by Oliver Samuel

Keynote address given at the Balint Society Oxford Weekend, September 12th 2003

I want to worry about three related problems:

1. How necessary to ordinary doctoring is an understanding of the doctor-patient relationship? So many doctors and others seem to manage without.
2. How can there be any serious consideration of the doctor-patient relationship that does not include the patient's own perspective?
3. Is this Balint stuff just an optional extra?

Following a career practising family medicine, I now find myself on the other side of the counter. I have retired from clinical practice and, such are the inconveniences of the passing years, find myself a consumer of healthcare. So I want to apply a little my Balint practitioner's experience of struggling to understand the doctor-patient relationship to considering the subject from the other end: the patient-doctor relationship. So let's start with a case – *my* case.

A while ago I felt unwell and phoned my GP's surgery to ask for an appointment. I was told that I could see my own doctor in two weeks time, but another doctor could fit me in a bit sooner. I protested that I was unwell now and was told that, if I was an emergency, I could be seen today, but not by my own doctor. The doctor who saw me later that day was a very presentable young woman who looked frazzled and distracted. She heard my story, briefly examined me and gave me a prescription. The consultation lasted only a few minutes and, although I agreed with the prescription, took the drugs and got better, it left me feeling that she was not the doctor I would seek out next time I needed one. She wasn't particularly interested in me or my problems – just adding one more 'extra' into her queue.

Last winter I again felt unwell and became quite anxious about things. I rang the surgery for an appointment with my own doctor and this time was able to see him quite quickly. I felt a bit guilty at crashing the appointment system about a symptom that was almost certainly related to anxiety, but I was feeling quite scared.

The doctor brushed my apologies aside, listened attentively to the story, accepting what I said but rejecting gently my proffered diagnosis. He smilingly agreed that it might be all in the mind, but suggested that it could equally well be entirely organic. I was briefly examined and then politely and rapidly despatched for a whole series of investigations. He told me that he wanted to be available should I need him and he explained to me how to get a quick appointment despite the practice appointment system; he told me that he would always respond to a telephone request to phone back and, further, offered me his e-mail address as another alternative way of getting in touch.

All things turned out well, although I now have to swallow a few pills. But a few weeks later, I seemed to be developing new symptoms. I felt diffident about crashing through the appointment system yet again, even though the doctor himself had told me how to go about it. So, following the other instructions, I sent him an e-mail describing what I had noticed. Later that morning he telephoned to confirm that I was describing a well-known side-effect of the medication and to make some suggestions about what to do. I was delighted to discover that e-mail worked as a valid form of primary communication between us.

I want now to reflect on these minor encounters with doctors. The first doctor seemed more concerned with her own agenda than with me. At the time, I wondered if my age or my professional background made me more difficult for her to manage, but I had no real clues about what she thought. I felt that I might just as well phoned NHS Direct (God forbid!) or simply purchased my own antibiotics over the counter. And although she did everything that was necessary, politely and efficiently, I felt that she cared nothing at all about me. I felt 'put down' by her, even though technically she did everything that she was called on to do. The second doctor – my doctor – took a serious and personal interest; gave me time and attention that allowed me to tell him about my anxieties as well as about the symptoms. But he remained in charge of the consultation and sorted my problems out his way. He then made himself available for future demands by offering me three alternative modes of communication. And they actually worked. And because I now trust this doctor, I was delighted to find that I could use e-mail as a way of getting past the practice system and getting advice personally from him and not just from the doctor on duty at the time.

So although I now feel comfortable relying on him, how firmly is that trust based? I know my doctor only superficially, having consulted him but a few times. He has my medical record and he heard what I had to say, and he also knew something about my professional background. He has in the past reviewed books for a journal that I edit. But he has never been to my house and knows nothing of my family or outside interests. He really doesn't know very much about me.

My knowledge of him is also pretty superficial. He copes comfortably with me, despite my medical background, and is well able

to overrule my opinion in a friendly but authoritative way. It makes me feel comfortable to have him in charge. My confidence is the product of his empathy and independent thinking. I exercise my autonomy, as do so many patients, by cheerfully letting myself be dependent on my doctor's knowledge and skill.

Outside the consulting room, I do know a bit about him. He has a good name in the village and also in the local postgraduate community in which I have several contacts. More than that, I know from the unstoppable local gossip that he has an unconventional family life, but no mention of any of this ever comes into our medical time together. There we have a close, trusting, dependent relationship but one that is probably is not completely open. I feel that I could talk to him about intimate problems and allow him to see some of the moods and internal terrors that keep me awake. I feel safe in his hands and for me that is enough.

What I have described is an effective working relationship that might become intense if necessary, but is completely circumscribed. There are areas of knowledge that each of us has about the other that we do not allow into the consulting room – or perhaps we let it all in but only call on those parts of what we know of each other that are going to help. I have shown the benefit I enjoy in having a doctor that I can trust and he has opened up electronics as (for me) a novel mode for consulting, which despite the apparent remoteness seems to offer a surprising degree of both immediacy and personal contact.

But what of the other side? Does he get anything out of having yet another elderly doctor on his books? How can I tell, save that when I was in his position, I found that that personal involvement with patients was what eased the pain induced by overwhelming bureaucracy. So maybe I serve a small function in helping to keep him professionally alive in the stifling struggles of the new NHS, just as his efforts on my behalf help to keep me going.

How much of ourselves do we need to share in order to have an effective therapeutic relationship? Could the same doctor cope equally well if I came with less dependent overtones in a totally different situation? I hope he could. Does any of this matter? It may be that I would be perfectly adequately managed by the first doctor, who would need to invest that much less in it all. After all technical competence must always come first. How often is empathy and understanding more than a supportive luxury that we could actually manage without? And which of us actually needs it most? The patient or the doctor?

Let me repeat the questions with which I started.

- How necessary to ordinary doctoring is an understanding of the doctor-patient relationship? So many doctors and others seem to manage without.
- How can there be any serious consideration of the doctor-patient relationship that does not include the patient's own perspective?
- Is this Balint stuff just an optional extra?

I hope that the rest of this weekend may move us a little closer to finding out.

Caring for Patients, Caring for Doctors – Three years in the Tower Hamlets Vocational Training Scheme

by David Watt, GP, VTS Group Leader

Over the last 20 years Balint groups in Britain have become more common in VTS schemes than elsewhere. Though starting from the Balint model they have adapted to the needs of these schemes, enabling doctors in training to gain the benefit of Balint work. This has also been the case in other countries, particularly the USA, where Balint work is focused in Family Medicine Residencies. The benefits of Balint training as I explain them to my VTS participants are firstly of a general kind in relation to higher education:

1. To allow and develop imaginative and creative thinking
2. To keep a critical and informed mind
3. To develop awareness of others' interests and needs
4. To develop an ability, and sense of enjoyment, in lifelong learning
   (Taken from Jaques, D *Learning in Groups.* Kogan Page, 1991)

Secondly, there are benefits peculiar to Balint work:

1. To provide an outlet for anxieties and frustrations generated by work
2. To arouse interest in patients previously found annoying or upsetting
3. To open the mind to other possibilities, both of diagnosis and of day to day management of patients
4. To provide support during the VTS
5. To improve communication between doctor and patient and between doctor and other health workers

To use Balint type group work in a VTS scheme some principles have had to be relaxed. VTS groups do not in general meet weekly as few course organisers can be persuaded to give this much time, and the pressure of summative assessment and RCGP membership exams are so heavy for current trainees. Groups cannot be stable or closed. GP registrars and hospital SHOs are expected to come to the group as part of their half-day release time. The experience is universal that some may regularly vote with their feet and not turn up, or attend irregularly, and that there will be the faithful attendees. Whom may we be serving the best? The occasional attendance of someone poorly motivated may be as important for them or their future patients as someone who is already in their own personal therapy!! Because of the more flexible attendance the leadership arrangements may not be entirely stable. If a large number of trainees attend, two groups may have to be run by the leader and co-leader. Though always trying to focus on the doctor patient relationship, most VTS course leaders will be familiar with the odd crisis in the scheme, a renegade trainer, a recent hospital disaster, an upcoming exam, which may monopolise the time, being too important for the participants to ignore or side step, in order to talk about their everyday work with patients.

I wish to talk about the work my group did in three academic terms from 1998-2001. I started leading regularly, on the Tower Hamlets GP Vocational Training scheme in 1995 with Mary Burd, a clinical psychologist. Previously Erica Jones was the GP leader. Our attendance is between 10 and 20 on almost all occasions and the group is divided into two. Trainees are either with me or with Mary for the whole academic year. If fewer than ten attend we have just one group, as we have to if one of us is unable to be present. On this scheme hospital SHOs and GP registrars attend so some people are with the group for three whole years. The group meets only four times a term, on Wednesday afternoon, usually at fortnightly intervals, for 1 hour and 15 minutes. .

Over the years I have kept short notes on the groups' casework which have enabled me to look back at the work of the group. Each case was typically summarised in notes of about 100 words. These I examined earlier this year for subject content with no particular structure or plan in mind about what I would do with the material. I hope it was thus relatively clear of bias or selective analysis, though of course my original notes will have been somewhat personal. The patient's age and sex were extracted along with a shortened case summary.

The case numbers for the three years and age/sex composition are presented in the following tables.Both men and women presented,

Tower Hamlets VTS Group –Tables

Year	Presenters				Cases		
	registrar	SHO	Male	Female	Male	Female	n/k
1998-1999	15	7	11	11	8	15	1
1999-2000	15	3	9	9	7	10	1
2000-2001	14	4	8	10	7	11	0

Age ranges of cases-total 1998-2001

0-18	18-30	30-40	40-50	50-60	60-70	70+	Total
6	20	10	7	5	2	8	58

both hospital SHOs and GPs. Most interestingly the age range of patients seemed to relate to the age of the group members. Over 60% of patients were below 40, or perhaps almost peers of the group. There was also a large number of very elderly cases, who may relate to participants' worries about their grandparents.

The shortened case summaries for the year 1998-9 are presented in the following figure:

1998-9	presenter	status	patient	age	Case Material
14.10.98	Male	Reg	male	30s	Aggressive, needy, how much to help, being new trainee, obeying instincts
	Male	Reg	male	young	New trainee, drug addict. Not supported by practice
	Male	Reg	fem	young	Patient disobeying practice rules and doctors morality (TOP)
4.11.98	Female 1	Reg	fem	21	TOP, how involved to be
	Male	Reg	fem	30	Extramarital pregnancy, TOP or not, doctors moral views-very involved
25.11.98	Male	Reg	fem	young	Pregnancy, doctor involved in moral decisions
	Male 1	Reg	fem	30s	Opening Pandora's box or not, get an earful and may be left unresolved. Felt let down by trainer
16.12.98	Male 1	Reg	Couple	?50s	Home visit, drunk, confusing, inappropriate behaviour. End up bonding and carrying a lot of their problems
	Female 2	Reg	Couple	50s	Frequent attenders, no emotional depth but sent Christmas card
	Male	Reg	Fem	young	Anger with trainer, over attached patient-confidences/trust
3.2.99	Female 2	Reg	Male	old	Fear/avoidance of death. How to be involved. Home visit
	Male 2	SHO	?	90	?withdrawal of treatment-death. Patient wants to die
17.2.99	Female 3	SHO Ger	Fem	78	Breaking bad news-cancer. ? against family wishes
	Female 4	Reg	fem	40s	Polysymptomatic. What is wanted? GP left uneasy
17.3.99	Male 2	SHO Gynae	fem	young	Psychosomatic/difficult to help/patient complaint. Anger with consultant
7.4.99	Female 5	Reg	male	40s	Interesting patient on repeat prescription. Get involved, change or not?
26.5.99	Female unknown	SHO Ger	fem	old	Elder abuse. Still prefer home to hosp-empathy with patient
	Female 6	SHO Psych	male	50s	Risk of suicide. Responsibility. Unsupportive seniors/nurses
9.6.99	Male	Reg	fem	40s	Non compliant/serious illness. Will not let doctor open Pandora's box
	Female unknown	SHO Gynae	fem	young	Poor teamwork. Severe pain unknown(not serious) cause. Need for continuity
30.6.99	Female 5	Reg	fem	25	What does patient want, medical cure, ?something else
	Female 6	SHO Psych	male	?30s	Lying patient ? Seen as favour. Doctor drawn in and deceived

To illustrate the nature of the group I will talk about the first few cases in the year. The first was presented by a registrar who appeared quite tough but who described a threatening man in his 30's who was very "in your face". This unpleasant impression was changed at the second encounter when he appeared as a needy withdrawing alcoholic with housing problems. The registrar did not know which character to believe and so where to put his efforts, whether to obey his original instincts of distrust or not. Then the mature registrar, a plump avuncular man, described a drug addict "really buttering him up". The addict expected special treatment with prescribed methadone because a partner in the practice usually did this, he said. There seemed to be no practice policy to support the new registrar in his first weeks in this difficult area. The third case was from a young, practising registrar. A woman "gatecrashed" an evening surgery, bypassing emergency protocols, to demand an abortion. The registrar, though willing to arrange this, felt compromised both in the way of working and in his morals. When discussed with his trainer it was suggested he should have sent her away. The registrar said "but she would cry".

This I hope gives a general idea of the kind of cases we discussed and that it appeared to be a Balint type group. Themes seemed to run through the year from fortnight to fortnight and I have tried to draw them out in the following modification of the previous table.

Table 1998-9 with themes

	presenter		
	Male	Case material	**Themes**
14.10.98	Male	Aggressive, needy, how much to help, being new trainee, obeying instincts	**Neediness of new GP trainees**
	Male Female 1	New trainee, drug addict. Not supported by practice Patient disobeying practice rules and doctors morality(TOP)	***How***
4.11.98	Male	TOP, how involved to be	
	Male	Extramarital preg, TOP or not, doctors moral views-very involved	***Deep***
25.11.98	Male 1	Pregnancy, Dr involved in moral decisions	
	Male 1	Opening Pandora's box or not, get an earful and may be left unresolved. Felt let down by trainer	***To***
16.12.98	Female 2	Home visit, drunk, confusing, inappropriate	***Go***
		behaviour. End up bonding and carrying a lot of their problems	
	Male	Frequent attenders, no emotional depth but sent Christmas card	***With***
	Female 2	Anger with trainer, over attached patient-confidences/trust	***Patients***
3.2.99	Male 2	Fear/avoidance of death. How to be involved. Home visit	**Death**
	Female 3	?withdrawal of treatment-death. Patient wants to die	
17.2.99	Female 4	Breaking bad news-cancer. ? against family wishes	
	Male 2	Polysymptomatic, Asian patient. What is wanted? GP left uneasy	***What is really***
17.3.99	Female 5	Psychosomatic/difficult to help/patient complaint. Anger with consultant	***Wrong***
7.4.99	Female unknown	Interesting patient on repeat prescription. Get involved, change or not?	***With patient***
26.5.99	Female 6	Elder abuse. Still prefer home to hosp-empathy with patient	**Responsibility**
	Male	Risk of suicide. Responsibility. Unsupportive seniors/nurses	
9.6.99	Female unknown	Non compliant/serious illness. Will not let doctor open Pandora's box	
	Female 5	Poor teamwork. Severe pain unknown (not serious) cause. Need for continuity	
30.6.99	Female 6	What does patient want, medical cure, ?something else	
		Lying patient ? truth, why. Seen as favour-doctor drawn in and deceived	**Truth**

Looking through the 3 years it became quite clear that themes recurred each year with some regularity. It began to look as if there might even be a relatively standard curriculum for the group each year.

For the three years the summary themes were as follows. Recurrent themes are illustrated by typeface:

Themes in ongoing
(but changing membership) VTS group

1998-1999

Neediness of new GP trainees
How deep to go with patients
DEATH
What is Really wrong with patient
Responsibility
Truth

1999-2000

New Trainees helpless
Opening Pandora's box
Problems with the system
SUICIDE
Exams (of trainees)
Sexuality
Children in consultation
Communication

2000-2001

Overwhelmed
Limits of doctors
The system
Cultural differences
Boundaries/sexuality/culture/racism
Fear of missing something/being a good doctor
Boundaries again

Some themes recurred year by year. Others seemed of particular importance to the individual group at the particular time, such as in1999-2000 the interest in sexuality, and in children and sexuality, or in 2000-2001 the discussion arising around cultural differences.

These themes represent areas commonly thought to be difficult or essential subjects for young doctors to deal with. They were the concerns of the participants and in the Balint group work arose spontaneously to be discussed. By attending to them the group was learning about them and caring for the members, who in turn were enabled to care better for their patients.

Balint unifies – world wide
Report on the 13th International Balint Congress, Berlin 2003

by Steffen Haefner and Simone Hoeckele

For the first time since the 5th International Congress (1980) in Cologne an International Balint Congress took place in Germany from October 1st to 5th 2003. About 160 participants from 25 countries discussed the topic 'The doctor, the patient and their well-being – world wide'.

For a congress around the German Day of Reunification (October 3rd) there could be no better place for a conference site than Berlin. The capital of Germany having been annually the host of a Balint workshop since 1983, the International Congress was at the same time the 21st Berlin conference. 160 participants, 79 women and 81 men, 22 to 90 years old, came from 25 countries in Europe and overseas, including even one from Australia. The oldest participant had even made the acquaintance of Michael Balint and participated in Balint-groups with Enid Balint.

The aim of the conference was to learn about the experiences in different health systems and to 'to merge science and medicine'. The president of the congress, Heide Otten, explained the choice of the topic of the congress 'The doctor, the patient and their well-being – world wide (in the context of today's health-systems)' and emphasized the important role of preventing burn-out of physicians. This was underlined by the picture 'Science and Charity' by the fifteen year old Pablo Picasso on the front page of the congress programme and the congress advertisements.

Werner Koenig, as local host, made a wonderful choice to locate the conference in the Kaiserin-Friedrich Stiftung just in the heart of the university hospital Charité which has a very long tradition. The foundation is named after Viktoria (1840-1901), the eldest daughter of Queen Victoria, and widow of the emperor Friedrich III, who reigned over the country for only 99 days before he died tragically from laryngeal cancer in 1888, the year in which three emperors ruled in Germany. After his death, the empress Viktoria was very engaged in the continuing education of physicians.

Especially for a Balint congress, site and location were very well chosen, as Michael Balint lived as a young physician and biochemist from 1920 to 1924 in Berlin and worked in the laboratory of Otto Warburg, who was awarded the Nobel Prize in 1931, on his doctoral thesis in biochemistry – while being analysed by Hanns Sachs. In his presentation, Ernst Richard Petzold, the president of the German Balint Society, remembered that Balint was the first physician at the Charité to treat psychosomatic patients with the new method of psychoanalysis.

John Salinsky, who was to retire from his post as General Secretary of the International Balint Federation at the end of the meeting, started the programme with a historical overview: *'Fiat Lux:* the history of the Balint movement', and showed by a light bulb joke that congress presentations may be full of humour. How many psychotherapists do you need to change a light bulb? Only one, but the light bulb must *really, really want to change*! That physicians have to change too, underlined what Benyamin Maoz (Israel) had to say in his presentation 'Balint groups as a way to prevent burnout of physicians'. He referred to the results of his research in Israel: a general practitioner is able neither to recognize nor to treat psychic problems in his patients if he has to see more than 4.6 patients per hour. Maoz emphasized the importance of the doctor's well-being and taking care of his health, for example by going more often on holiday, in order to help his patients in a better way. Guenther Bergmann (Austria) gave an excellent overview about 'the visions and challenges for Balint work in medicine in the new century' within the context of a rapidly changing world. After this view into the future Michelle Moreau-Ricaud, an outstanding expert on the life of Michael Balint, invited the participants to an excursion into history. She explained the special relationship of Balint to Berlin and why he had chosen just this city for his research. It might also be that not so many Balint doctors know that 'Balint' is the Hungarian name for Valentine, the 'saint of the lovers'. Further interesting details of Balint's life are mentioned in Moreau-Ricaud's contribution to the volume of abstracts[1] edited by John Salinsky and Heide Otten, summarizing the congress presentations on more than two hundred pages.

The following day Michel Delbrouck (Belgium) gave a very detailed overview about burnout-syndromes and the disorders they tend to hide behind, for example Karoshi (death by working too much) in Japan. Further contributions to the section 'Balint work around the world' came from Israel, Great Britain, Sweden, Switzerland and Hungary. In the following session 'Student Balint Work', Iveta Zedková (Czech Republic) and Barbara Jugowar (Poland) presented projects of student Balint work in Olomouc and Poznan that are full of commitment and may be a hope for the future. In this context it is important to remember that Poland integrated Balint work in the medical curriculum as early as in the year 1991.

These presentations preceded the highlight of this morning plenary session, the award of the Ascona prize. The presentation of the prizes will now be held in alternate years at the International Congress and in Ascona. Tim

Niemeyer, studying medicine in Marburg (Germany), got the first prize. The second prize was awarded to Istvan Gyoeri from Debrecen (Hungary) and the third prize went to Alexandra Monica Constantinescu from Bucarest (Romania).

But there was Balint work at the congress, too. Fishbowl and demonstration groups (prismatic, with imagination, with sculpture) made part of the programme as well as Balint-groups and groups for leadership training – in English, French, Polish and German. Thus the whole spectrum of Balint work was demonstrated enabling every participant to enjoy the setting and technique of other countries. Despite English being the official language of the congress, it was very evident that an ability to speak perfect English was not the most important thing in understanding the case. In the section 'Modifications of Balint work', Stephan Alder and Alfred Drees presented the theoretical concepts of Balint-groups with active and guided imagination and of prismatic Balint-groups. In the section 'Research' Donald Nease (Ann Arbor, Michigan, USA) presented special programmes for leadership training. This might be the reason why many participants asked in the final session for more possibilities to discuss during the congress, this having been sometimes a little bit difficult because of the large number of contributions to the conference. But informal post-conference meetings took place at the very popular inn 'Staendige Vertretung' a traditional meeting-point and always with plenty of people.

Also in view of the social programme it was well worth while to pay a visit to Berlin. The sightseeing tours by bus gave an impression of the rapid changes along the former border between East and West Germany and the vibrant life of the new capital. A guided sightseeing tour around the historic area of the 'Charité', nowadays the largest hospital in Europe, was a walk into German history of medicine, with outstanding physicians such as Robert Koch in the field of bacteriology, Ferdinand Sauerbruch in surgery and Albrecht von Graefe in ophthalmology. It was also at the Charité that the first hospital for children was established. The monument of Robert Koch (1843-1910) just in front of the Kaiserin-Friedrich-Stiftung was very impressive for the Balintians as he does not only listen to his patients, but looks at them, too. So they wondered if Robert Koch was an early Balint-doctor.

Usually every conference has its conference dinner for going on discussing the issues of the day in an informal atmosphere. The funky Klezmer sound of the "Grine Kuzine" (have a look at http://www.kuzine.de if you cannot remember it well) were a very good contrast to the waltzes usually played at congresses. It was the musicians' speciality to combine East European songs and folk music with modern elements inviting the dancers for many a polonaise and round dance. In order to get an impression, have a look at the pictures of the dance evening in the photo gallery of the conference on the homepage of the German Balint Society (http://www.balintgesellschaft.de).

That Balint has a gender impact was demonstrated by a final statement of a female participant who summed up: 'I have never been in surrounding where so many men smiled.' This declaration could be the starting point for discussions at the next International Conference!

So everything is changing. Participants could experience this on the final boat cruise on the river Spree from former East to former West and back, passing along the places where there was the wall between East and West. Despite leaving the boat near the formerly so-called 'Palace of Tears' (one of the checkpoints between East and West Berlin near the Friedrichstrasse station), the participants left in a very good mood and with many new impressions, remembering an outstanding conference and the hearty welcome of Helga and Werner Koenig – looking forward to meeting again at the next International Conference in Stockholm.

Reference

Salinsky, J., Otten, H. (Eds) (2003) *The Doctor, the Patient and their well-being – world wide. Proceedings of the Thirteenth International Balint Congress*, Berlin: Ruckzuckdruck. Celle 2003.

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Curricula vitae

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Pictures from Berlin

Report on Oxford Balint Weekend 2003

by Tom Russ, medical student, University of Edinburgh

First college rooms, a kingdom of my own:
What words of mine can tell my gratitude?

Summoned by Bells, John Betjeman

I echo Betjeman's words to express my sincere gratitude for having been given the opportunity to take part in the Balint Society's Oxford weekend this year, and would like to extend my thanks to all concerned.

I started the weekend with a slightly hazy view of what Balint groups were all about, based on a chance conversation at a party in London and dipping into *The Doctor, his Patient, and the Illness*. I left the weekend with my enthusiasm whetted but perhaps not much more idea exactly what 'Balint' entails.

'Balint' provides a forum to which doctors and others can bring a patient with whom they are having trouble, or who has stuck in their mind for some reason or other, for discussion. This will hopefully allow the doctor to view the patient as a human being once more and perhaps understand their situation a little. This support framework for discussing difficulties and patients who are preying on one's mind is a very valuable resource that should not be taken for granted. I have certainly experienced its value over this weekend and look forward to D.V. joining a Balint group once I am qualified and working as a doctor. However I sensed that, for some, 'Balint' had become something more than this. The starting question of "has anyone a patient they would like to bring?" had taken on an almost liturgical significance, and the ritual of the group had gone beyond merely a process to prevent burnout.

This was my first experience of a Balint group and it was entirely positive. I found it fascinating to be in a group with people from such different backgrounds. The question of explanation for newcomers was discussed in our group at the end of the weekend and I believe that no explanation is necessary. I found it much more profitable to try and work out for myself the etiquette of the group discussions. Though I was slightly apprehensive about bringing a patient that I had seen to the group, I did in the last session, and found the insight of having 'my' patient discussed by the group fascinating and rewarding. I felt valued by the group who reported that they found the different perspective of students in the group interesting.

The food and the social aspects of the weekend were marvellous. I met some fascinating people and had a great deal of fun exploring Oxford at night with the other students. Oxford is a wonderful city by day and by night, and I really enjoyed spending a weekend there. I have very fond memories of Christ Church meadow in the early morning and of an afternoon in Blackwell's!

Balint Groups: psychosocial nonsense or a real insight into the doctor-patient relationship?

by Bruno Rushforth and Wendy Brown

We've all come across them, but how should we react? That patient who keeps returning to their family doctor, with volumes of notes, numerous letters from specialists, but no disease is ever found? Or the patient who hasn't visited the doctor for twenty years, and then presents with depression but says he doesn't want to talk about it? Or what about the patient who keeps bringing you gifts?

This is where psychosocial medicine comes in. Love it or hate it, you can't ignore it. Around the globe, medical training is increasingly demanding an understanding of patients' problems that goes beyond the organic nature of disease. Some students resent having to study these 'soft' behavioural and social sciences, which take them away from the 'real' medicine of anatomy, physiology and pharmacology. Yet to ignore the powerful influence of health beliefs and emotions is to deny the psychosomatic dimension of many patients' presentations.

A key element is how the doctor responds in the consultation room. Indeed, the doctor-patient relationship itself can be a powerful therapeutic tool. But it is also important to acknowledge how some patients make us feel. Understanding our own emotional responses to difficult consultations can sometimes shed light on the patient's underlying problems.

To explore these issues in the doctor-patient relationship we attended a weekend in Oxford, organised by the Balint Society. Who are they? We hear you ask. Good question – until the advert appeared in the *studentBMJ* we'd not heard of them either. The UK Balint Society is part of an International Federation of 36 member countries (see above) who continue the work of Hungarian psychoanalyst Michael Balint and his British wife Enid. The Balints wanted to integrate psychological thinking into doctors' training, and started groups in London in the 1950s where doctors could discuss 'difficult' patients and their reactions to them. By participating in these Balint groups, doctors were helped to understand their own, and their patients' feelings, thoughts and motivations. Sounds a bit touchy-feely, we hear you say. Well yes: the sessions don't end with a group hug, but it's a far cry from the surgical ward round.

The weekend consisted mainly of small group work. Each group met for one and a half hours, several times over the weekend, to discuss prepared cases. One doctor wanted to talk about how she had found herself despising a patient simply because the patient had never had a job. Another member spoke about the problems he faced, as a part-time family doctor, giving adequate support to a demanding patient. One medical student raised the issue of how he had tried to deal with an inappropriate advance by a patient. After the person had outlined their case, others would offer their perspective on that particular doctor-patient relationship. The weekend also had a number of plenary sessions, where recent research on the impact of attending Balint groups was presented.

We had very different views about the weekend. One of us (BR) became a card-carrying member, while the other (WB) had serious reservations. The patient case studies in the groups were quite intense, with people offering their own analysis of what was really going on in the consultation room. But this sometimes felt like unscientific psychobabble, or a therapy session for the doctors involved, and often ignored what the patient had actually said and done, in favour of a 'deeper' interpretation. (Why did she sit with her legs crossed? Maybe she was abused as a child?)

However, the case discussions did provide a rare opportunity to view the patient as a complex, multi-layered individual with a variety of motives and life circumstances, which might combine to explain their visit to the doctor. They also allowed group members to examine their own emotional responses to patients, something that doctors rarely have a chance to explore in any depth. And in today's climate where medical students are taught the importance of empathy and communication skills, the next generation of doctors will probably be more open to this kind of analysis of their interactions with patients.

But will it make you a better doctor? And do busy clinicians really have time for Balint groups? What is clear is that to be a good doctor requires some kind of reflection on your dealings with patients, whatever form that takes. The question that remains unanswered is whether Balint groups offer a practical and evidence-based solution. However, we can all agree that to fully understand patients' complaints we need to have an insight into the various dimensions of health and illness, both organic and non-organic. We ignore psychosocial medicine at our peril.

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14th International Balint Congress, Stockholm, Sweden, August 2005: *www.internatinalbalintcongreess.de*

The Balint Society, UK: *www.balint.co.uk* (with international links)

Oxford Weekend at Exeter College, 17-19th September 2004
Cost for students £25 (includes accommodation and food)

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Book Reviews

Medicine and Literature: the doctor's companion to the classics (volume two) by John Salinsky, Radcliffe Medical Press, £19.95, pp 271, ISBN 1-85775-830-7

This book is a delight: a casket of treasures for doctors and for everyone. In its pages we are transported, with John Salinsky's light deft touch, through great books we have read and others we have always meant to read. Three of the essays and three postscripts are by other writers. In this, the second volume of Medicine and Literature they explore with warmth, humour, personal revelations and admonitions to both writers and characters, *As You Like It, Emma, Frankenstein, Jane Eyre, Moby-Dick, Fathers and Sons, Strange Case of Dr Jekyll and Mr Hyde* (with particular reference to film adaptations) *The Death of Ivan Ilyich, Heart of Darkness, The Metamorphosis, The Burrow and Josephine the Singer,* (three animal stories by Kafka), *Women in Love, A Passage to India, Mrs Dalloway, Decline and Fall and One Hundred Years of Solitude.*

At first I felt some resistance to the idea of reading a book about other books, especially ones I have always held preciously to my heart like *Jane Eyre,* with my own strong imaginings of the characters...but I was soon taken with the 'voice of the other' in these pages. It was like the very best times of being read to, as child and adult; the stories held their suspense and at times the ending, or a crucial scene was withheld, with a gentle cajoling to read the book myself. The musings of these authors became as absorbing as the novels themselves.

Doctors of varied character and approach make their appearance in several of these books, and are pounced on with glee for comment and analysis, as in *Emma* where 'Dr Perry always said that wrapping up well was an excellent protection. This worked very well when little Emma had the measles. And Dr Perry visited her four times a day for a week! (Doesn't he have any other patients? What is the man thinking of?)'

A quote from *Emma* lit my own relationship to books: Mr. Knightley says, 'Emma has been meaning to read more ever since she was twelve years old. I have seen a great many lists... of books that she meant to read regularly through – and very good lists they were – very well chosen ... But I have done with expecting any course of steady reading from Emma.' John adds: 'Oh dear. Sounds like a GP trainer lamenting the lack of application of a registrar.'

In his introduction to the essays, John persuades doctors to read for refreshment, as well as for the depth of understanding of people's lives and feelings given to us by these authors. 'Love, death and family relationships preoccupy many of our characters; others are caught up in the single-minded pursuit of an idea, an ambition or the thirst for revenge.' As with our patients.

Also, 'If I am getting bored or restless in a consultation, I sometimes try to detach myself and listen to my patient in a slightly different way, as if I were reading about him in a novel. Of course, it doesn't always make a difference, but when it does, it can make my sinking heart revive and beat in sympathy with that of a fellow human being.'

As the latest 'New GP Contract' threatens to infiltrate our thinking with patients, this book is a wonderful antidote!

Two of Kafka's short stories, *The Burrow* and *Josephine the Singer or the Mouse Folk* about a singing or piping mouse, surprised and interested me, and were so akin to unspoken aspects of my life, that I went straight down to the bookshop and ordered *The Penguin Complete Short Stories,* to illuminate my hours...

In the postscripts to the Kafka stories and *The Death of Ivan Ilyich,* as well as the essay about the filming of *Dr Jekyll and Mr Hyde,* I felt some loss of the lightness of touch and enjoyable conspiratorial romping through the books.

Much that was written about the authors was touching. Kafka died from TB of the larynx and lungs at the age of 41; DH Lawrence was always quite frail and he died from TB aged 44.There is also compassionate writing about Virginia Woolf's depressive illness, and her suicide at 59. Tolstoy apparently suffered never-to-be-assuaged anxiety about death, what it might usher in or open onto, and he used his own near-death experience to brilliantly describe these for his characters.

I read *Women in Love* as a teenager, and John's essay brought it all back, with so much added detail, knowledge about DH Lawrence himself, his doubts, beliefs and tortures which are reflected in the book, so that I now have a much richer relationship with the book.

I think that the *tour de force* of thinking and writing comes with *Women in Love.* John admits to a previous lifelong struggle to appreciate Lawrence, but he generously describes here how he stuck with this book, discovered much about Lawrence's life, and could say at the end, after Gerald's death in the Alps: 'I am standing in the snow at the end of *Women in Love,* still stunned by the tragedy of Gerald's death...As I walk slowly back to my hotel through the crisp snow, I reflect on the experience of reading and living with *Women in Love* as follows.

It's a beautiful book. Nobody else can write like Lawrence at his best. The poetic descriptions (the moon, the lake at night with the boats and lanterns, the animals, the snow and ice at the climax) are all wonderful. There are also very subtle descriptions of the lovers' states of mind as they veer between love and hate, desire and detachment, affection and contempt.'

And finally: 'I have spent a long time

with this book. Its music appealed to me instantly but it took me longer to get to know the characters and to appreciate their feelings. Still, it was well worth the effort, and Rupert, Gerald, Ursula and Gudrun have become permanent residents of my inner world of literature.'

Here is Lawrence, describing a night lake, a stone thrown at the moon's reflection by Rupert…

> *Ursula was aware of the bright moon leaping and swaying, all distorted in her eyes. It seemed to shoot out arms of fire like a cuttlefish. Like a luminous polyp, palpitating strongly before her.... Then again, there was a burst of sound and a burst of brilliant light, the moon had exploded on the water and was flying asunder in flakes of white and dangerous fire.*

It is for their loving, vivid conveying of the colour of these wonderful stories that I thank John and his co-authors.

Tessa Dresser

Difficult Consultations With Adolescents. Edited by Chris Donovan & Heather Suckling, Radcliffe Medical Press, £21.95, pp130, ISBN 1 85775 882X

General Practitioners know, both from personal experience and from research evidence, that consultations with adolescents are shorter than those with adults. Why should that be? One reason could be the monosyllabic shyness and/or sullenness of many teenagers. But consider also the possibility that the doctor, too, is shy, being required to revisit his own most painful years and problems. Many doctors have never successfully solved their own adolescent dilemmas – they have merely become old enough for these dilemmas to be overlooked by others. But the pain may remain.

Then there is envy. The doctor may catch him/herself thinking, 'What on earth are you fretting about? You have youth, health, looks, and many more years ahead of you than I have – why fuss so much about spots or friendships?' When the doctor is impatient with the relative insignificance of the young person's problems, the cause may be middle-aged regret and a sense of personal loss.

This book, inspired by a project undertaken by the RCGP Adolescent Task Group, is a successful attempt to dissect and closely observe the adolescent consultation. It describes a multidisciplinary Balint group, focussed specifically on 10-19-year-olds, which met on only six occasions. Ten case presentations are examined in detail and reflected upon. The factual case is in each instance followed by notes on the doctor's feelings and the group's feelings, along with comments from the group leader. This approach squeezes added value from each account, yet still leaves room for readers to make their own observations and draw their own conclusions. As a result, the book is educational in the best sense of the word.

For those familiar with Balint work, the novelty lies in the fact that presenters were required to bring only cases in the specific age range. This in no way invalidates the effectiveness of the work – after all, psychiatrists in training are required to participate in Balint groups restricted to a specific type of patient, the psychiatric case. But of course, the mystery of how presenters choose their cases is somewhat restricted here. It would be interesting to know how often or seldom an adolescent consultation is chosen for presentation in an ordinary Balint group, in relation to the age distribution of that doctor's consultees.

Although this book's chapters are by a number of different authors, the editors have succeeded in producing a concise volume that reads well, and is without annoying overlap. Analysis of the cases is followed by more general chapters, giving the respective perspectives of a GP, a nurse, and a psychiatrist. There are useful factual appendices. Most importantly, reading this book leaves one with a sense of hope and a way forward in an often-neglected type of consultation.

Pat Tate

Obituary

Dr Stephen Pasmore (1910-2003)

Stephen Pasmore (born 1910, qualified 1933) was the son of the Superintendent of Warlingham Park Mental Hospital. This was opened in 1903 and Stephen's father had insisted it not be called an asylum. He had an elder brother, Victor, the famous artist, and a younger sister who pre-deceased them both. He had a rather Victorian upbringing in a house in the hospital grounds. His father died rather young and the family had quite a struggle in material terms. He went to University College followed by University College Hospital, London where he had a house job. I did not meet him until I joined the psychosexual seminar sponsored by the Family Planning Association in 1960. His wife, Jean, was also a member, but the group was so large that we split into two, Jean being in one and Stephen in the other (they had previously been the first married couple to be members of a GP Balint group). In my perception, Stephen had the indefinable air of a culture difference which I associate with the generation who went to work before the Second World War. They possess an urbanity and courtesy that my own generation seems to lack. But this never prevented Stephen from drinking in the wisdom of Balint, and many of his cases presented in that FPA group were of young female students at the college where he acted as visiting doctor. Jean was also qualified, of course, and they went into private practice in the mid nineteen thirties and remained there throughout the blitz and beyond, joining the Health Service at its inception. (Jean became involved in work with the FPA and gradually shifted the focus of her work away from general practice.) The demography of Kensington has, I think, been for a long time special in housing the very rich and the very poor and Stephen revelled in this wide spectrum. He founded the Kensington Society. His practice was centred on their town house in Edwardes Square with the consulting room in the front and the waiting room behind. Their dining room and kitchen were in the semi-basement and their sitting room on the first floor. He was always buying pictures and there was a wonderful full-length portrait of a woman of the eighteenth century hanging in his consulting room. He also collected second-hand books in large numbers. The Balint Society Council met for a long time in the dining room, and there was Victor Pasmore on the passage wall leading to it. I well remember discussions held in that room when Cyril Gill was secretary, with Tom Main present, as to how to validate non-psychoanalytic Balint group leaders (in case you thought the subject was new!) I worked again with him in the group that produced the concept of the 'flash'. His chapter in *Six Minutes for the Patient* is the essence of Stephen's thinking. Over the years we became friends as well as colleagues, and I drove Stephen and Jean to the Balint International Congress in Cologne. It was not a memorable Congress in Balint terms, because the German organizer died of a heart attack three weeks before the opening, but there was a wonderful exhibition of Turner pictures of the Rhine valley in the local art gallery, and we drove down the river and identified many of the locations. We also searched for a particular Rhenish castle which Stephen had depicted in a marquetry picture, one of the skills he acquired after retirement. He also studied book-binding and wrote a history of the Borough of Richmond (to which they had retired). He was an active member of the Richmond History Association to which he has left a legacy. He cultivated an enormous walled garden behind their charming Georgian cottage on Ham Common while Jean produced *cordon bleu* meals for their guests. I was very privileged to be asked to speak at their Golden Wedding. He leaves a daughter, eight grandchildren and four great- grandchildren. Another daughter and his son pre-deceased him.

Michael Courtenay

Secretary's Report 2003-2004

The Oxford Weekend 2003 was attended by 42 delegates. These included 7 medical students and 11 therapists of various kinds (doctor, nurse, counsellor). The keynote speaker was Oliver Samuels. Opportunities were given for newer leaders to work alongside Balint Society accredited leaders. This is becoming an important function of the weekend as there are currently a lot of people wanting to train as leaders. On Saturday there was a 90-minute short paper session. The presenters were John Salinsky and Ruth Pinder who spoke about the Balint Society research project, with Ruth presenting a case study of a group from the project. Maria O'Kane from Northern Ireland presented a difficult patient from within a group that she has led entitled 'Can I trust thee doctor as thy self? – the importance of the secret in the Balint group'. Lastly I presented some qualitative work on the material dealt with over three years in the VTS Balint group which I lead, entitled 'Caring for Patients, Caring for Doctors'. The large number of medical students was welcomed by all but was rather expensive for the Society.

The lecture series had four presentations at the RCGP. Typical attendance is between 15 and 20 and we would welcome more members or guests. The meetings are in seminar form generally with about half presentation and half discussion. On 28th October Dr James Willis spoke on 'The Threat that Government Directives Pose to the Potency of the Drug Doctor'. He spoke carefully about how little this aspect of our work is currently valued. On November 18th Sandra Linford, a psychotherapist interest in our work, spoke about the difficulties of trying to set up psychotherapy training in Lithuania. Several Balint society members have been involved in similar work in eastern Europe trying to establish Balint work and general practice training. After the Christmas break, on February 17th, Oliver Samuel presented 'Being Someone for Someone'. This was based on his Prize Essay which appeared in the journal, but went on to become a group event, when a doctor described a patient who was still very present for him and with whom he had a supportive personal relationship. A very senior doctor spoke at length about a case which had never been closed after his retirement and continued to cause worry. The final lecture was by Sheila Cross, a retired paediatrician, who works with Childline. She told us much about their valuable work: it provides a place that troubled children can get emotional help in a very non-threatening environment, mainly through the telephone.

May 14th-16th was the fourth Chester weekend, ably managed and led by Caroline Palmer and Marie Campkin. There was again one close-knit group of doctors and therapists willing to share great depth of emotion.

All through the year, now trying to meet about four times a year, the Group Leaders Workshop flourished. It meets on pre arranged and circulated dates on a Tuesday evening at the Tavistock Clinic and is led by the Vice President of the Society Dr Andrew Elder. The next meeting will be on October 12th 2004. There are several new groups whose leaders are now using the workshop and we are also experimenting with different ways of presenting a group, for instance with pre-circulated notes (rather than impossibly expensive transcripts).

Finally, on June 29th, we had a lovely Annual Dinner attended by 24 members in the Atrium of the Royal Society of Medicine. Dr Roger Neighbour attended as the guest of the Society in his new role as President of the RCGP. Heather Suckling spoke after dinner about all the Balint work she has been able to get involved with following her retirement – a call to others to try to do likewise.

As I write in July I am now looking forward to the Oxford Weekend from September 17th to 19th, again at Exeter College.

David Watt
Society 2004;00:00.

Report on Fourth Chester Balint Weekend (May 2004)

(Or How a Circle Helped us Understand Triangles)

by Dr Caroline Palmer

One glorious weekend in early May, a group of 11 came together for a workshop in the comfortable surroundings of the charming and homely Gladstone Centre in Chester, and unburdened themselves of their contrasting, uncomfortable feelings generated by their intense work with their patients.

The group consisted of eight GPs, two Consultant Psychotherapists, and a Primary Care Counsellor who all worked well and with enthusiasm with cases readily brought. Conversation and questions abounded, and it was sometimes hard to create a reflective space amongst the busyness of the group work. On the other hand, some group members revealed more about their own private lives than often occurs, and could admit the personal resonance and impact of their case, which hopefully reflects that the group felt safe. It was noticeable that often the role of the presenter in the group echoed the role of the patient in the consultation, and often the patient's words such as a heartfelt 'I can't go on', might well have been the subconscious feelings of the doctor too.

Sundowners at Chester, May 2004

Many of the cases involved couples, and the GP or therapist was therefore often drawn into a triangular relationship, which like the 'eternal triangle' can feel both seductive and dangerous.

Within the group too, other triangles emerged, e.g. Presenter-Group-Leader; or Sceptic-Devotees-Undecided, etc. Another triangle that seemed to permeate much of the work was that of the GP feeling caught in a triangle of patient demands, government requirements and the doctor's own intuitive feelings and needs. This is an especially uncomfortable triangle when the government agenda insists on further involvement with the patient, but your instincts are to disengage as soon as practically possible due to frankly disliking the patient!

It was also interesting to note that the GPs who have a 'cradle to the grave' responsibility were most burdened by the apparently never-ending nature of their commitment, while the other professionals in the group had difficulties in maintaining the contract boundaries, i.e. felt the triangular forces of client need, structural departmental dogma and rules, and their own enthusiastic, and perhaps occasionally foolhardy enjoyment of challenge.

Several of the cases were also 'Poisoned Chalices' especially passed on from colleagues, or brought via a relative, thus creating further triangles to try to understand. Difficult, undermining colleagues, and practice procedure and structure especially for locums, can also exert a distorting triangular effect on the doctor-patient relationship. Triangles were so pervasive that one of the cases even involved a fantasy 3D triangle or pyramid, a hard confining structure, within which a warm crouched circular being could just survive, a metaphor perhaps for the seed of warm humanity still alive inside the GP despite the confines of the New Contract, and government agenda!

And perhaps the Balint group is by its nature a tool for triangulation, (not only the doctor, patient, and the group) but the doctor using the group to gain further insight and understanding of the triad of the patient, the doctor him or herself and the relationship between them. Thus the triangle or pyramid not only contains a warm empathic circular being inside, but can also be surrounded by a warm empathic circular being outside, i.e. the Balint Group, which can help nurture and revive the human face of General Practice.

Those in the North, or willing to visit the North, and wanting to sit in such a circle again, can be reassured that another weekend workshop is planned for May13th to 15th 2005, so put the date in your diaries now!

ANNOUNCEMENT

THE 14th INTERNATIONAL BALINT CONGRESS STOCKHOLM
24-27 AUGUST 2005

The International Balint Federation (www.balintgesellschaft.de/ibf) holds an International Balint Congress every second year. These conferences provide a wonderful opportunity for Balint enthusiasts to get together and share their ideas. They also provide an ideal way for beginners to learn about Balint ideas from the experts and to get a taste of being in a group. The last very successful Congress was in Berlin in 2003, and we are already looking forward to the next one, which will be hosted by the Swedish Balint Society. The Congress will be held in central Stockholm from Wednesday 24th to Saturday 27th August 2005. Each morning there will be one or two papers by invited speakers followed by discussion led by appointed discussants. This will be followed by short paper sessions. Papers will be read and discussed in English. In the late afternoons there will be Balint groups in different languages, providing everyone with the chance to be in a group and to learn how Balint groups vary in different countries. There will be excellent Swedish food, congenial company and plenty of opportunities to explore this beautiful northern city of islands, ships and waterways. The first notice for the Congress will be sent out in September 2004. Meanwhile watch the website for further information.

The Balint Society Prize Essay, 2005

The Council of the Balint Society will award a prize of £500 for the best essay on the Balint group and the doctor-patient relationship.

Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with three copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.

Length of essay is not critical.

Entry is open to all, except for members of the Balint Society Council.

Where clinical histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in medical journals.

Essays should be signed with a *nom de plume*, and should be accompanied by a sealed envelope containing the writer's identity.

The judges will consist of the Balint Society Council and their decision is final.

The entries will be considered for publication in the Journal of the Balint Society.

The prizewinner will be announced at the Annual General Meeting.

Entries must be received by **1st May 2005** and sent to:

Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS

International Balint Award for Students

Medical students are invited to submit a paper based on their personal experience of relationships with patients. Prizes totalling SFR 10,000 will be awarded to the best essays.

The criteria by which the reports will be judged are as follows:

1. Exposition: the presentation of a truly personal experience of a student-patient relationship.
2. Reflection. A description of how the student actually experienced the relationship either individually or as part of a medical team. This could reflect multiple relations between students and staff of various specialties and the working routine within different institutions.
3. Action. The student's perception of the demands he or she felt exposed to and an illustration of how he or she responded.
4. Progression: a discussion of possible ways in which future medical training might enhance the state of awareness for individual students, a procedure which tends to be neglected at present.

NB: Inclusion of a description of the writer's experience in a Balint group will be an advantage.

Six copies of the written submission, each containing the author's name and full address should be posted not later than 31 March 2005 to Dr med Alex Amman, Graffenriedstrasse, 1, CH 3074, Muri, Switzerland.

email enquiries:alex.ammann@insel.ch

You should also send one copy (preferably by email) to Dr J Salinsky (JVSalinsky@aol.com)

Guidance for Contributors

All manuscripts for publication in the Journal should be forwarded to the Editor, Dr John Salinsky, 32 Wentworth Hill, Wembley, Middlesex, HA9 9SG, UK. Email: JVSalinsky@aol.com

Style

Articles should be typed on one side of paper only and double-spaced. Abbreviations must be explained. Research papers will be peer reviewed to assess their suitability for publication.

References

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article. All references should give the names and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of Index Medicus, year of publication, volume number, and the first and last page numbers.

We welcome the submission of articles on 3.5 inch computer disk. Authors should supply the name of the file on each disk and send a hard copy in addition. Better still, you could send them by email to **JVSalinsky@aol.com**

The Balint Society motif kindly designed by Mr Victor Pasmore, C.B.E.

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