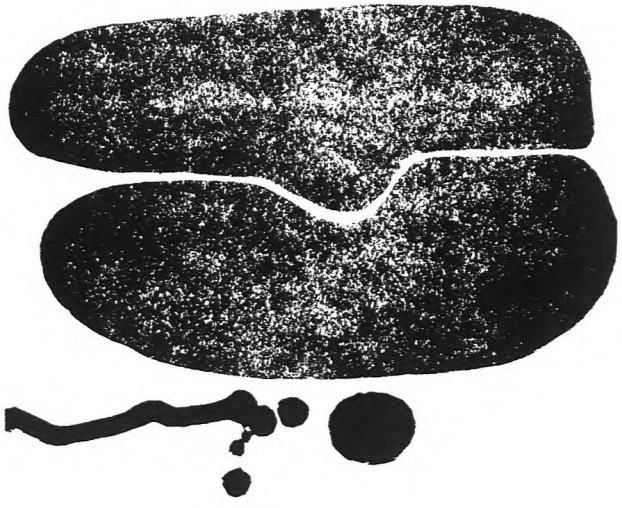
Journal
of the
Balint Society

2009



Vol. 37

JOURNAL OF THE BALINT SOCIETY

Vol. 37, 2009

Editor: John Salinsky
Assistant editor: Mary Salinsky

International Balint Congress in Romania.

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 regular 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 general practitioners and 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. Balint weekends are held each year in Northumberland, Whalley Abbey, Lancashire and Oxford. There is a Balint study day in London in February (see 'Programme of Meetings').

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. Leader training groups are also available as part of weekends.

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.

Programme of Meetings of the Balint Society for the Fortieth Session, 2009-2010

Lecture series 2009-2010

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 Mike Peters — **Tuesday 13 October**
'BMA Doctors for Doctors: experience of working with colleagues in difficulty'

Drs Brian Fine and Carol Cheale — **Tuesday 10 November**

Josephine Harrison — **Tuesday 16 March**
'Clinical Health Psychology: two cases'

To be announced — **April**

London Day Conference at Canonbury Academy — **Thursday 18 February**

The Group Leaders Workshop will meet at the Tavistock Clinic, Belsize Lane. London NW3 at 8.30 pm on 17/24 November, 11 February and 18 May

The Lancashire Balint Weekend will be from 14-16 May 2010 at Whalley Abbey, near Clitheroe.

The Northumberland Balint Weekend will be at Longhirst Hall from 2-4 July 2010.

The Oxford Balint Weekend 2010 will be held in September. Date and college TBA

The **Annual Dinner** will be held in **June 2010** at the Royal Society of Medicine

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

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. See also the INTERNATIONAL BALINT FEDERATION WEBSITE: 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, Finnish and International Balint websites. More are coming all the time.

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

Editorial

What do we learn from taking part in a Balint group? The group experience is described as training but what are we being trained to do for our patients? Are we really being trained at all? At the beginning of a group's life, the members feel that the principal benefit is the opportunity to discharge some of the anxiety and distress accumulated by a fortnight of close encounters with unhappy and demanding patients.

A Balint group is typically receptive and non-judgmental; a sympathetic hearing is guaranteed to begin with; even if your colleagues' helpful suggestions begin to sound a bit challenging later on. And some of their ideas may give you hope for a fresh approach that will jolt that difficult patient out of the repetitive pattern that you find so frustrating.

Because we really want our patients to change. We hope to communicate our understanding across to them in a flash - which will induce transformation and bring about healing. We would like our 'somatising' patient to realise that his disagreeable bodily sensations can be dispersed if he can only gain access to the emotions that they represent.

We would like our anxious patients to calm down and conquer their fear. They might do this by reconnecting adult fears with childhood experiences (psychodynamic) or by learning techniques to deal with them such as those of Cognitive Behavioural therapy. We would like them to talk about their sadness, to cry freely in our presence and, eventually, to come to terms with their loss. The lonely should find new and fulfilling relationships or repair old ones. Those whose existence seems bleak and pointless should find meaning at last.

It would be nice, wouldn't it? And sometimes it really does happen. But not all that often and probably not entirely due to our therapeutic efforts. More often, it is the doctor, not the patient who changes. As we relax in the nurturing environment of the group we find our empathy for the patient beginning to flower. And with empathy comes greater tolerance. Perhaps this patient is not so bad after all. I quite like her in a funny sort of way. When we see her again we are more prepared to give her room to just be herself (much as the group does for us). As we listen to those vague accounts of 'giddiness' or tingling feet or stabbing pains in all sorts of places, we are less inclined to dismiss them as 'psychosomatic' and more likely to think: I've had those too and they are not nice. We are in a better frame of mind to experience what Carl Edvard Rudebeck has called 'bodily empathy'. The patient may well appreciate this sharing of her bodily experience. But where do we go next? Some patients seem unreasonably eager to run to specialists for reassurance. This can be irritating to the doctor and even hurtful to her feelings. She has prescribed the best treatment, including generous doses of the drug 'doctor', but the patient is still unsatisfied. He remains unconvinced that his symptoms are harmless. Again, Carl Edvard Rudebeck can be helpful. He points out that a symptom involving any organ or part of the body can seem like a terrible threat to continuing bodily function. Tingling in the feet may suggest to an elderly patient that he is going to lose the ability to walk; those stabbing eye pains which we know are harmless (through our disease based education) seem like the first signs of blindness, giddiness will lead to a stroke and pains in the left side of the chest to heart attack and death. Again bodily empathy comes to the rescue. Have we never had those fears? Never had a strange sensation that won't go away? Never accepted an antibiotic from a fellow doctor, 'just to be on the safe side'? Of course we have. And we have been grateful for the attention of the kindly specialist to whom we have referred ourselves because we don't want to bother our GP over nothing.

So let's not feel too bad about letting our patients go to see a specialist even if we can't justify it in terms of the risk of organic disease. We might even allow them a favourite medicine 'of no proven value'. Hopefully, when our patient no longer has to fight with the doctor, he will relax and allow us to see some of his nicer qualities. We, in return, will feel a greater warmth for this previously tiresome, even dreaded patient.

Maybe he will tell us about his family; about the wife who died, or the son who went abroad and never gets in touch. Another may reveal his disappointed hopes. Nurtured by the doctor's new way of seeing and feeling, a younger patient may start to spread his wings and attempt to fly. Just a short distance to begin with, while we hold our breath. And if he crashes? Or never even takes off? We will be disappointed. But life is difficult and our patients often resemble Chekhovian characters who are high on good intentions but low on achievement. Never mind. We have still been there with them as a friend, as a witness and as a doctor. Relaxation, tolerance and bodily empathy are some of the qualities we can learn from the Balint group that will help our patients.

John Salinsky

Reference:

Rudebeck, Carl Edvard (1999) 'The Doctor the patient and the body' in Proceedings of the 11th International Balint Congress 1998 (ed. J Salinsky) Limited Edition Press, Southport.

The Balint Society Guidelines for Accreditation of Balint Group Leaders (British)

(Adopted by Council December 4th 2008)

The following are intended as guidelines, not prescriptive rules. The intention is to be flexible and encouraging to those who show interest in developing themselves as potential Balint group leaders whilst at the same time indicating a desirable set of standards and encouraging continuing development of leaders.

1. **A leader should be a Member of the Balint Society**

2. **Leaders should have had appropriate basic professional training e.g. General Practitioner, Psychoanalyst, Psychoanalytical Psychotherapist, Nurse or Psychologist.**

3. **Leaders should have had (preferably substantial) prior experience of being in a Balint group as a group member before leading.**

4. **Leaders should have acquired an understanding of the importance of the doctor-patient relationship as the focus of study in Balint groups.**

5. **Leaders should have worked with an accredited leader for a period of time judged to be sufficient by that leader.**

6. **Leaders should arrange adequate supervision (appropriate for their level of experience) for a recommended minimum period of two years – this might be by presenting their group at the Group Leaders' Workshop; by attending residential week-end Workshops for Leadership Training; by supervision with a supervisor who has been recognised by the council of the Balint Society.**

7. **Leaders should demonstrate that:**

- **they understand and maintain appropriate boundaries for Balint group work to be undertaken**
- **they create a safe environment within the group which is conducive to learning and leaves group members free to participate in an individual way**
- **they focus the work on the doctor-patient relationship**
- **they do not direct the group to seek solutions and do not resort to didactic teaching**
- **they have an awareness of group processes and unconscious factors that are likely to affect the task of the group.**

BALINT GROUP LEADERSHIP ACCREDITATION

In order to obtain accreditation as a Balint Group Leader the applicant must provide the council of the Balint Society with evidence that the criteria are satisfied.

1. **The applicant must submit a completed application with details of their experience and training.**

2. **The applicant must provide a reference from an accredited Balint group leader with whom the applicant has led a (preferably on-going) group. The council of the Balint Society may also (or instead) require one of the council's approved supervisors to observe the applicant's leadership skills before confirming suitability for accreditation.**

3. **The applicant should be prepared to submit himself/herself for interview by the accreditation committee (appointed by council).**

4. **Lists of the Balint Society's accredited leaders and recognised Balint group supervisors are available on the society's website or by application to the Secretary of the Balint Society.**

5. **Application forms for accreditation are available from the Secretary of the Balint Society.**

6. **The decision of the council of the Balint Society is final.**

A Case for Balint

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Introduction

Who has a case?" This question is often posed by one of the leaders as the Balint group moves from informal conversation to beginning its work of the day. The historical evolution of the Case Method and how it became related to the Balint group seminar and Problem-Based Learning (PBL) in medical education will be explored in the following paper.[1,2,3,4,5,6,7,8] Next the paper will elaborate the core competencies achieved through the Balint group seminar and their relation to the basic American College of Graduate Medical Education (ACGME) required competencies for all residents. Research distinctively oriented by Balint conceptualization of the doctor-patient relationship will be outlined.

The Case Method

In 1869 Charles William Elliot became president of Harvard. He sought to reorganize the professional schools and breaking precedent, he personally presided at meetings of the medical faculty. By 1871 the medical faculty was ready to undertake a major restructuring of medical education at Harvard. The particulars of that renovation and those reforms that accompanied it at Johns Hopkins University are a significant part of American medical history well documented by Paul Starr in his comprehensive, objective and insightful book, The Social Transformation of American Medicine: the Rise of a Sovereign Profession and the Making of a Vast Industry.[9] Another one of Elliot's early actions in 1870 was to appoint Christopher Columbus Langdell as Professor and dean of the Law School. It is Langdell who is the pioneer of the Case Method and it is that case method, after several iterations that would eventually lead the Harvard Medical School in 1985 to creating its "New Pathway," a case method curriculum, or what is now more generally referred to as the problem based curriculum – Problem Based Learning.

The migration of the Case Method from Harvard's Law School to its Medical School needs to be followed in some detail because it will reveal a phase at which the case method entered the Harvard School of Business and from that point of origin influenced a British social worker by the name of Enid Eichholtz, soon to be Enid Balint. Langdell insisted that students deal only with original cases; therefore, he selected a set of cases and published them with only a brief commentary. Having read those, the students were then interrogated with questions from the instructor about the facts of the case, points at issue, judicial reasoning, and underlying principles. This method of questioning was called the "Socratic method" and it could be abused. Students revolted at this methodology and for a time enrolment dropped. In the past students were simply following a methodology of reading opinions in texts and reciting; they were not confronting the law as an immediate, practiced reality. According to David A. Garvin, Christensen Professor of Business Administration at Harvard Business School, "By 1920 the case method had become the dominant form of legal education. It remains so today."[1] This was very much a hub-and-spoke social process, with little or no dialogue student-to-student and the instructor front and center. There are several pros and cons of this particular case method teaching modality that could be elaborated; however, that would deter us from directly following the evolutionary narrative of the Case Method.

Edwin F. Gay, first Dean of the Harvard Business School, founded in 1908, said that professors would employ an analogous teaching methodology to that used in the Law School. In 1919 the new dean, Wallace P. Donham, a graduate of Harvard Law School, decided that cases in business might admit more than one solution and that they were surrounded by relevant and irrelevant material. Cases were to describe real problems and students were to be left to size up the situation and decide what actions were appropriate. A collection of such business problems constituted the first text in a casebook series published in 1920. Dunham convened a series of informal faculty discussions to explore the school's new method of instruction. In Garvin's words, "These meetings led to a broad commitment to case-method teaching and, in 1921, a formal faculty vote that officially changed the name of the school's approach from the "problem method" to the "case method."1 He established and funded the Bureau of Business Research that from 1922-1925 developed and wrote cases for multiple courses. By 1922 such casebooks had been adopted by 85 institutions. The Harvard faculty published books in 1931, 1953, 1954, 1969, 1981 and 1991 that further disseminated the case-method. According to Garvin, "Today, business schools around the globe teach by the case method."[1] Instructors more often pose general questions to the students and attempt to facilitate inter-student dialogue. At other times faculty may call on students who have expertise because of their country of origin or work experience to provide a helpful perspective in seeing the problem at hand. The hub-and-spoke interaction process no longer applied.

Enid Eichholtz completed graduate training in social work at Bristol University. Organizing the Citizens' Advice Bureau in London led her to contact the Tavistock Institute of Human Relations where she set up the Family Discussion Bureau. This Bureau consisted of a group of social workers from the Family Welfare Association. It was in leading this group of social

workers that Enid was following a case method protocol imported originally from the Harvard School of Business. The main modification in this methodology came with Michael Balint's suggestion that case presentation be given spontaneously and not prepared beforehand in written form. It was experimentation with this methodology for two years from 1948 to 1950 that led Enid and Michael to believe a comparable process would be affecting in working with the cases of general practitioners. Notwithstanding their individual, intimate and ongoing history with the psychoanalytic community, and the GP-groups inception at the Tavistock Clinic/Institute of Human Relations, their method of operation with the GP-group follows the case method protocol developed at Harvard University. An elaboration of this unfolding history can be found in the paper "A History of the Theoretical Roots of the Balint Group of Method."[10] The misconception of the Balint seminar as a disguised form of some variation of psychoanalytic group therapy has for too long cast a shadow over Balint group work and made it appear as something other than the professional, practice oriented, educational methodology that is directing many major universities in their schools of law, business and medicine.

Now, back to the narrative of the case-method in the reorganization of medical education at Harvard. In 1977 Daniel Tosteson became dean of Harvard Medical School. Daniel saw a need for reforming medical education and commissioned several planning groups, the first of which involved Roland Christensen of the business school who was looked on as an expert in the case method and case-teaching seminars. He was joined by Gordon Moore Professor of ambulatory care and prevention, a recent graduate of the Harvard business school's Advance Management Program. Pilot testing for the "New Pathway" began in 1985 and by 1992 it had become the school's sole mode of instruction. This was a curriculum based on the case method. According to Garvin, "A sequence of courses called "Patient-Doctor" spans the first three years; in them, students learn to interview patients, take a history, and conduct physical examinations."[1] The heart of the curriculum is a tutorial, and ungraded discussion group of six or eight students, that will meet three times each week to discuss, analyze and then prepare to study a patient case that has been especially developed for the New Pathway. The students create their own learning agenda and then self-select the areas to pursue through individual study. Students learn to listen carefully to each other in as much as each becomes a teacher and team player in their joint, coordinated case study. The tutors in this process speak infrequently; most often ask short, focused questions and prompt self-reflection and self-directed learning. I have chosen to comment on these aspects of the New Pathway to show the similarity between that methodology and the process of the Balint group seminar: self-selection of a single patient's case as revealed through a direct patient encounter(s) and then assessed by each member of the group from the intellectual, emotional and cultural perspective in which the doctor patient encounter focuses for them.

For Daniel Tosteson the "principal objective of medical schools should be to encourage each student to assume responsibility for his or her own learning."[1] Daniel felt that medicine was "a kind of problem solving." Every doctor patient encounter is "unique in a personal, social, and biologic sense... All these aspects of uniqueness impose on both the physician and patient the need to learn about the always new situation, to find the plan of action that is most likely to improve the health of that particular patient at that particular time."[1] These words of Daniel articulate precisely the ultimate objective of Balint work. Thus, I trust that the reader is led to see the educational structure of the case based curriculum and the Balint group seminar as following a significantly similar methodology and having the same ultimate learning objective.

At Harvard, a pilot study compared a group of randomly chosen students for the New Pathway with those taught in a traditional way. Board scores of both groups were comparable; there were no significant differences in biomedical knowledge. However, "New Pathway graduates reported being more committed to careers in primary care and psychiatry, more comfortable interpersonally, more confident dealing with psychosocial issues, and more likely to display humanistic attitudes." Becal observed that doctors who completed Balint training were better able to work comfortably within realistic limits of family medicine and make more appropriate referrals. He also observed that those doctors were better able to do their work without the interfering influences of their own unresolved psychological issues.[11] Others have shown that residents who completed Balint training were three times more likely to choose family medicine as their specialty were they to be starting their careers over.[12] Some similarities in behavioral outcomes are to be noted between New Pathway medical students and those physicians completing Balint training.

Schools of medicine, law and business are continuing to explore new pathways of introducing experiential activities, cases, that simulate the situations that will be encountered in professional practice, whatever that practice may be. In that sense, one could say that the case method, particularly as it is realized in the Balint process, is the enactment of a doctor patient encounter that has been completed only in one sense. It has been completed in the sense that the patient was seen and patient notes were dictated; however, issues of that case are still alive and felt in the person of the presenting physician. The presenter is now sharing the encounter with the group of other physicians who are asked to consider empathically the case and offer their

perspective on the doctor's dilemma: how they imagine as a physician they would treat this patient and how they see the presenter treating the patient. The knowledge that each participant takes from the encounter is learning to entertain a variety of ways in which to care for this patient: what kind of doctor one could be for this patient. Both patient and doctor are given new depth of character and the role of doctor is more realistically assessed as to what practical, ethical, humanistic or spiritual profile it might or should assume.

Balint and ACGME Competencies

Before reviewing either the Balint (See Table 1)[13] or the ACGME (See Table 2) educational competencies the larger context in which they both occur needs to be illuminated. Here I referred to the university or its graduate education extensions in the many university affiliated residency training programs. It is the thoughts of Alfred North Whitehead preserved in his little book, The Aims of Education, hat need to be considered.

> So far as the mere imparting of information is concerned, no university has had any justification for existence since the popularization of printing in the fifteenth century. The justification for a university is that it preserves the connection between knowledge and the zest of life, by uniting the young and the old in the imaginative consideration of learning. The university imparts information, but it imparts it imaginatively. A university which fails in this respect has no reason for existence. This atmosphere of excitement, arising from imaginative consideration, transforms knowledge. Imagination is not to be divorced from the facts: it is a way of illuminating the facts.[14]

It is this element of imaginative exploration of a patient's problem and of the doctor patient relationship that is explicit in the Balint seminar. Item number two in the list of Balint competencies approaches this idea in stating," divergent thinking leading to novel approaches." I bothered to comment on the imaginative exploration of a problem because so much of modern medicine assigns levels of service by documented number of systems reviewed and best practices recommends treatment protocols to be followed. This is not a profile of an imaginative assessment or treatment process. While aspects of this scientific regimentation of practice are certainly beneficial, they overlook the contextual particularity of the singular doctor patient relationship at that definite moment of encounter. I believe, as Whitehead has indicated, that there is an excitement generated in the Balint seminar because the imaginative element is elicited and supported. Balint work on the doctor-patient relationship is not divorced from the facts of the case, but rather imagining them in a different light.

Several and sometimes many of the elements in the Balint list of educational competencies meaningfully address items 1, 4, 5 and 6 of the ACGME Competencies. ACGME, No.1. (*Compassionate care*) The skill for accomplishing this understanding is empathy.[15,16] Compassionate care follows naturally when the doctor is able to put him/herself in the patient's shoes and develop an imaginative understanding of the patient as a person and the ways this person is experiencing his/her disease, the illness. The skill for accomplishing this understanding is empathy. Empathy is the skill used for understanding the doctor-patient relationship which encompasses how the doctor's connection or relationship to the patient is communicated by the thoughts and feelings that passed between them, be they conscious or unconscious. In this context, empathy is seen as a self reflecting skill which the doctor employs to recognize and decipher their interpersonal communications and to respond accurately and with compassion to his/her patient. We believe this biphasic, empathic process is the underpinning of a therapeutic doctor-patient relationship. No one person more profoundly affected the way in which empathy would be understood, studied, researched, and embodied within and beyond that the medical subculture than Carl Rogers.[17]

Empathy is a vitally important part of Balint work.[18,19,20,21,22] Group members are encouraged to identify and express thoughts and feelings generated by the patient, and then to speculate on the meaning of these. By analogy these forms of communication are seen as the clinical manifestations of the patient's state of mind and ways of interacting with others. Another way in which empathy is conveyed in the Balint process is through the behavior of the leaders. Experienced Balint leaders try to understand the reasons for the residents' trouble with the relationship and use this understanding to cast a new light on the patient as a person and the way this person interacts with others. When this happens, the group members generally develop compassion for the hitherto troubling patient. At other times when reflecting how the mood of the discussion in the group reflects the doctor-patient encounter, the mood of the patient, or the mood of the resident, the leader empathizes with the group.[23]

Finally, it can be noted that empathy builds trust, facilitates the efficient exchange of relevant information which in turn enhances diagnosis, patient education and compliance.[24,25,26] However, what is harder if not impossible to objectify, is the personal care, sincerity, compassion or love, that is conveyed when, at the deepest level, the doctor has expressed simply and clearly the fears and hopes of the patient leaving him or her not alone in their suffering. The physician is in the moment the container of fear and hope, doubt and faith, action and waiting, uncertainty and resolve. This may allow the patient to feel complete and whole in him or

herself in ways that embrace symptoms and penetrate to the core of their being. This might rightly be called the foundation of healing; it most certainly is the foundation of professional treatment and personalized care.[27]

The potency of this self reflective quality and empathy to improve medical care was well presented by Novak, Suchman, Clark, et.al.," Calibrating the Physician, Personal Awareness and Effective Patient Care."[28] The four additions to medical courses they recommended are addressed on a regular basis in each Balint seminar: 1. Physicians' beliefs and attitudes, 2 Physicians' feeling responses in medical care, 3. Challenging clinical situations, and, 4. Physician self-care. The Balint group is the natural, professional setting for cultivating empathy and self reflection leading to personalized, effective and compassionate patient care.

ACGME, No. 4, (*Communications skills*) A Balint group provides its participants the subjective experience of self reflection and self expression from the perspective of being in the professional role of the doctor. A psychologically unmindful doctor is at risk for being cast solely in the role of initiator, leader or director and never as the one acted upon, a subject. Balint group work casts light on how the doctor as subject accepts or defends against the expectations and projections of the patient, family, friends, nurses and professional colleagues.[29] He learns the interpersonal skills of being in a professional relationship and how to communicate this experience in an affective and collaborative (patient centered) way.

It is the subjective dimension of the doctor-patient relationship that is given voice within the Balint group. Within the group the doctor's behavior, feelings and thoughts about him/herself and the patient are articulated in the company of peers where implicitly a range of responses to the patient can be noted. The group can begin to explore the various roles that may characterize the patient and the doctor and then move on to raise the question, "What kind of doctor does this patient need?" The group honors there may be a variety of responses to these questions and attempts only to specify a probable field within which more helpful responses may lie. The Balint group is not to replace other educational efforts to teach about the doctor's role.[30,31,32] It is the necessary subjective, personally focused complement to a medical curriculum that from 1910 has become increasingly objectively and biomedically focused on disease and not the living patient in his or her unique social and cultural setting.

ACGME, No.5, (*Professionalism*) A professional must be committed to carrying out professional responsibilities, adhere to ethical principles and be sensitive to patience of diverse backgrounds. The sociologist Edward Gross further defines a professional as a person who possesses a wide theoretical knowledge and applies it to the solution of current but unstandardized, vital problems. By unstandardized, Gross meant individual cases each with its unique and unexpected features. He said, "... it is this feature more than any other, which creates a dilemma in professional education, for how is one to train a person to become expert in the unstandardized?"[33] It is precisely here were Balint work plays the most important and critical role in medical education and in the evolving role of the physician. It is the interplay of specific patient and doctor personalities (a doctor-patient relationship) on the disease process that is largely responsible for the "unstandardized" case presentation, the illness. In fact the entire purpose of a Balint group's coming together is to study the "unstandardized" relationship between the doctor, the patient and the illness.

ACGME, No. 6. (*Systems based practice*) This competency is asking the resident to demonstrate knowledge, skills, behaviors and attitudes reflective of someone who knows and works in a larger healthcare system that includes many allied health professionals and many community social services. When you consider the second Balint competency you see a clear and direct response to this ACGME competency. However, this second Balint competency includes a systems awareness of, and responsiveness to the more intimate social system of the patient. Since the patient population of family medicine is not categorized by certain disease processes, certain age groups, or certain treatment modalities there is a social system competency that is required in beginning to define more precisely how the physician is to identify and to care for the patient(s). Balint noted in his writing that a mother could present through her child. Since it is common in family medicine for more than one person to be present during an office visit, a question that must be addressed is, "Who is the patient(s)?" When is it appropriate to ask one person of a couple to leave and to return to the exam room? In the case of concurrent visits of grandmother, mother and child how does one address health care or parenting issues? From whom does one take the history(s)? The issue then often arises of the doctor becoming triangulated with one or more of the family members, or been delegated to play a specific role in the family system.[34,35,36] What is the doctor been induced to think, feel or do that isn't being addressed by the family? Still a more subtle kind of triangulation was noted by Balint around the repeat prescription.[37] By this he meant the tolerance of either patient, doctor or both for intimacy had to be titrated with a repeat prescription. In other words, doctor and patient needed some kind of ongoing contact but were able to resolve that need only around the ritual of a return visit for a prescription.

Balint Oriented Research

When Enid Eichholtz established the Family Discussion Bureau at the Tavistock Clinic it was

understood to be an undertaking that involved training with research. This was the prototype for the GP-group that was to follow it. Therefore, it seems to follow naturally that Michael should have labeled this method "training cum research." Those individuals who pursue Balint work certainly support evaluation of patient care practices and the assimilation of scientific findings leading to improve patient outcomes in studies with their own patient population and other patient groups. (ACGME, No.3) They are particularly invested in research that focuses attention on the physician's attitudes, values and personal behavior that lead to improve patient outcomes. In Michael's words, such research proceeds with:

...the recognition of the need for a pharmacology of the most frequently prescribed drug, the doctor. The study of the "apostolic function" is perhaps the most direct way of studying the chief–the therapeutic–effect of this drug.[38]

By apostolic function Balint meant the belief system carried by the doctor of what was right and wrong for patients to expect and to endure, and to convert the unbelieving among his/her patients to this faith.

Balint research then, focus on the doctor and what he or she can continue to learn about behaviors, attitudes and values affecting individual patient care as well as how his/her professional style has led to certain configurations in their practice: weight, diabetic and hypertensive control, immunizations, hospitalizations, emergency room visits, home visits, consultations to whom, number and age of patients seen, patients lost to follow-up, frequency of various diagnostic categories, levels of service, time spent counseling, etc. With any of these variables the question could then be raised, what would be the difference in practice profiles between a Balint trained and non Balint trained physician. Such a study did result in one physician's profiling his own practice before, during and after Balint training.

1. Who are the physicians likely not to benefit from Balint training?[39] 2. Should Balint training be required of all medical students when they begin to see patients? Residents?[40] Fellows? Faculty? 3. What personality attributes characterize those who pursue Balint training?[41,42] 4. What is a sufficient intensity and length of initial Balint training? 5. What amounts of ongoing Balint work is helpful, or necessary, for the continuing education of the graduate family physician? 6. How homogeneous or heterogeneous should a Balint group be? i.e. Participants' number of years in training? Various health-care roles? Various medical specialties?

One cannot close a discussion of research in Balint group work without mentioning two substantive and very different types of studies; both of these resulted in books. One of these books involves both a qualitative and quantitative self-study by a practicing, Pennsylvania general practitioner of his practice from 1956 to 1964, before, during and after his significant three-year involvement in Balint training. This book by Greco and Pittenger is entitled One Man's Practice: Effects of Developing Insight on Doctor-Patient Transactions.[43] The second book is a more extensive, controlled study with discussion and presentation of medical and psychologically related findings by two teams of psychiatrists who, on a randomized basis, observed in their office the practice of eight general practitioners before, during and after their Balint training. Observations began in 1962 and some continued as long as 27 months. These physicians were also asked to evaluate their patient encounters on the same form used by the psychiatrists. This book, by L. Zabarenko, Pittenger and R.N. Zabarenko is entitled Primary Medical Practice: a Psychiatric Evaluation.[44] Both books should be noted because they open the doors to a variety of effective ways in which Balint work can be analyzed and evaluated both objectively and subjectively. Both of these studies grew out of the direct, American consultation of Michael and Enid Balint.

Concluding Comments

Following the historical evolution of the case method of study has revealed a pedagogical taproot which has fed Problem-Based Learning (PBL) in medicine, business and law, as well as the Balint seminar. This method of instruction has taken seriously the need of professionals to experience in as real focus as possible the actual life situation that they will confront on leaving their graduate training. It places their learning in an interactive, social context that is at the heart of their professional functioning and personal adjustment. The Balint seminar preserves the principles of medical science while contextualizing then in an ever changing, personal doctor-patient relationship. The 12 enumerated Balint competencies in Table 1. address many of the ACGME required competencies enumerated in Table 2. The Balint competencies also achieve some goals not conceptualized by the ACGME: securing for the practitioner more comfort interpersonally, competence dealing with psychosocial issues and feeling secure in the choice of a family medicine career.

Health is an evolving field, and medical education often lags behind. By 2020 it is projected that chronic disease will be the leading cause of disability. While treating acute illness was the mainstay of medical care two decades ago, physicians of the future will see fewer acute problems and, instead, will need to manage patients with chronic disease. Yet,

...the dominant mode of medical education remains disease oriented, hospital-based, and intent on cure. This mismatch between the way that medical education is delivered and the reality of medical practice can lead to disillusion doctors and poorly served patients.[45]

We believe that Balint group work significantly addresses this mismatch and offers a direct, timely and clinically relevant approach to caring more effective for the patient, and sparing the resident from future disillusionment as a doctor. The Balint case method seminar offers a contemporaneous, professional, social matrix within which the physician can judge the away in which he or she is to evolve and accommodate to the changing social climate both as a doctor and as a person.

The Balint seminar recognizes the significant place of scientific medicine in treating the ill, and at the same time creates the context in which full self reflection and self expression can occur. When the subjective dimension of medical education and practices is ignored in physician education it will also be ignored in patient care. The art of medicine is finding that fine balance of treatment and caring that best address the disease and the illness each person presents as a patient. This is the meaning of patient centered medicine and the educational objective of the Balint seminar.[46]

Table 1 – Balint Competencies

1. Improves listening skills with both patients and colleagues.
2. Encourages integrative, creative and divergent thinking leading to novel approaches to recurring problems.
3. Encourages empathy; empathetic skills are modeled; residents are able to experience themselves in the place of both the patient and the physician.
4. Improves observation skills.
5. Develops and encourages a repertoire of behaviors that may be therapeutic for a variety of patients.
6. Increases sensitivity to and skill in address psychological aspects of the patient's illness.
7. Improves ability to hear and react to difficult cases of colleagues in a supportive manner.
8. Demonstrates a method for appropriately expressing frustration, pain and joy.
9. Encourages camaraderie and intimacy among group members, thereby enhancing teamwork, communication and mutual support.
10. Encourages self-reflection.
11. Encourages self-evaluation.
12. Improves satisfaction of practicing physicians.

Table 2 – ACGME Competencies

The residency program must require its residents to obtain competence in six areas listed below to the level expected of a new practitioner. Programs must define specific knowledge, behaviors and attitudes required, and provide educational experience as needed in order for their residents to demonstrate the following:

1. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;
2. Medical knowledge about established and evolving biomedical, clinical and cognate sciences, as well as the application of this knowledge to patient care;
3. Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence and improvements in patient care;
4. Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families and other health professionals;
5. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to patients of diverse backgrounds;
6. Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

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A History Of The Theoretical Roots Of The Balint Group Method

Alan H. Johnson, Ph.D.

Introduction

In 2004 this author, together with three of his long-established Balint colleagues, brought to fruition a study that involved the very careful quantitative and qualitative analysis of data generated in meticulously coding and analyzing the characteristic behaviors of 21 experienced Balint group leader (11 family physicians, 6 psychologists, 3 MD psychoanalysts, 1 social worker)[1]. However, the theory(ies) integrating and directing those behaviors was never explored, individually or collectively, with those 21 experienced group leaders. It was, in fact, noted that there were similarities between the behaviors of these Balint group leaders and the behaviors characteristic of other small group leaders.

Three of these authors had extensive graduate training and group laboratory experience in working with and studying small group dynamics. Following our graduate studies we entered careers in medical education through which we began a long, exciting and rewarding engagement with Balint groups. While I had made extensive study of Jungian analysis and did further study and training analysis for over a year at the Jung Institute in Zürich, it was not those analytic studies that I thought best prepared me to listen, observe, assess and intervene in the Balint process. My insights, intuitions, and interpretations were certainly enriched by my analytic studies. However, it was the long hours that I spent in training groups with various leaders from the National Training Laboratory (NTL), the teaching and leading of both undergraduate and graduate courses in group process, and the intense group experiences while training for Gestalt Therapy certification that provided a greater depth of insight and sympathy for small group process.

It was this background that led me to question more carefully the thinking and theoretical orientation of those individuals who had initiated the Balint group movement and who were unto this day leading Balint groups. While the Balint movement is the benefactor of many effective, creative, insightful, generous and supporting leaders, I have limited my study to reviewing the contribution of just two of them: Michael and Enid Balint. It is from their work and writing that I will make inference as to the origins of the theoretical background of the Balint group method. I have also written a short section attempting to orient the development of the Tavistock Clinic within the international scene of group therapy and group theory since it was the home of the GP group—what would come to be called the Balint Group.

Enid's Contribution to the Group Method

Michael Parsons in his introduction to Enid Balint's book, *Before I Was a I: Psychoanalysis and the Imagination* said:

> For almost 30 years she has been developing, both with her husband, Michael Balint and also in her own right, a group method of helping General medical practitioners look at what they do in a new way.[2]

What precisely is this "group method" and what precisely was the cultural, social and institutional ground that supported and shaped its growth? How is it that a woman who says, "I can only work as a psychoanalyst," co- created with another noted psychoanalyst a "group method" when all of their most intense personal analysis and most all of their extensive writing was focused on explaining the unconscious psychological dynamics and development of one person in the hermetically sealed confines of individual psychoanalysis? More interesting still is the question: why is it that the leaders of this "group method" that continues unto to this very day are suggested, if not explicitly required in some countries, to pursue psychoanalytic training or certification in order to facilitate Balint groups? Protracted psychoanalytic therapy, individual case supervision and certification have maintained its intense individual focus with individual analysts, yet its trainee is asked to perform, often with a co-leader, in a group context when facilitating a time contracted Balint group.

The sports analogy that I am drawn to in viewing the present historical situation goes as follows: A baseball pitcher is trained in an elongated racquetball like court to pitch to a single batter against a back stop that collects his pitches. The batter, with no game to win, and minimally interactive, has several swing patterns that very randomly in response to his pitches. When his pitches achieve the ratio of six of ten pitches in the strike zone he is judged proficient. He then is sent to a Class B team and put on the pitcher's mound to play baseball. Now, of course, there is a catcher behind the batter, many different left and right-handed hitters and seven persons around him, three of whom are standing near bases waiting to interact with him and each other at a split second notice. The pitcher's training was task-focused, dyadically contextualized and highly idiosyncratic. The team play is goal focused (incorporating multiple tasks) inter-player, crowd, weather and field contextualized, and highly group process dependent. I draw the sports analogy to highlight my historically focused question: whence cometh the "group method" of Balint work? Though highly skilled in

accurately throwing the baseball, the pitcher, so trained, seems a most unlikely person to anticipate or conceptualize how the team is to play, facilitate that team play, shape interpersonal exchanges or concurrently spark the individual play of each of its members.

The Historical Search Begins

In exploring the question of the origins of "group method" in Balint work I was first drawn to Enid Balint's role in the evolving history of the Balint movement. One simple piece of chronological information first caught my attention: Michael Balint dates, 12/3/1896–12/31/1970 and Enid Balint dates, 12/12/1903–7/30/1994. For almost a quarter of a century after Michael's death Enid became the exclusive Balint spokesperson who explicitly or by implication through writing, supervising or consulting with leaders and groups on at least three continents defined what the "group method" would come to mean. More than twenty years before Michael's death, they had theorized, experimented, consulted, taught, tested and wrote about that "group method."

Enid Flora Albu was born in London and completed her secondary school education at Cheltenham Ladies College. Her baccalaureate degree of science in economics was awarded by London University. She next completed training in social work at Bristol University. During that time she was a pupil of philologist David Eichholtz whom she later married in 1926 and with whom she had two daughters. They divorced in 1952. In June 1948 she began her training at the British Psychoanalytic Society and qualified in January 1954. In 1953 Enid would marry Michael Balint and continued with him to pursue a lifelong career of working with General Practitioners even after Michael's death in 1970. Enid then married a third time to the diplomat, Robin Edmonds.

Parsons seems to feel that Enid's appreciation of the irrational aspects of human relationship began for her when organizing the Citizens' Advice Bureau in London where she was helping families whose homes had been bombed. "This led to contact with the Tavistock Institute of Human Relations, and there she set up the Family Discussion Bureau." The Family Discussion Bureau was composed of a group of social workers from the Family Welfare Association. Its inception in 1948 at the Tavistock Institute was to provide a facility for those who sought help with their own marital problems and for professional workers to study the development of techniques for dealing with these problems. Enid Eichholtz was the leader of this group of social workers. It is interesting to note that we see here the prefiguring of training with research that was to characterize the GP groups.

In leading this group of social workers, Enid, was following a casework method imported originally from the Harvard School of Business. This casework method had been pioneered by Harvard in the 1920s and began as a way to incorporate vignettes of the real business world into the classroom. One such vignette would constitute the focal point of the group's work. Under the skillful guidance of a faculty member a group of eight or nine students worked together to analyze and synthesized conflicting data and points of view, as well as to define and prioritize goals, and also to persuade and inspire others who thought differently. Members of this group worked together for their entire first year on a rich variety of such real life vignettes.

> Every student is also a teacher. A great part of what students learn at HBS comes from listening to the dozens of contrasting analyses, opinions, and perspectives of their sectionmates, a constellation of exceptionally talented people from an extraordinary range of personal and professional backgrounds.[3]

At Harvard today a wide variety of teaching methodologies are in use; however, "...more than 80% of HBS classes are built on the case method."[4] I think it's important at this point to note what a significant role listening, synthesizing, persuading and inspiring played in the casework method. One could say that empathic engagement is not the exclusive property or prerogative of a psychotherapist. A second historical corollary should also be noted here, and that is that much of the incorporation of experiential group learning, and teaching, in the United States took place within, and was supported by, schools of business in many of the larger universities.

Enid felt the need for further assistance with this group and so requested the help of a psychoanalyst from the Tavistock clinic. Michael Balint was assigned to work with her. "Together they developed the 'case discussion seminar' which became the vehicle for the basic psychological training in this and other disciplines."[5] One of Michael's chief contributions to this evolving group process was to require case presentations to be made spontaneously. This would be following the format that had been used in the Budapest school of case supervision. Michael's other influence in this process focused on having the group pay particular attention to the counter-transference between the client and the caseworker.[6]

In October of 1984 at the sixth International Balint Conference in Montreux, Enid presented a paper on "Research, Changes, and Development in Balint Groups." This paper was first published in 1987 in the book *While I'm Here Doctor*,[7] and later, in 1993, in her last book, *Before I Was I*. In this paper she recounts how her work with Michael began and the changes she perceived that had transpired 15 years after his death and 35 years after their work began. I will excerpt a series of passages that best seem to characterize the developmental process of this Balint group method.

> In 1949 Michael Balint led a group of nonmedical professional workers at the

Tavistock Clinic – a mixed group I had started in 1948 with the aim of trying to understand and work with people with marital difficulties. We then decided to start working with General practitioners using the same techniques we had developed during the previous work.

Our method of work and our research method were stable and consisted of discussion, in a structured setting, of a doctor's difficulties with a patient, one particular relationship at one particular time. The same leader, the same doctors, discussed patients together in the same place over a longish period. Verbatim transcripts were made of each meeting.

We found the use of the doctor's own notes distracting during the discussion itself, and we soon adopted a method based on the method of the supervision used by Hungarian psychoanalysts. This was to engage students to speak freely without notes, contradict themselves if necessary, have second thoughts, remember things they thought they had forgotten; so that a complete picture emerged in which the feelings of the doctor himself were evident alongside the facts he was reporting.

Hunches, fantasies, and feelings should be expressed without embarrassment but not treated as sacred. The work of the group and of the doctor in charge of the patient is to see if what is said is true – to examine on what such fantasies and hunches are based – so that the doctor can, if appropriate, change his ideas about his patient. This is all done in a stable setting, and each doctor gets accustomed to looking at his and his colleagues' work, with the same strictness and freedom.

We still make a working diagnosis, but we are now more observant of changes, however minute, which take place in the doctor-patient relationship, as shown in the doctor's feelings about his patients and in the patients' complaints – even changes which take place during one consultation.

I now often think it is unnecessary and can be unhelpful at any given time to try to discover what a patient thinks is the cause of his presence symptom or unhappiness. In general practice work with patient's feelings in the present, and the changes in them seem more important and more reliable.

The value of Balint groups is to facilitate observations. When did we begin to observe the changes in our focus of interest, changes in the techniques we were trying to devise for general practitioners? It is difficult to say, but a new appraisal started in January 1966, when a research team consisting of ten general practitioners and two, sometimes three, psychoanalytic leaders met at University College Hospital under the leadership of Michael Balint and myself. The group ended in 1971, a year after Michael Balint died. A book, *Six Minutes for the Patient* based on the research in the group, was published in 1973. The new techniques that we were aiming at had to be based on a reliable understanding of the patient's individuality and particularly of the developing relationship between the patient and the doctor, that is to say, on processes rather than states. ... in the new technique the therapist's role was to tune in to the patient and to see what it was like both for himself and for the patient and what changes occurred and how varied and inconsistent his feelings and the stories that he got were. The need here to identify and then withdraw from the identification is paramount. The technique which arose out of these ideas was called the 'flash' and consisted of a moment of mutual understanding between a doctor and his patient which was communicated by the doctor to his patient. It was not an understanding about the patient's past about which the doctor was very likely completely aware, but was usually about something in the patient's current life and which was reflected in the relationship with the doctor for a brief time.

We are now more concerned with making observations about changes that take place in a doctor's feelings about his patient and a patient's feeling about his doctor, changes which are not communicated at the time by the doctor to the patient. This is crucial.

In the flash technique, when a flash occurred the doctor communicated his thoughts and feelings to the patient. Nowadays we prefer to wait and see what happens to a patient when a doctor's feelings change – sometimes suddenly–about him.[8]

This extensive quotation of Enid's own words provides, in part, her historical perspective on the developmental of the group method that characterized her work and Michael's with GP groups. She notes the origin of the work in the Family Discussion Bureau and the importance of the continuity of the GP group meeting over a "longish period," which was about two years. The importance of spontaneous presentations is recognized with the complete freedom for the expression of a variety of fantasies as well as the need then to review those hunches and assess their credibility. Dealing in the here and now with the feelings of both doctor and patient, and observing the changes in those feelings, even if minute, is clearly recognized. It is the monitoring of the process of the relationship and not just noting states that is most important. Enid uses the word 'paramount' to emphasize the importance of the doctor learning to identify and then withdraw from the patient. The "flash" technique is discussed as it was first considered, and then later modified. Just how formative the casework method, imported from the Harvard Business School, was in stylizing the overall GP group method is hard to assess. Enid's long-standing

and close relationship with Rickman and other members of the Tavistock Institute of Human Relations must have had significant influence which cannot be overlooked. I will return later to reflect further on these and related issues.

Michael's Contribution to the Group Method

Early History

Mihály Bergsmann was the first of two children born to an orthodox, Jewish, general practitioner on December the third, 1896, in Josefstadt, Budapest, a German speaking, largely Jewish quarter in Pest. His sister, Emmi, followed a year and a half later. Balint, as did many of his Jewish middle-class compatriots, converted to Unitarianism and changed his name. Lavinia Gomez in her book, *An Introduction to Objective Relations* said "...taken together they present a clear rebuff to his familial traditions," though not unusual in his social context.[9] By 1914 Michael began studying medicine at the Semmelweiss University of Budapest. Shortly thereafter, he was called to the Army and during the First Full War served in Russia and later in Italy where in 1916 a hand injury brought him home. Even with this interruption he was able to complete his studies and qualified in medicine by 1918.

Michael became close friends with Alice Székely-Kovács after meeting at a seminar on Freud. Their families were known to each other and Alice's mother was a psychoanalyst. Gomez comments, "... Balint seems to have fallen in love with Alice and psychoanalysis simultaneously."[10] Shortly after qualifying in medicine, Michael and Alice married. Michael's interests as a student were biochemistry and psychoanalysis. They began attending lectures of Sandor Ferenczi (1873-1933), who in 1919 became the world's first university professor of psychoanalysis. The preceding year at the Congress of analyst in Budapest, Ferenczi had been elected president of the International Psychoanalytic Association.

Ferenczi was to have a profound and long-lasting effect on Michael's life. In fact, Michael was to become his literary executor.[11] A Hungarian School of Psychoanalysis developed in Budapest between the two world wars and would constitute a rich cultural and professional context in which Michael's and Alice's life would further develop. Ferenczi was the heart of that school. Paul Roazen said that, "Many consider Ferenczi to have been the warmest, most human, most sensitive of the early psychoanalytic group."[12] In a letter to Alice's sister, Michael admitted that he neglected his father for a long time. "We never got along too well. We were never really on good terms. But I inherited my intelligence, my logical mind, my capacity for work from him."[13] These words convey a sense of honoring his father, but at a distance. In Gomez's words, "Ferenczi seems to have been Balint's good father, and perhaps his work with the medical profession brought his two fathers, both general practitioners, together in his mind."[14] According to Haynal, "Ferenczi's work was brought to fulfillment by Balint, who was not so much his pupil as his successor."[15]

By 1919, with changes in government, Balint's future seemed more uncertain in Budapest so he and Alice moved to Berlin. There Michael's work was divided between the biochemical laboratory of Otto Warburg and the Berlin Institute of Psychoanalysis where he conducted psychoanalytic treatments, and began in 1922, together with Alice, personal analysis with Hans Sachs. In 1924, after completing his Ph.D. in biochemistry at the University of Berlin, they decided to return to Budapest. According to Gomez they found Sachs "... dogmatic and domineering, and returned to Budapest to train with Ferenczi."[16] According to Harold Stewart, author of *Michael Balint, Object Relations Pure and Applied*, Michael also saw psychosomatic patients at the Berlin Charite Hospital. "This made him one of the first people treating psychosomatic disorders by psychoanalysis."[17]

Both Michael and Alice, on their return to Budapest, began analysis with Ferenczi which continued for two years until it was interrupted by Ferenczi's eight month visit to New York. Somewhere around 1926 Michael's professional identity made a decided shift to psychoanalysis.[18] Papers that he wrote, that Alice wrote and that they wrote together centered on psychoanalytic topics, and none of these dealt with group process or group therapy. Michael became a member of the Hungarian Psychoanalytic Society and helped in 1930 to establish the Psychoanalytic Outpatient Clinic in Budapest. He became vice-director of the Budapest Psychoanalytic Institute from 1931 to 1935 and from 1935 to 1939 its director.

In Stewart's words, "In 1932, the Hungarian government came to resemble a racist, pro-Hitler state...."[19] If Michael was to reach out to general practitioners it seemed unlikely that any institution could offer him a place for testing his ideas. So Michael took the initiative, and in his words of retrospect, this is what followed.

> ... I decided to gather a few general practitioners in a kind of seminar for the study of psychotherapeutic possibilities in their practice. Although I had only vague ideas of what was needed by my colleagues – e.g. I started the seminar with a series of lectures, which I know now are quite useless – the interest remained alive and even a second group was formed. However, the political situation deteriorated further... a plain-clothes policemen attended each of [the meetings] taking copious notes. No proper discussion could develop under these circumstances and the group of doctors disintegrated eventually.[20]

Here we see the beginnings of what might be called a Balint group; however, it resembled more nearly a Balint lecture assembly with guarded discussion. On a lighter note, Michael noted that it was amusing to those assembled to find that the recorders of their meeting would approach them individually after the meeting with

medical questions concerning their wife or children. "Psychotherapeutic possibilities in their practice" is several steps removed from helping GPs to appreciate their counter-transference with the patient. This is a learning objective for the Balint group that will arise only in another decade.

In 1939 with the help of Ernest Jones and John Rickman (Jones had done analysis with Ferenczi, as had Melanie Klein) Michael, Alice and their son John emigrated to Manchester, England. In August of that same year, Alice, then just 40 years old, died suddenly due to a ruptured aortic aneurysm. Michael obtained his British credentials to practice medicine. As well, he pursued a postgraduate Master of Science degree which he received from the University of Manchester in 1945. His thesis was on "Individual Differences in Early Infancy," a study of infants feeding rhythms. According to Stewart Michael was appointed consultant psychiatrist to the Manchester Northern Royal Hospital and Director of two Child guidance clinics: North East Lancashire and County Borough of Preston Child Guidance Clinics. In 1945 Michael would move to London and there he was appointed director of Chislehurst Child Guidance Clinic from 1945 to 1947. Just before moving to London, Michael married his second wife, Edna Oakeshott, a young, divorced mother of three children. She had a Ph.D. and taught as an assistant in Pedagogy at the University of Manchester. They separated two years later; however, they did not divorce until 1952. In 1947 Michael became a British citizen.

I have detailed many of the particulars of Michael's professional, educational development and clinical activities to this point to illustrate the fact that he had little, or no exposure, up to this time, to group psychotherapy or clinic experiences that varied from the traditional, one-on-one doctor patient relationship. His psychoanalytic training and practice, particularly given the strong emphasis to counter transference that was integral to the Budapest school, alerted him to the ever-present dimensions of transference and counter transference in the doctor patient relationship. He had not as yet developed an educational strategy for conveying those insights to the general practitioner. His strong desire to see beyond theory to method and application to achieve that educational goal with general practitioners was soon to be realized in a new setting.

Modern History

French, biographer, Michelle Moreau Ricaud, portrays Michael's arrival in London as a kind of professional homecoming, a return from the remote, English countryside.[21] In her words:

> His life in London, his "modern history," in his own words, was a success. His application to a post of consultant at the Tavistock clinic was accepted in 1949. He first attended seminars on group therapy led by John Rickman and his analysand, Wilfred Bion, who taught Balint about group process. He then responded to the request of Enid Albu Eichholtz to be involved in the training of social workers who were under tremendous pressure in the postwar period. The casework seminars, which Balint conducted with Enid served as a basis for the future training seminars for doctors–"The Balint Groups"–which made him famous all over the world.[22]

Ms Eichholtz will become the future Mrs. Balint. Her history we have explored earlier in this paper. Before accepting his position at the Tavistock clinic Michael had been commissioned by the British Society of Psychoanalysis to go to Hungary in 1948 to get in touch with surviving analysts. It was at that time he learned the particulars surrounding the 1945 suicide of his mother and father in attempting to escape deportation by the Nazis.

Moreau Ricaud goes on in these words to further characterize the Balint group:

> In London, Balint took up his reflections again within the National Health Service treatment program, using the teaching he had received from Rickman, Bion, and Enid Albu. With a group of general practitioners he implemented genuine medical research, together with medical training. He named his method "training cum research", before the French simply renamed it as the Balint groups.
>
> The aim of the group work, which was modest, was to bring about a change in the personality of the practitioner, in a group climate of trust and freedom.[23]

In 1965, Michael, then 69, gave an extensive interview to Dr. Bluma Swerdloff, the transcript of which was published by the *American Journal of Psychoanalysis*.[24] In this interview he reflects upon his early encounter with group theory on entering the Tavistock clinic. I quote him in detail to note the somewhat circumspect perspective he takes on the relevance of group process to what he hopes to accomplish in group work. It is difficult to discern from his interview how his critical evaluation of the group therapy process with psychoanalytic candidate may have applied to his theorizing and work with GP groups.

> MB: First I look around me and I wanted to learn something about groups. I heard Bion talk about it, and I said, "This is something I must learn." So, I went and learned it. During the whole time, I did my analytic work in addition to it. Then there was this great problem of what to do with young psychiatrists who were interested in dynamic psychology but couldn't afford analysis. All sorts of ideas were brought up. One idea was: "We can put them into groups and let them experience something like group therapy sessions, *à la* analysis." If the candidate wants to learn analysis, he must have analysis, this

is somewhat cheaper, let's have a look at it. It went on for some time. I had my doubts about it, whether it was alright, but I accepted it. There were, I think, three such training groups; we explored the idea but then it was finished.

Q: It didn't work.

MB: It proved to be absolutely untenable, it was insincere and impossible. The people who were in the group were colleagues, not only at that moment, but would remain colleagues who would know each other all of their lives. It is an impossibility to expect that they should talk to each other honestly about their personal problems.[25]

In Michael's 1957 edition of *The Doctor, hIs Patient and the Illness*,[26] and in further additions, no references are made to the work of Bion or Rickman. In the 1993 edition of *The Doctor, the Patient And the Group: Balint Revisited*[27] there is still no mention of Bion or Rickman.; none of their works are listed in the bibliography. The aim of this book was to see what developments had occurred in Balint work since its inception in 1950. Enid noted they had no difficulty in discussing the doctor-patient relationships but, "... we had more difficulty in discussing the theoretical developments or the usefulness of different ideas about research."[28] Enid next observed that presently few psychoanalysts work with general practitioners in the field. "If psychoanalysts are involved in such work it is not their theory that helps but their ways of looking at patients and listening to them."[29] Finding, little or no incorporation of group theory and dynamics in the literature about the developments of the Balint "group method" leaves me questioning precisely what was, or is, the theoretical foundation of the Balint group method. Just how much of Michael's and Enid's thinking, theorizing and experimenting with the GP group was influenced by the staff and programs of the Tavistock Clinic and the Tavistock Institute of Human Relations? Much of medicine proceeds empirically, and so it would seem with the Balint group method.

Appendix I of *The Doctor, his Patient and the Illness*, "... is intended in the first instance for psychiatrists who may consider undertaking the training of general practitioners or students in the field of medicine– and not primarily for general practitioners." Herein Michael outlines, within 15 pages, some of the parameters for the Balint group, characteristics of its leaders and learning objectives. When comparing the GP group to other training schemes he introduces the idea of a three tiered-structure. (Figure 1) In working with the Family Discussion Bureau he identifies the first tier involving the worker and client relationship, the second tier involving the client and partner relationship, and the third tier involving the worker and group relationship. Michael sees a comparable three-tier system describing the work in the GP group. However, he notes that in the case of the Family Discussion Bureau the client is dealing with an external object, the partner," essentially libidinal relations to objects of love and hate." In the GP group the patient is essentially not dealing with an external object, but rather an illness. It is in this area of the patient's relationship to his or her illness that Michael felt more research was necessary. He also felt that this was the reason "our interpretations have hitherto been more limited and less detailed then in either of the other training schemes." I will return in discussion to further reflections on this three-tiered system.

Michael felt that it was important that the group leader "merge as far as possible into the group," and also that he avoid "allowing the group to develop into an openly therapeutic venture." The caveat is also articulated that the group should not be allowed to degenerate into a mutual admiration society. He saw the attitude of the group leader as the "most important factor" in the development of the group.

> By allowing everybody to be themselves, to have their say in their own way and in their own time, by watching for proper cues – that is, speaking only when something is really expected from him and making his point in a form which, instead of prescribing the right way, opens up possibilities for the doctors to discover by themselves some right way of dealing with the patient's problem – the leader can demonstrate in the "here and now" situation what he wants to teach.[30]

As an objective of learning he felt the physician needed to understand that "listening" is something very different from "history-taking." The often quoted phrase "limited, though considerable, change in the doctor's personality" is a learning objective which Michael considers essential. However, he notes that while this cardinal learning object is equally true for the psychoanalyst, the protocol for achieving it has not been clearly established and the rather expensive principle in psychoanalysis has been followed that "the more, the safer." He does, however, recognize three components of training that have characterized the psychoanalytic as well as the Jungian school: personal analysis, theoretical courses, and practical work under supervision. Weekly meetings of groups of about eight in an "emotionally free and friendly atmosphere" for several years constitute the basic structure of the GP group.

Group Psychotherapy, Group Theory and the Tavistock Clinic

The founders of modern group psychotherapy were doctors of medicine. Today the majority of group psychotherapists are not doctors of medicine; they are psychologists, sociologists, social workers, nurses, educators, ministers and others. A similar transformation has taken place in the leadership of Balint groups throughout the international community.

"Group psychotherapy as an organized social movement originated in the USA in

1931."[31] This movement came about as the result of the dynamic leadership of a Viennese psychiatrist, J. L. Moreno who came to the United States in 1925. His book, The *Application of the Group Method to Classification* was the first book on group psychotherapy and it was the first time that the term "group therapy" and "group psychotherapy" were put into circulation. It was not until the end of the Second World War that Moreno was invited to the Tavistock Clinic in London for a stay of several months to introduce the new methods of group psychotherapy. S. H. Foulkes and Maxwell Jones are only two of the list of British group psychotherapists who attended psychodrama and sociodrama sessions at the Psychodramatic Institute in New York which opened in 1942. They were two of the most significant early representative of the new group psychotherapeutic movement in England. It was H. Ezriel and J. Sutherland of the Tavistock Clinic who came closer to Moreno's position by interpreting every group session as taking place in the here-and-now. They abandoned the reference to traumatic experiences in the past.[32] We might note that Michael in his 1957 book, *The Doctor, his Patient and the Illness*, twice makes a reference in the first appendix on "Training" to the GP group leader or training analyst working in the "here-and-now."[33]

The Tavistock clinic, founded in 1920, focused efforts in its first 12 years on introducing psychotherapeutic methods in treating patients with neurotic and allied health problems. By 1932 the staff began to devote more attention to the psychological education of allied health and service professionals. Gradually the clinic staff and the staff of a newly founded, affiliated organization, The Tavistock Institute of Human Relations, became interested in develop training groups that would study natural groups such as couples and families.[34] The intellectual roots of the Tavistock Group Relations approach are found in the psychoanalytically based work of W.R. Bion who applied some of Melanie Klein's ideas about the infant-mother relationship to the behaviour of adults in groups.[35] The underlying presupposition is that certain fundamental human behaviors may be examined and will emerge in an environment where safety is assured, boundaries are clearly identified and the group leader behaves in a manner that is work relevant but "socially deviant." "That is, expectations that the authority will provide direction or will satisfy individuals' wishes for emotional gratification are not met."[36] By way of analogy to the Balint group, one would note that the leader or co-leaders do not outline the way in which the presenting physician should present or relate to his or her patient and, in fact, move the group discussion away from suggesting behavioral prescription to the presenter. The first Tavistock group conference, involving psychoanalyst, social psychologist, and social systems theorists, was held in 1957 at the University of Leicester. This remains an ongoing, international site of Tavistock group relations training and study.[37]

> The Tavistock laboratory method is oriented to learning about the significance of group and social structure and the ways in which individuals are called upon to fill roles for groups in the absence of a clear, task of relevant division of labor.[38]

In the United States, as well, the need to understand, to study, to effectively utilize and to further develop groups led to the formation of a variety of training sites. The T- Group (training group) originated at the National Training Laboratory In Group Development held in Bethel, Maine, in 1947. Industrial sociology in part prompted by Western Electric research, the development of psychoanalytic theory from Freud's treatment of anxious, middle-class folks and group therapy arising from the need to treat combat tension seen in many veterans are just a few of the instances of theory interdigitating with real-life experiences that have led to more extensive in-depth study of groups. I very much concur with Bradford, Gibb and Benne in this thought about the relation of T-groups and therapy groups:

> ...if, in an attempt to theorize about the nature of T-Groups, we rely too heavily on conceptions from standard social science literature, we shall bog down into a debate as to whether the T Group is a therapy group –that is, dealing with the reorganization of the personality – or a training group which is concerned with the reorganization of a role. Out of this dilemma developed two general approaches to groups: groups which are psychoanalytic oriented and have as their main goal the reconstitution of interpersonal behaviors; and training groups which have as their main goal learning about group behavior. Actually the T Group by its very nature must involve both relevant personality and roll relationships. Attention by the trainer to one, to the exclusion of the other, will limit richness of the group experience. Conceivably, a therapy group of Dr. Bion's at Tavistock, in London, might not differ very much from a T-Group at Bethel.[39]

I take this opportunity while exploring the roots of the Balint group, hopefully to elucidate historically present themes that perennially re-occurring in medical education's attempt to assess the merits of Balint groups. For medical educators persistently to seek out a "subjective free" or "therapy free" educational experience, or to advocate strongly for it, is to miss the heart of the issue. At issue is: the education of a physician or the education of a biomedical technician. Are they willing to recognize the potency of Doctor as teacher, counselor, confessor, healer, drug? Are they willing to recognize all of the emotional turmoil experienced by a physician that generates, either consciously or unconsciously, his or her counter-transference? Can they naïvely continued to think that to advocate strongly for the assumption of a "professional role" does not

implicate a change in personality or that a change in personality does not implicate a change in professional role? All of these questions, and more, were, and are present at the inception of the Balint "group method." It is a limited, though considerable, change in the doctor's personality and role that is being pursued. This is not just the acquisition of theoretical knowledge; it is the incorporation of a personal skill.[40]

Robert Gosling, psychoanalyst and former director of the Tavistock clinic, was an early colleague of Michael.[41] Gosling worked with him in developing the general practitioners' group. This is how Robert described the Tavistock Clinic at the time of Michael's arrival. He said the clinic had three principal preoccupations:

1. A devotion to the furtherance of psychoanalysis and its social effectiveness
2. Providing postgraduate courses to a variety of mental health workers
3. Excitement about groups and their possible uses[42]

While there may have been excitement at the Tavistock Clinic concerning new uses for groups, theorizing about their processes, and structured workshops for experimentation with groups, Michael didn't seem overly interested. In Gosling's words, "He was not much interested in the topic of group dynamics as such; he was simply an adept practitioner!" About his style of leadership Gosling said this:

> His approach to this new task [GP Seminars] was more that of an adventurer or sportsmen than a classroom teacher; the atmosphere he created was nearer to that of a mountaineer's bivouac or a tennis court than to that of a lecture theater; he expected people to exert themselves and go home feeling stretched and stimulated. He was an attractive man: highly intelligent, vigorous, enthusiastic, challenging and provocative. Counter-dependency was his preferred stance.... He enjoyed being a stimulant to growth, even an irritant.
>
> Although early in the life of a seminar there was always a compulsion to keep the proceedings in line with the decorum and insincerity usual in such professional meetings, what gradually developed was much more of a rough and tumble. At times one might become alarmed at the amount of turmoil Balint's leadership encouraged, but he was once heard to say, Don't worry. To be a GP you have to be as tough as old boots![44]

There was, however, a mitigating influence to this "rough and tumble" in the GP seminars; and that was the presence of Enid Eichholtz. Before beginning the GP seminars, Enid Eichholtz, née Albu had asked the Tavistock Clinic for help with the Family Discussion Bureau. Michael was assigned to join her in her work with this professional group addressing marital difficulties.

It seems important here to clarifying the fact that the GP seminars at the Tavistock clinic were not identified as "Balint Groups." At the Tavistock clinic those people assembled to be leaders of groups for GPs, clergy, children's home staff, health visitors or lawyers had to be psychoanalyst and they formed a group called "GP and Allied Professional Workshop." I quote now Antonia Shooter a clinical psychologist and psychoanalyst who was one of the early group leaders of a GP seminar. "The term Balint Group was not used at the Tavistock, because the work was felt to derive from the ideas of Bion and from a group of colleagues using the Tavistock Group Relations Approach."[45] She then goes on to say, "Nor did any psychoanalysts join the Balint Society when it first started [1969]. It was felt that there should not be a personal 'brand name' of one doctor."[46] Shooter was required, as part of her training to observe for two years the process of the GP seminar. Discussions followed those periods of observing the seminar process. After those two years, Shooter went on to co-lead GP seminars with other qualified GP leaders.

Dr. Hendrik Ruitenbeek writing in 1970 about the new group therapies asserts that the older concepts of transference and counter-transference are no longer adequate to describe the subtleties of human communication. He feels that this insight has become apparent even to psychoanalysts. As well he notes the passing of the relatively neutral position of the analyst and the noninvolvement of the group analyst. In what way those changes may have mitigated the strong psychoanalytic orientation of the group work going on in the Tavistock clinic is hard to know, and equally hard to assess is just to what extent those changes in the new group psychotherapies affected group process within the GP seminars. For Ruitenbeek the "... new group psychotherapies see their heritage more in the line and history of the desire for human encounter rather than the invention of one person."[47]

This need for encounter he sees arising from an increasing sense of alienation and estrangement among people living in large cities. "This loss of a sense of community and the absence of meaningful social activities probably has contributed to the desire to participate in the groups...."[48] For Europeans we would also add the major social upheavals of two world wars within 20 years of each other leading to the physical as well as the social destruction and estrangement within nations, cities, and towns. It is within this social and cultural setting that GP groups began their work with physicians, suffering under the same conditions they were attempting to address in their patients. This particular group of physicians was, as well, in many ways the "outcast" of their medical subculture and had to function in isolated pockets away from the "hospital health club" that other specialized physicians enjoyed.

It would be well for us to remember these social and cultural dimensions when attempting

to understand the many factors that influenced the group method of early Balint work. It would seem that 'groups' became a place and a way in which identity, personal and/or professional was reflected upon by the person and the group with sufficient longevity and consistency until self-acceptance and group- acceptance came to some mutual accommodation. The need for establishing community, both personal and professional was accomplished around a case discussion in which all had equal status and equal authority. Similar personal and professional needs of affirming identity and community affiliation still exist today; they are dynamic, living processes which can only be realized and sustained in the group.

Discussion

In an inquiring way, I have reviewed the career developments, publications and interviews of Michael and Enid Balint, attempting to identify the persons, experiences, institutional affiliations and social currents that led them to the development of the case conference group method which characterized the GP Group or, what was to become known as the Balint group. From 1926 to his death in 1970 Michael Balint was a practicing psychoanalyst who took on administrative roles, research and writing responsibilities and positions of leadership both as officer and training analyst in the Hungarian and British psychoanalytic societies In 1954 Enid completed her training as a psychoanalyst and in 1963 became a training analyst in the British Psycho-Analytical Society. From 1950 until her death in 1994 she, together with Michael, pursued the training of general practitioners in England as well as traveling to lecture and give demonstrations in Europe and in the United States. In 1961 Michael retired from the Tavistock Clinic, having reached the age of 65. He immediately joined the staff of the University College Hospital and began case discussion groups for medical students. He continued with his GP groups and student groups until his death. From 1968 until his death he served as president of the British Psycho-Analytical Society.

In 1969 the general practitioners of the British Balint Groups founded the British Balint Society for advancement of this work. The Society then hosted in 1972 an International Congress in London. The success of this Congress lead to a second International Congress in Brussels in 1974. By 1975 the Balint societies of France, Belgium, Italy and Great Britain founded the International Balint Federation. "The aims of the Federation were (and are) to foster and encourage the continuation and growth of talent work around the world."[49] As of 2002 there were 19 national affiliates in the Federation and Balint activities in perhaps another dozen countries. So what had begun as casework conferences created groups, and several of these groups were the seeds for a professional society that would first become a national organization, and finally an international federation. It would seem that something more than professional development was at work in the conceptualization, creation and support of this evolving, international community wherein personal as well as professional identity was being nurtured and reformed.

In 1980 in recognition of Enid's work with general practitioners she was made an honorary fellow of the Royal College of General Practitioners. Together Michael and Enid were practicing psychoanalyst and devoted advocates for the psychoanalytic training of General practitioners. In fact, they will write together in 1961 a book, *Psychotherapeutic Techniques in Medicine*.[50] Nowhere in it, however, are their references to Bion or Rickman and only one comment mentions Rickman's name. There is no elaboration of their group work with general practitioners. In the opening chapter they make a very insightful observation about the results of group methods.

> Perhaps one might be justified in saying that after a successful psycho-analytic treatment a patient is definitely less neurotic (or psychotic) but perhaps not necessarily really mature; on the other hand, after a successful treatment by group methods the patient is not necessarily less neurotic but inevitably more mature.[51]

This quote leaves me with the question: did Michael and Enid intend that the GP groups should primarily reduce personal anxiety or primarily promote professional maturity? Certainly it is not as though it is either one or the other, probably both follow to some degree; however, it would have been helpful to hear their thoughts on that issue. How did they balance these two concerns? It would say much about how the leader of a Balint group might choose to intervene, not only at one moment, but something about the general posture that he or she would assume as leader. This question has relevance because recent literature points to the fact that many Balint group leaders struggle with knowing whether they are facilitating a support group (reducing anxiety) or a case discussion group (furthering professional maturity).[52]

In attempting honestly to uncover the theoretical roots of Enid's and Michael's thinking in developing their GP group method, and, at the same time, to honor the influence of the institutions of which they were part and the society within which they were living, I have created more an historical "impressionistic painting" than a technical diagram of their Group Method. However, in my research I came across such a "technical diagram" of the Balint Group method, dated 2002. This was a statement by Peter Kutter, professor of psychoanalysis at the University of Frankfurt, and training and supervising analyst of the German Psychoanalytic Association. The statement comes from his paper, "From the Balint Method Toward Profession-Related Supervision" that appeared in *The*

American Journal of Psychoanalysis.[53] While I have presented sufficient information to call into question his sweeping generalizations; nevertheless, I think it is important to see how someone, in a positions of influence, interprets the Balint group method.

> The Balint method originated in the medical field. Therefore, its roots are to be found in both psychoanalysis and medicine. The participants were medical doctors, the leaders likewise medical doctors but at the same time psychoanalysts. So what they were doing, following Michael Balint, corresponded to a psychoanalytic supervision. This description, together with control, stands for what an experienced psychoanalyst does with a junior colleague when the latter reports to him about problems with individual patients.... In this respect, supervision is applied psychoanalysis.... Hence the Balint method is also psychoanalytic supervision. The Balint method and psychoanalytic supervision are therefore synonymous. [54]

It is such statements as Dr. Kutter's that create spurious connections between psychoanalysis and the Balint group method. We might say that he (and others before and after him) commits the genetic fallacy by saying: a thing is what it came from. These statements also would seem to imply that the group method is a process of supervisees learning from a superior supervisor with minimal or no learning acquired through peer interaction. Such statements are far removed from the case conference method where every participant is seen as a "teacher." Further these statements would seem to relegate to little or no value the diverse social and cultural perspectives provided by the various backgrounds of the participants in the group: one is simply being supervised. Had the statement appeared several decades earlier, I might not have found it anachronistic. However, the number of psychoanalysts leading or co-leading Balint groups currently is very, very small in the United States, and I believe they are in the minority of group leaders in other countries as well.[55] What is important about this statement of Dr. Kutter is that it creates a clear picture of a medical treatment model that would seem entirely congruent within a biomedical subculture. The challenge of Kutter's statement is to find an equally clear and coherent statement that would allow leaders, learners and other related professionals to understand the process, professional goals and personal experience of the Balint Group Method as an educational experience within and beyond the boundaries of formal medical education.

Earlier I said I would return in discussion to Michael's Three-Tiered Group Structure. This model very nicely allows him to show the significant difference between a client relating to a partner (Social Work Group) and a patient relating to an illness (GP Group). However, what is not highlighted in this model is the multiplicity of relationships that are concurrently created, partially conscious, between each group member and the patient as well as each group member and the illness. The group, at any one time, is hosting not just the presenters' patient but a poly faceted object (patient), illness and relationship. This makes group process something more complex than a series of dyadic relationships. This also creates the climate in which all members have the opportunity to see, hear and feel a variety of "doctor-patient relationships" and "patient-illness relationships." I believe this is truly the creative dimension of the Balint group that moves it far beyond a simple problem solving group exercise. Were these insights understood in the Balint Group Method? They may have been allowed to emerge; were they conceptualized? We have moved beyond transference and counter-transference.

Summary

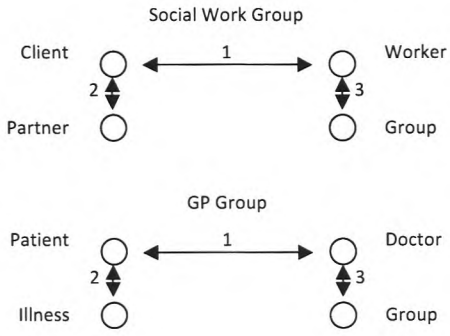
By 1950 at the Tavistock Clinic and the Tavistock Institute Of Human Relations institutional readiness and social needs were in perfect alignment to support Michael and Enid Balint in their experimental efforts to bring to a marginally franchised group of general practitioners psychological insights that would significantly change their perceptions of patients and their own sense of professional and personal identity. The family discussion Bureau organized by Enid Balint in 1948 and operating on the principles of a case conference model used at the Harvard Business School established the prototype for what was to become the GP group. Modifications to this case conference model were made that called for the spontaneous presentation of the case and encouraged free moving speculation as well as reflective thinking to judge the credibility of some of those speculations. Michael and Enid, as skilled psychoanalysts, were both sensitive to and focused upon issues of counter-transference between doctor and patient. However, they did not allow the group to move into a psychoanalytic treatment of participants nor indulge the formation of a mutual admiration society. For Enid the skill of learning to listen seems to have been of utmost importance. She encouraged the physician to learn to identify with a patient and then to step out of that identification as a way of genuinely coming to hear and to understand the patient. While Michael may have verbalized the value of the group leader merging as much as possible with the group, his behavior, in fact, modeled a much more evocative, challenging or confrontational interpersonal style.

Both Michael and Enid were intimately associated with the British Psychoanalytical Society and the staff on the Tavistock Clinic. They were knowledgeable of the psychoanalytic group theory and therapy advanced by Bion and Rickman. However, the psychoanalytic orientation to group process of these analysts seems not to have significantly directed Michael's and Enid's work with general

practitioners nor were their concepts or writings discussed in Michael's and Enid's writings on the GP groups. Too closely to identify the Balint group method with psychoanalysis, psychoanalytic group theory or the Tavistock Clinic is to commit what I earlier identified as the genetic fallacy: a thing is what it came from. The case discussion method from the Harvard Business School may say more about the Balint group method than has hitherto been acknowledged. This also brings the Balint group method more in line with a teaching modality than a treatment or supervisory modality. The language that is used in identifying the historical roots of the Balint group movement can say much about how, today, we attempt to identify what should constitutes a Balint group, and how others choose to interpret our work.

Figure 1

Three-Tiered Group Structure



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The Doctor, Her Patients and the Gifts: the meaning of gifts as reflected in the discussions of a Balint group

by Henry Jablonski, MD MSc, Sweden,
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Introduction

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

A basic uncomplicated exchange could look like this, interpreted by me as the doctor:

'You offer me a severe sore throat and a deteriorating general condition. This gives me the opportunity to feel useful and competent (and thus to earn my living in a decent way), and I give you a diagnosis, a cure and assurance in return'. A gift during treatment can be seen as some kind of interference or intervention in this basic relational exchange. As a clinical doctor, you will have to relate to a gift from a patient whether you want it or not. The daughter of an experienced GP said: 'Mom, you ought to make an exhibition of all the strange gifts that you have received over the years from your patients. It would be amazing.'

The idea of such a Doctor's Museum of Gifts – real or imaginary – is challenging. It should – apart from the exhibited gift itself – contain

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

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

Design

I suggested to a Balint group of very experienced GPs working in areas with a large immigrant population – in our eighth and final semester of cooperation – that we all should write down a story or two about gifts and that we should look at them using our normal method of working. Some members sighed. I could sense their unspoken objection: 'Don't you think we have enough things to do already in our offices, without writing you stories?'

I insisted on reminding them of a couple of stories about gifts told in the group over the years. They agreed after all that this was indeed a meaningful theme. For two and a half sessions we discussed eight reports on gifts – seven from the GPs and one from me, a psychoanalytically orientated psychiatrist. I also suggested to the group members that we should present a joint paper at the next IBF meeting or at a GP meeting. The group considered this for some time but the members in the end declined. So with their permission I will give a shorter presentation with a couple of examples. The reports have been modified to prevent any identification of the patients. I will, one day, report on this work more extensively.

A model for assessing the meaning of the gift?

I suppose I share with many of you the impulse to systematise when you look into a clinical material. Often this should be done explicitly beforehand to merit the name of scientific enquiry. Thus scientifically, in the conventional logico-empiricist sense, this is a pre-study. You could look for parameters judging the meaning of the gift in the doctor-patient matrix. It would be multi-dimensional, of course, since the gift and its relational context is so complex. From these cases and from others I could go on and try to develop a more systematic view.

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

A small but significant etymological remark

The Swedish noun *gåva* has the same etymological origins as the English *gift* and the German *Gabe*, deriving from *to give, zu geben, att giva*. But it is fascinating that the Swedish noun *gift* also means *poison* – indicating the universal ambiguity of a gift. It can be both a blessing and a curse. But in either case it can be felt as 'an offer that you cannot refuse'. Many times this is the starting point of Balint casework – the doctor vaguely feels that he is trapped. (In

Swedish *gift* also means *married*. Maybe this also could be linked to the ambiguities in too many human relationships, so wisely illustrated in the ancient Transylvanian song *Szerelem*)

Cultural and professional attitudes towards gifts in Sweden

There is something appealing and nice about receiving gifts. The code of conduct towards gifts in a Swedish born and Swedish medically trained doctor – whether he became a GP or went somewhat astray and became a psychoanalyst – is governed by the fact that Sweden culturally and legally is a non-bribing society. There are strict rules. As a public servant you are not supposed to receive gifts. Gifts are un-Swedish and looked upon with a certain reserve. Doctors are aware of this, and many have overly conscientious fears of being suspected of bribery by receiving even small gifts. The national health system pays the publicly employed doctor well enough so that he, as opposed to doctors in some other countries, does not have to think about money when meeting with his patients. They do not have to give us gifts, nor pay us extra money, to get state-of-the-art medical treatment. When I try to look at this from the outside, I see a culture of puritanism, but also of innocent good intention and decency. The latter I like very much.

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

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

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

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

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

A remark on the cases

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

It is important to note that five out of the seven GP cases presented could be labelled as 'poisoned' gifts, with a main (conscious and unconscious) purpose to corrupt the doctor by enticing, seducing, openly bribing, belittling, etc. Only two cases were expressions of 'love and appreciation' – the most moving one (and very complicated) I have not included in this paper. (Nor will you hear about the case that I presented to the group.) This bias might not be quite that heavy in clinical daily life. After all, cases brought to a Balint group do not reflect the total composition of the doctor-patient relationships at a doctor's surgery. But the overall estimate of these doctors was that the 'poisoned' gifts

dominated their practices. This is a good enough reason to discuss this issue from the aspects of mental health and prevention of burnout in doctors. It may be indicative of a general problem which is not only confined to gifts.

I also have a premonition that some of you, reading these examples that I am going to present, might think that the doctor is naive. I do not. I am quite convinced that every one of us has such examples in our 'mental clinical archives'. The offers by the patients and how they are received by the doctors will much depend on personalities and hidden agendas. A bystander usually thinks more clearly because of lack of involvement. If we could be the intelligent, back-seat driver of our own private and professional lives, we would seldom get trapped. And when we did we would get out of the trap very fast and never be caught again. Life would be efficient and we would be spared a lot of frustrations, surprises and ... a good part of life itself. Then again, there is nothing wrong in learning from experience and mistakes, little by little – as Balint group work and psychoanalytical psychotherapy invites us to do.

Case 1: The doctor as an emotional alchemist

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

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

The medical student did not look concerned or surprised. He said his mother is working at the Migration Authority and she also often gets gifts. I brought the pieces home. My youngest daughter suggested that I could get rid of them by bringing them to the Midsummer flea market of our community of country house owners. So I brought the stuff to the country house. As I was cleaning I noticed a small table. The knitted cloth fitted perfectly and now it is on the table. I felt good about that.'

Discussion in the group

The presenter clarified that she is also the doctor of the patient's wife. She emphasised that she got along well with the husband as a patient and actually found it quite difficult to understand what the wife was doing there. The group was wondering why the wife would have to bring the gifts instead of her husband. Was it something cultural? Was the man too shy to bring them himself? There was also some speculation that the wife might be worried about the health of her husband and her need to control that he was given proper attention by his doctor. But these view points faded away.

Then followed questions about when these items were given and how they were handed over by the wife. It seemed they were given arbitrarily over the seasons – a chocolate Santa Claus for summer, an Easter Hare for the autumn call. Never wrapped up as gifts but rather handed over in a small plastic bag or picked up from one, just as had been done with these knitted items. It was clear they could not have been purchased from the same store that the plastic bag came from – a low price hobby and tool store.

I asked the group: 'I wonder – from which one of these two patients is the gift?'

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

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

The tone of the discussions had so far been tentative and low pitched – a kind of beating around the bush. Now, there was some more energy in the discussions and the reactions of the presenter. Were these really gifts as a token of appreciation and gratitude? Could one really explain the junk quality of what was given to the doctor as a cultural idiosyncrasy? Would she have brought such stuff to a Lebanese doctor during her stays in her native country? The presenter found the discussion interesting. She became aware of her wondering what would be the reason for the call of the wife in the week to come.

'At any rate – it was nice that the cloth fitted the table in my summer house,' she concluded.

Comments

It seemed to me that the doctor unconsciously/automatically had disregarded these junk presents, as they had an embarrassingly depreciating quality, which

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

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

Case 2: Doctor or daughter?

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

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

I discussed this patient in our Balint group more than a year ago. You remember, the consultations dragged on, often for more than double the time I had allocated. There was always something more though I always take that into account beforehand. But it was never enough, always more questions and worries. Often I had to interrupt to end the session. After discussing it in the group and thinking of her as an abandoned child who was anxious that there would never be another meeting again with her caretaker, I started seeing her on a more regular and scheduled basis, once a month, once every two months. Overall I do not think that I have spent more time with her than before. But my patient seemed to calm down and I have a definite feeling that she is not going to the hospitals and to other doctors as much as she used to before. My patient thinks that a brand new medication will work a miracle. But then again when she reads about the side effects she does not dare to try them. She experiences herself as very sick. But she looks very agile and takes long walks daily for at least two hours.

Over the years she used to bring me some typical cakes from our home country, a few in a little bag. On one occasion she brought me at least 60 of them! She had baked them herself, she confided. She told me sternly I should not share these cakes with my colleagues or with the staff at our centre. They were for me only! I could put them in the freezer at home.

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

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

Discussion in the group

The group discussed the exclusive demands of the patient onto the doctor and the doctor's feeling of 'too much-ness'. The group recognised that the doctor felt much sympathy and concern for her patient. She felt sorry for this woman in exile. The discussion in the group a year before had helped the doctor to structure the treatment and it had helped. The patient seemed calmer and her overall use/abuse of medical care had diminished. But it also seemed to have stirred up a stronger transference in the patient onto her doctor, a mother-daughter-relation. The presenting doctor nodded affirmingly. Indeed, the patient liked her doctor. She was grateful, but also demanding and possessive. The presenting doctor (I was about to write daughter) felt trapped. Though she cared a lot, it seemed she had a need for a certain distance to her patient. There was nothing wrong with the cakes. They were most homely (German: heimisch) to the doctor as opposed to her uncanny (German: unheimische) feelings. She recognised being emotionally locked in a conflict between her strong feelings for her patient and her guilt for not allowing the patient to be too close. This was strongly reinforced by the controlling, anxious and 'never-pleased' attitude of the patient and *her* doctor's wish for a certain degree of distance/independency in her way of caring.

Comments

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

Consultation without a stethoscope: an informal evaluation of a Balint Group for GP Trainees

Nick Humphreys, psychotherapist

Abstract

Balint groups pay close attention to the doctor-patient relationship. They provide a learning opportunity for General Practitioner trainees in the subjective aspects of consultation, a potentially rich, but also intangible and frequently uncomfortable area of the work. This study sets out to examine the utility of the approach using small-group work in vocational training. It attempts to evaluate members' experience of the group, to capture its personal and professional impact, and to offer some critical analysis of the findings.

Introduction

Balint groups originated in this country in the 1950s through case discussion seminars for general practitioners. Their originator, Michael Balint, a psychoanalyst, ran these groups at the Tavistock Clinic in London. He invited an examination of troubling everyday practice and offered a structure within which to learn from it. Emphasis was given to understanding the emotional aspect of the relationship and to self-examination as potentially useful sources of information. This forms an area of clinical observation concerned with the more unconscious and subjective aspects of consultation. The method is derived from principles of psychoanalytical theory but is not a modified form of psychoanalytic practice. The doctor-patient relationship is thought about in detail but in the language of everyday clinical practice. (Norell JS and Balint E, 1973). Balint drew attention to the need for psychological examination in many consultations and the difficulties this can raise for the doctor.

'We cannot help feeling personally involved, because we all have problems of a similar nature, with which we either cope well or not so well. Somehow when we examine our patient, we cannot escape examining ourselves.' (Balint, 1995).

Background

This paper is the outcome of a request to the Leicester psychodynamic psychotherapy department by two GP educators seeking an independent evaluation of a Balint group they had conducted for GP trainees. Both facilitators taught on the local Vocational Training Scheme (VTS), and having been in a Balint group themselves for a number of years, decided to set up a group for trainees who were looking to deepen their understanding of the doctor-patient relationship in general practice. For the duration of the group the trainers secured a regular supervision arrangement with a registered psychotherapist. The group began with seven members, and over the two years of its duration membership varied with between five to eight members attending.

The group started life in a room in the VTS training department, and then moved to a more amenable room in the psychotherapy department. This helped to emphasise boundaries of privacy and safety as well as commitment to the group because the location was more remote for the majority and all members attended in their own time. Within the group emphasis was placed on thinking about feelings and exploring relationships with patients with a view to increasing understanding rather than finding solutions to problems. The facilitators had been impressed by changes they observed in the trainees and sought the evaluation to try to capture some of these training outcomes.

Six members of the group responded to the invitation to attend an evaluative session and four members actually attended. The small number of respondents significantly limited generalisation of findings to a larger population. Also, members were self-selected and there was no available control group of trainees where learning outcomes could be compared to others who had not chosen to undertake a Balint group. A formal study was not feasible and it was therefore decided to conduct an informal evaluation using a focus group approach. This necessitated accepting certain evaluative disadvantages. For example, the direct interaction between respondents, and between evaluator and respondents, tended to compromise the independence of individual contributions. Also, the open-ended nature of the questions the group were asked to consider produced correspondingly open responses that could not be precisely summarised or interpreted.

However, the evaluative process was determined partly by the nature of the group that was the subject of study as well as the small size of the research group. The focus group method of direct interaction with members of the group also offered certain advantages. Focus groups create lines of communication between participants, and between participants and the facilitator. This provides opportunity for the clarification and probing of responses. The participants in the evaluation were encouraged to consider the reasoning behind their opinions, to articulate and explain their views, and to react to and build upon one another's responses. It allowed the group sufficient freedom for its views and feelings to emerge in an interactive format appropriate to the object of study.

'Focus groups are group discussions organised to explore people's views and experiences on a specific set of issues.'

(Kitzinger,1994). The focus group technique is distinguished by its explicit use of group interaction to produce data and insights. (Morgan, 1988). The free-flowing discussion reflected the group culture, its norms and values, established over the two years it had been meeting. The dimensions of the group experience to be covered by the evaluation were agreed beforehand with the group facilitators. They were used to structure and focus the evaluation while allowing group discussion with emergent themes to develop naturally.

The areas for study were concerned with:
1. Motivation for joining the group.
2. The experience of joining the group.
3. The value of in-depth focus on the doctor-patient relationship.
4. The learning experience.
5. The impact of the group experience on professional practice and personal outlook.
6. The application of Balint groups in training programmes.

The Evaluation

Motivation for Joining the Group

I introduced the evaluation and asked each member to say a little about why they had decided to join the group.

There were two levels of response to the question, one rational and readily formulated, the other subjective, emotionally based and harder to formulate. Of the more thought out responses, there was a search for a forum where the process of reflection could be taken to a deeper level.

'I wanted an opportunity to reflect more in-depth. I wanted something to complement and extend the reflective practice I was getting in VTS training.'

The emotionally based responses conveyed commitment to the importance of the doctor-patient relationship and also emphasised the search for in-depth understanding. Some members had a clear sense of an active interest they readily applied to the prospect of joining the group. For others interest was latent and stirred by joining the group.

'It seemed like it would be an interesting thing to try.'

'I think I'd always known that the relationship aspect of consultation interested me. People are interesting and complex and we need more than NICE guidelines.'

A division was identified between doctors interested in the Balint approach and others who were not. The division was felt to be partly about doctors who were more comfortable with rationalistic approaches to patient care and others whose approach to the patient naturally included intuitive and emotionally based responses. The difficult territory of relationship seemed to underscore this problem; it was difficult because it was not clearly marked and the uncertainty could lead to high levels of anxiety. On the one hand, a Balint group was recognized to be an arena that would not be everyone's cup of tea, while on the other 'GPs need to be trained to have some idea about their involvement in trying to enable their patients.'

The Balint group was seen as a vital model in enabling longer, more in-depth conversations in consultations. One member talked about her experience of a training attachment with a GP who had been in a Balint group and whose interest had stimulated her own. This had been helpful to her and she felt it pointed to a gap in training provision due to lack of attention to the complexity of relationship in consultations. She felt the therapeutic efficacy of relationship was subsumed under a directive of 'unconditional positive regard' for the patient that was inadequate to the task. What was needed was a process capable of discerning what emotional elements doctor and patient jointly brought to the consultation and how they impacted on it. She had joined the group to further her interest and deepen her understanding of this.

The Experience of Joining the Group

I said I would like to understand something of the experience of joining the group, and of coming together to work as a group.

Members started at different times so people who had been in the group the longest tended to work as culture carriers for the group as a whole. The process was described generally as gradual but difficult, and specifically as involving risk-taking in relation to talking openly about oneself in the clinical encounter. Several enabling factors were identified: particularly, stability in the group arising out of regular attendance, and commitment to contribute actively to the group. The group was seen to have been enabled by a largely benign culture stemming from the quality of facilitation that helped the group to feel safe, and subsequently, by a willingness to share personal struggles with difficult clinical material. Cohesiveness was assisted by an element of universality in the group: members were seen to be concerned with similar issues. Clear boundaries were established in relation to the subject matter of the group and to rules about confidentiality. The two facilitators were seen to both safeguard and to model the task, described as

'Showing us the way and sometimes modelling by being honest and open to their own vulnerabilities.'

'It was clear they believed in the Balint experience and it was helpful that this led the way rather than anything that was theoretically led.'

'They prompted rather than taught and helped us to find our own way as individuals.'

'Allied to case discussion as the foundation process for the group was the task of opening up the role of the GP. This was core to what the facilitators brought to the group. The basic mode of work was case study discussion, from which it was possible to think about psychodynamic processes. The group took a pragmatic approach close to the concerns of clinical reality.'

The size of the group was also felt to be right. This meant not too small to make it too intimate and therefore difficult to challenge, and not so big as to feel persecutory and unsafe. Time was cited as a further factor. Six months was seen as a minimum requirement and the newest member of the group said she had been disappointed that it was ending as she had just started to feel able to contribute and to gain from what the group had to offer.

The Value of In-Depth Focus on the Doctor-Patient Relationship

I drew attention to several references made to in-depth reflection, thought, consultation, etc, and asked the group to focus on what they meant by the experience of depth.

The group's thinking about this gravitated towards aspects of the interpersonal encounter in consultation that had a particular impact, that might be felt to be significant and were often not readily accessible or easily formulated. One member said that experientially a consultation might leave the doctor feeling uncomfortable or dissatisfied without quite knowing why.

'A consultation might stay with you, it might be difficult to switch off from or you might even feel haunted by it.'

In part, the experience of depth seemed to refer to the impact of the person of the patient on the doctor, and the often largely unconscious processes of the encounter. If such experience could not be thought about, doctors were seen to be less able to locate what was happening as a product of the relationship, essentially as something occurring between doctor and patient, rather than something occurring only within the doctor that tended to be experienced as distress and understood as inadequacy. The experience of depth involved entry into this 'in-between' area where the doctor was required to make use of their person and their emotional responsiveness as a gauge to what was happening between them. Two particular features of this were highlighted. One pointed to the fluidity of mental boundaries between doctor and patient at the level of emotional communication. One member referred to understanding that what she felt may well reflect what the patient was feeling and this could be an important source of information. The other highlighted the importance of being able to differentiate between the patient's feelings in the doctor and the doctor's own feelings. Awareness of how the doctor might be responding to the patient was a good indicator of how the patient may be experiencing the doctor.

These aspects of subjective emotionally based communication that it could be difficult to be fully conscious of during the consultation, were seen to form a not so visible but very present agenda that could easily disturb the rational objective relationship. Members felt there was an emphasis in training on packaging and attempting to limit the intrusiveness of subjective factors, and described a sense of relief about being able to use oneself as a person rather than be required to conceal one's emotional self. It was the experience of members that the doctor's greater openness to, and understanding of, these elements of the relationship helped to contain the patient's emotional communications and increased the patient's experience of feeling understood. In other words the doctor's emotional responsiveness could become a therapeutic tool helping to translate disturbance into shared thinking. This was seen as a useful alternative to attempts to dispose of disturbance by over-organized, rational thought.

There was a strong contention in the group that attempts to exclude the emotional encounter had a damaging effect, producing unprocessed anxiety, which was stressful if not sufficiently understood, and could lead to burn out; or could manifest in a form of covert aggression towards the patient, such as defensive brevity, or defensive reassurance, not listening, or avoiding eye contact. Defensive practice at best was seen to lead to soulless work.

The Learning Experience

I asked the group to consider the nature of the learning experience and what they felt they had gained from the group.

There was a high level of agreement that the Balint group afforded a greater capacity for reflective practice, and supported entry to the clinical encounter at depth, which had a direct impact on the quality of personal satisfaction at work.

'Something about being a happier doctor. This was one of the biggest things I took from the Balint group: feeling happier with what I was doing on a day-to-day basis.'

In part this was seen to involve a re-assessment and re-orientation to the task of consultation, capable of embracing more of the human experience of illness through a willingness to enter into the difficulty of it. This involved developing qualities of humility and empathy by which the doctor might get alongside the difficulty. It covers the idea that consultations, like life, are allowed to be difficult.

Furthermore, the difficulty inherent in consultations was seen to provide an opportunity, a sort of gap in the meeting with the patient that a diagnostic label, a history taking, a set of medical notes or an examination, would not cover. Work undertaken in this space could not be readily defined but might be fundamental to understanding the patient's relation to their problem and to their system of meaning.

I noted the problem for the doctor of erecting a defensive barrier between self and patient, and said the Balint group experience seemed to have helped to develop a new boundary in relation to clinical work.

The notion of a barrier was seen to be not altogether unhealthy, and indeed might at times be necessary, as in the face of experience that would otherwise be overwhelming.

'There have been times in my practice when a barrier has been necessary. I needed it to protect myself because I had no other way to behave at my disposal.'

A psychic barrier against the impact of death was given as an example, and the safety of the group, its cohesiveness and the level of trust it fostered, enabled members

'To enter into areas of the work I couldn't before. I could be upset and could deal with it and come out of it.'

I suggested that one way of qualifying what the group had offered would be to think of it helping to develop not so much a particular skill or competence, but what might be described as various capacities.

One member described feeling newly kitted out for her job, and used the image of a tool belt as a representation of feeling better equipped to adjust her approach to different patients. This also worked as an image of how the group process of interpersonal learning – imaged as the group circle – had been taken into the self and continued to function as a supportive resource. The experience of having difficult encounters with patients reflected upon within the group was seen as bedrock for the doctor's ability to think reflectively about his or her patients.

The Impact of the Group Experience on Professional Practice and Personal Outlook

I asked if members felt the gains from the group had been transferable to the workplace.

Following the end of the Balint group, members experienced a strong sense of the continuity of the group within themselves. It was described as an enduring and reliable resource whose contribution to training was for one member tested over several different jobs. One common factor was less anxiety about the clinical encounter. Relative to the importance of knowing what to do was greater confidence in the ability to engage the patient and in the value of doing so. The newest member, who had been in the group for six months, felt that being in the group for longer would have assisted with the transfer of gains. She spoke of having increased awareness of the hidden elements of human interaction but did not yet feel able to translate the group experience into her own practice.

Members gave emphasis to feeling better equipped to work with patients commonly labelled as personality disorder. This group of patients were seen to elicit counteractive defences in doctors because of their particular capacity 'to get under the doctor's skin'. These defences were seen to gloss over the interpersonal difficulty of the encounter by reducing it to ideas about 'attention seeking' or 'manipulation.' Reference was made to the value of one particular session that was given over to the problem of personality disorder, and the extent to which the group had enabled thinking about the patient particularly in understanding the behaviour and the mode of communication.

'One thing that came up a lot was that how you feel might be about the patient. A consultation that has gone badly might need to be understood as something that has gone on between you rather than only as something that you have done wrong. If it isn't necessarily my failure it is something that I can more readily think about.'

Other comments reflected qualities of resilience the group had helped members to bring into the workplace, particularly a greater capacity to endure clinical work that was emotionally demanding.

'Knowing that it is not your responsibility to resolve it helps you to feel more available to emotionally charged situations and steadier in them.'

'In medicine you get your diagnosis and you give your prescription. But Balint has enabled me to say I don't always need to come up with a diagnosis, being there is enough and may do more for the patient than giving them a prescription.'

'I knew the doctor-patient relationship was important but Balint helped me realise the scope of it, especially in General Practice. Our relationships with our patients are key to what we can do.'

One member referred to pressure in medical training to find answers quickly.

'The workload might dictate that a problem should be managed in ten minutes.'

'So you look for clues and don't want people to put too many complexities into the soup. Lots of GPs feel that every consultation is a diagnostic challenge.'

One thought was that this position could easily be reinforced by the power invested in the doctor by the patient, which could be difficult not to rise to, and that such a level of expectation can make it hard to realise the doctor is required to respond to an interpersonal demand rather than a medical challenge. One interpersonal gain from the group involved experiential knowledge of the value of listening, of being listened to, and the emotional availability of others towards oneself. The majority of members felt this had been gained through the experience they had had themselves of being the object of the group's interest. Opening their own 'cans of worms' as one member described it, placed them in a better position to know both when and when not to attempt the same with their patients. Coming to understand that the patient could be engaged by the relationship, that it had a therapeutic function and could endure beyond the session, had helped shape some modification in practice.

'I realised I could offer another appointment and not have everything wrapped up in ten minutes. That was a revelation.'

Overall the Balint group experience had helped challenge certain aspects of the power relationship between doctor and patient that could too easily remain unquestioned and work as a barrier to good listening. Emphasis was given to

the therapeutic function of the relationship rather than the efficacy of the doctor and medical practice alone. Members felt the group had provided a greater repertoire for understanding the kinds of interpersonal difficulties that commonly arise in consultations.

I asked members if their experience of the group had impacted on their personal outlook.

'I am happier as a doctor and a person.

'It has helped me in all aspects of my life.'

'It has been an in-depth learning experience and has given me a base and stability.'

These comments pointed to personal gains beyond those made within members' professional roles as doctors and colleagues, suggesting an increased emotional capacity within each individual, which extended beyond the consulting room and demonstrated the enduring nature of gains made in the Balint group.

The group context and the individual experience of being part of the group had given insight into the psychodynamics of interacting systems. Just as individual patients brought to consultations the pathology of the system of which they were a part – for example, their family – so colleagues could also be seen to bring not only their own talents and difficulties into the work but also to carry aspects of the work system of which they were a part. Trouble arose if one attempted to own this latter aspect or if one was required to own it by others in the system. Members felt the Balint group had helped to instil a better sense of one's place in this respect, and an eye on what one may be carrying for the system one was a part of, as well as for the patient.

'As part of a bigger system I cannot be all things to all people. The Balint group took hold of that for me and allowed me to properly hear it and accept it. It also taught me that it could be okay to have a bad day at work, that I could be a good-enough doctor and colleague.'

Through the experience of understanding their own defences, members appeared to experience an increasing recognition of and respect for defensive processes in their patients and in the institutions they worked in.

'Just as individuals need to organise themselves against too much contact with death, helplessness etc, so can whole departments and entire hospital Trusts!'

The Application of Balint Groups in Training Programmes

I asked the group if they visualised a wider application for Balint groups in training programmes as well as having a part to play in achieving greater integration between psychological and medical approaches.

The picture that developed in relation to this question was that the primary task of the group had been concerned with the development of a psychological approach to the patient and that emphasis on the interpersonal tended to move one away from the medical model of thought. One member suggested that practice within the medical model tended to change the ground so that it was much more difficult to think about the relationship or talk about feelings.

'In that approach if I think things are getting too near emotions I'll pick up my stethoscope... '

This seems to support Balint's (1995) comment, that 'medical training does not offer the future doctor sufficient experience in this skill.'

Reaching for a stethoscope points to a defensive state of mind Balint calls apostolic fervour, a condition of zealous certainty that excludes uncertainty and avoids self-examination. This tends to arise out of the doctor's need to diminish his or her anxiety rather than out of concern for the patient's welfare. A consensus suggested that Balint groups should be more available in GP education, but that they should not be compulsory because if people were present who were not interested this would negatively impact on the safety of the group. This consideration was not developed further in the evaluation, but it implied that some defence structures and personal attitudes would not be amenable to the process of the Balint group and the task of personal examination.

The group could see a place for a Balint approach to supervision where there were difficulties with consultations and the doctor might want to give more thought to the interpersonal aspects of the work. Members had no negative experience to speak of but thought it was important to acknowledge how difficult the groups could be, most notably the quality of intensity.

The lens on self and emotion could be very tiring and at times unpleasant. For most members, in the early phase of the group this was linked to fear of the group's potential negative judgement. More generally however, and at a deeper level, the strain reflected the difficulty of trying to understand the distress of people rather than merely observing pain in various conditions. It seemed to beg the question, how much strain can one stand yet keep one's capacity to think? It also seemed clear that training in a Balint group and subsequent change in practice increased the difficulty and complexity of the work. If responsibility to former ideals of practice was diminished or relativised, personal responsibility within the sphere of the relationship increased as things were seen more clearly and deeply. It was noteworthy that this was acknowledged but not complained about, and the reasonable conclusion would seem to be that the burden was offset by the work becoming more interesting and rewarding.

I said we needed to conclude here and thanked the members of the group for their contributions.

Some Further Thoughts

The Emotional/Rational Divide

I was interested in what had been said about divisions between doctors interested in the Balint approach and others who were not. It was suggested this division was between rationalistic and emotionally based responses. In the groups that Michael Balint ran at the Tavistock Clinic, he referred to categories of early leavers. Some were doctors who held firmly to well proven methods, others entered into the approach but then retreated to safer ground, while a third group who were obsessionally conscientious, entered enthusiastically but eventually faltered in the face of a perceived absence of reliable rules.

'All struggled with an absence of efficient time saving methods and intellectual problems which could be discussed and solved with detachment and objectivity.' (Balint. p 316. 1995).

On another level however, this is a difficulty in varying degrees for all. One problem of a very small evaluative cohort is that it tends to a greater degree of intimacy with less room for the management of ambivalence than would be typical for a larger group. Nevertheless the anxiety, roused by departure from familiar territory that Michael Balint's leavers were defending against, was also indicated in comments about the strain involved in being open to distress and comments about how tiring and unpleasant the focus on emotion could be. Main (1978), comments

'All of us have weak spots and against intolerably painful encounters it is inevitable that defences are erected, laughter, forgetfulness, aloofness, scotomata, denial and so forth. These allow the survival of the doctor but at cost to his effectiveness, and the clinical results can be deplorable. If sometimes the price paid for safety and the avoidance of any form of helplessness seems very high, it is worth remembering that defences are never there for nothing. The bigger the defence the surer one may be of the need for it. Every practitioner has a limit to what he can stand.' (Main, 1978).

Group Facilitation

Probably the most important enabling factor identified by the evaluation was the quality of facilitation. Establishing a climate of acceptance, safety and trust, was seen as an important leadership skill. Further research (Johnson, et al. 2004) supports this view and suggests safety is enhanced through attention to group structure:

'Maintaining boundaries and balancing participation between presenter and group and among group members.'

In the same study, emphasis is also given to what the members of the present group described as modelling and showing the way. This includes both modelling a personal approach to case analysis and thinking, and use of the group dynamic to illuminate the doctor-patient relationship under discussion.

The Learning Experience

The learning experience had largely consisted of discussion of the reports of members about their patients. Members were helped to recognize the traits of their particular approach to their patients. The group experience had not only been held in mind, but had become for most members an ongoing resource, providing a 'third eye' on their work to date. It also helped them to be both more aware of their subjectivity and to make more reliable use of it. Learning was intimately related to the development of the doctor's personality, expressed as a greater capacity for working within the sphere of the doctor-patient relationship. This involved being more open to the human experience of illness, seeing difficulties in the clinical encounter as needing to be understood rather than treated, and understanding the patient's problem and their relation to their problem in terms of the patient's system of meaning. Essential for such personal development to be achieved was an experience of safety and trust in the group relationships and the group process. Learning was essentially experiential, through exposure within the group to direct experience. The experience of understanding and acceptance in a context of personal vulnerability, allowed the doctors to tolerate a greater degree of medical helplessness in their work. The emphasis on understanding rather than finding solutions to problems, assisted with the problem of helplessness where anxiety was based on failure to understand.

Conclusion

The Balint group had engendered a source of pride, commitment and loyalty. Group discussion and focus on the clinical relationship seemed to have significantly impacted on the parameters of consultation, making them more fluid, bringing the therapeutic relationship into the foreground, increasing it's complexity, and enabling its use as a therapeutic tool. Although the therapeutic gains from the group were focused primarily on a new dimension for thinking about the patient, members also felt the group had positively impacted on the general task of working as a doctor: staying curious and alive to the task, maintaining a balance between professional duties and personal needs, listening and making psychological space for the patient in spite of the pressures of other things to be done. Group members had clearly felt supported and deeply influenced by the experience of the group. They presented the Balint group experience as a significant resource for training practitioners in the relatively unstructured nature of general practice

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My experience of facilitating a Balint Group for GPs and its interface with Supervision

Valerie Parker, primary care counsellor

Ever since I began working as a Primary Care Counsellor I have been fascinated by how the relationships between GPs and their patients effect medical consultations. I was therefore very interested when a GP asked for my help in exploring his inexplicable anxiety about his work. During our discussion we realised that much of his concern focussed not on worries about individual patients, but on his struggles with time-keeping. We began to wonder how this impacted on his relationships with his patients, and how his ability to assert himself varied according to the feelings evoked by individual patients. We also reflected on how firmer boundary-keeping might change these relationships.

Following our discussion, I was invited to run a workshop on boundaries and timekeeping for all the staff at the surgery. The issues that emerged were fascinating. We began to think about the power some patients have to elongate appointments or receive special attention, while other patients seem to be almost apologetic about having any time. We also reflected on how individual patients deal with their annoyance and frustration at being kept waiting and how this might affect their relationship with the doctor and the surgery. One of the GPs at the workshop was enthusiastic to develop the ideas further, and he asked me if I would be interested in setting up and facilitating a 'Balint'-type group with local GPs.

This was a great opportunity for me to develop my interest in the dynamics of the doctor/patient relationship and to experience leading a group, but I was apprehensive about what the doctors would be expecting. What is a Balint Group? Was this to be a supervision group, or merely a discussion group? How assertive should I be as a leader? I began to research information on Balint Groups, joined the Balint Society, and decided to enrol on a counselling Supervision Course with 'Counsellors in Primary Care', which I hoped would help me with the supervisory aspects of the work and its context in Primary Care. One of my concerns involved the problem of language and culture. I was aware that although GPs might be attending such a group to increase their reflective and psychological awareness, there is an inevitable cultural divide between the medical paradigm of diagnosis and cure and the more reflective psychological search for meaning in illness. I was conscious that while the doctors were hoping to open up their awareness and ways of thinking, it was important to be sensitive to their differing attitudes; developing and encouraging mutual respect would create an opportunity for growth and learning for us all.

Although I have always enjoyed working with GPs, I have also been conscious of some deeply embedded transference responses which could affect my confidence as a leader. The underlying danger is that my sense of awe, combined with a tendency to undermine my own ability and expertise when I feel under pressure, may either make me anxiously over-controlling and dominant, or too self-effacing and unable to assert a sense of leadership. When I explored these feelings I realised that the underlying dynamics in my relationship with my younger sister, who is a GP, probably affect my attitude to all doctors. I have always had a sense that her profession is more highly regarded in my family; in addition my sister and I have a tendency to be both over identified and competitive in our relationship with one another. It has been helpful to reflect on this and begin to clarify the effect that some of these unconscious projections may have on my relationship with the doctors.

In order to better understand the origin and context of Balint Groups, I read Michael Balint's seminal book *The Doctor, His Patient and the Illness* (1957) in which he describes his work with groups of doctors at the Tavistock Clinic in the early 1950s. These groups were established by Balint to investigate the relationships between patients and their doctors and to help the doctors develop more effective skills in understanding and relating to their patients. 'Balint Groups,' as they became known, usually comprised 10-12 'family doctors' and one or two facilitators and met weekly for a period of several years. The doctors were encouraged to present cases which they considered problematic or uncomfortable or provoked an unusual amount of frustration. They would discuss their reactions and insights, and reflect on what they felt was happening unconsciously in these relationships, with the aim that this might help them to understand their patients better. In the words of Balint:

> *'Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously, in the patient's mind when the doctor and patient are together.'*

I realised that in many ways a Balint Group is similar to a supervision group for counsellors – it provides the GPs with support, an opportunity to share problems and concerns, and helps them to think about their work in a new way. So how might such a group compare to a supervision group, and how would this affect my role as its facilitator? Hawkins and Shohet (2006) cite three main functions of supervision – developmental, resourcing and qualitative. Their definition of the developmental aspect of

supervision relates very closely to the aims of a Balint Group. To help a supervisee:

- *understand the client (patient) better*
- *become more aware of their own reactions and responses to the client*
- *understand the dynamics of how they and their client were interacting*
- *look at how they intervened and the consequences of their interventions*
- *explore other ways of working with this and other similar client situations.*

Hawkins and Shohet describe Resourcing as the process of supporting supervisees through the emotional stresses of their work. This would not be an overt aim of a Balint Group, although understanding the unconscious effects of their interactions with patients, and feeling supported by their colleagues may help doctors cope better with the stresses of their profession. The *Qualitative* function of supervision refers to the supervisor's responsibility for the work of their supervisees. This does not apply to Balint Groups in which the doctors remain individually accountable for their work.

Another important comparison with supervision involves the behaviour and involvement of the group leader. It is generally agreed that there is a very strong didactic element to counselling supervision (Kadushin1976, Proctor 2000). Onso (1985) even considers teaching to be *'the primary function'* of supervision. In the context of a doctors' group however, I believe teaching is inappropriate; it is important to stand back and allow any learning to evolve naturally through discussion and observation. This is strongly endorsed by Enid Balint et al (1993):
'The psychoanalyst is there as a facilitator – an opener of doors – not as an instructor.'

The concept of the leader as a support rather than a proactive manager or director is respectful, and reinforces the importance of allowing the GPs to maintain a sense of their own expertise. Gosling (1996) emphasises the importance of respecting the unfolding process:
'Using the Balint Method every effort was made to reinforce the GPs' authority in what they did or didn't do so that they would adopt new ways learned in the group only to the extent that they themselves found them useful in the light of experience.'

I have found it helpful to think of the group as a co-operative learning experience, much like Proctor's (2000) Co-operative Group Supervision model, in which the leader's most important function is predominantly to facilitate the group process. This involves containing the group and its members through the challenges and stresses of becoming a lively, functioning and collaborative entity. Tuckman's (1965) definitions of the stages of group development, *Forming, Storming, Norming and Performing*, have been a helpful guide to the unfolding process.

Forming

The primary task in the early stages of any group is to establish a solid framework or a *Group Working Agreement* (Proctor, 2000). From the very beginning it is fundamentally important that the leader or supervisor can manage the group confidently and firmly though this process. This includes establishing boundaries for time management, confidentiality and presenting behaviour and, in doing so, clarifying a firm sense of holding and containment. Bearing in mind my underlying concerns, I was aware that the task of establishing a clear position as leader, balancing assertiveness with openness and respect, was going to be challenging.

Before the real work of the group began, the GP who helped to set up the group called a preliminary meeting to discuss our ideas and to set out a proposal. I felt that it was important from the outset that I took administrative control, allowing Dr A to hand over responsibility and become a member alongside his colleagues. Ten GPs attended this meeting, all of whom decided to come to our first group. We established that I would be responsible for all communications, for the time keeping during the meetings, and for booking the venue. We planned to meet once a month for 90 minutes. I anticipated that this relative infrequency would make it difficult to establish a sense of unity and coherence in the group. During the early months several doctors decided to discontinue, and it took several months to establish a regular group. This concerned me, feeding into my own lack of confidence about my ability as leader. It was important to appreciate the insecurities present for every member of a group, and to realise the value of being proactive in managing boundaries and helping to establish a sense of safety for everyone.

The task of containment also includes managing external disturbances to the boundaries and I have realised that at these difficult moments it is helpful to make links with what is happening in the group as a way of refocusing attention. I recently had the experience of co-leading a short-term group at a Balint Society conference, and in our first session we were interrupted by several very annoying and uncomfortable intrusions. At one point a porter urgently came in requesting keys. Several members of the group were very angry, and it was clear that it would take some time to settle. I noticed how this disruption mirrored both the cases that we had been discussing that morning, in which someone had stood in the way of the relationship between a doctor and his patient. By making a link between these experiences, I was able to help the group refocus and return to their task with greater ease.

Storming

During the early stages of group life it is usual for the members to be preoccupied with trying to find a balance between individuality and belonging (Proctor 2000). This is a challenging time; all the members will be testing the boundaries and trying

to establish their own place in the group. Proctor suggests that participants will be primarily concerned with issues involving '*difference, competency and hierarchy*' – who speaks the most; who is the most insightful, and how to gain respect. The insecurity and anxiety present at this stage of the group was particularly demonstrated by Dr B. At the end of our second session, he took me to one side and said that he was worried about whether we would expect him to present a case at our next meeting. He explained that he was off work on long term sick leave but that only two members of the group knew this. I said that I thought his personal experience would be valuable to the group and I hoped that he would feel able to talk about this next time. The next day I received an email from him expressing his apprehension about presenting to the group when he is currently not seeing patients and asking for my clarification about how he could approach such a discussion.

My reply was as follows:

Firstly, I really appreciate that you are braving coming to the group, and I think that when and if you feel ready to share some of your experience, it will be very enriching for everyone, and will only serve to deepen the relevance of the group. I hope that you are able to talk to us at the next meeting and I would suggest that you don't prepare anything. We have not formalised what we present and this will develop and emerge as the group matures. However, beginning to look at the emotional impact and stress of your work on your life and reflecting on how your patterns of relating have affected your work would be extremely relevant. Starting to open up in this way will encourage everyone to look deeper at the inter-personal dynamics of their work and could be really helpful. It is important that we keep appropriate boundaries so that it does not become a 'therapy group,' but as facilitator I can keep an eye on this.

I think it was right that we did not speak on the phone, as contact about the group outside it should be kept to a minimum to ensure safety and confidentiality. If you agree and feel comfortable, then perhaps we should share our communication with the others, so that there is no danger of 'splitting' the relationships within the group.

I hope this helps. V

This exchange brought up some very important points. Firstly, it allowed me to establish my role as a guide to the appropriateness of the material – encouraging the GPs to open up to their personal experience, but ensuring that this is relevant and contained. It was also an opportunity for me to clarify boundaries about safety, confidentiality and openness within the group.

I was fully expecting that Dr B would now have the courage to open up to the group at our next meeting. What I did not anticipate was that I would fall ill and would be unable to attend. This presented another challenge about contracting. We had made no provision for my absence. In the event I rang Dr A, who decided to cancel the session, but two doctors missed his communication and did in fact turn up. This prompted me to reaffirm our arrangements and to circulate a list of personal telephone numbers. I have realised that throughout the life of a group boundaries need to be continually reaffirmed and reinforced. It seems to be a question of negotiating a delicate balance between containing frustration, anxiety and discomfort and interpreting and challenging, while maintaining an awareness of what is happening in the group and how this might be reflecting the dynamics of the patient/doctor relationship.

The following month I turned up to the meeting anticipating that Dr B would now speak, and was disconcerted when he did not volunteer to do so. Reflecting afterwards I was unsure how to proceed – should I leave it, ignoring our correspondence, and wait for him to find his own time, or should I confront him? I decided to telephone him the following day and he agreed to open up to the group at our next meeting. I wondered afterwards whether this intervention could be considered a boundary violation, and whether I should have let the situation unfold naturally. On the other hand it modelled an approach of facing emotional challenges, and it was important to ensure that Dr B became a full member of the group, which could not happen until he had participated fully. Ignoring the situation may have reinforced this split. As Proctor writes:

Collective energy is released when supervisees, with the help of a faciltative supervisor, can sufficiently acknowledge and respect their own, and other group members' needs for identity. By experiencing themselves as included and including; sufficiently influential and acknowledged; clear where they stand; acceptant of differences and of strengths and shortcomings, members can work freely, purposefully and creatively – at least from time to time.

Norming

As we all began to grow in confidence, I was able to be less proactive and develop a clearer perspective on the group as a whole. I began to notice the phenomenon of 'Parallel Process' – when the group dynamics seem to be unconsciously reflecting the material being discussed. It is often difficult to observe because I can also become a participant. I am learning to notice that when things feel confusing, or when I feel under pressure and unable to think, it might indicate such unconscious processes.

Dr B's presentation gave us all the first really clear example of Parallel Process. His case concerned a patient whose enormous need became overwhelming and so difficult to contain that it began to impact on Dr B's health. The patient was a woman in her thirties with a rare and terminal brain disease. She suffered from multiple nervous problems and debilitating and untreatable pain. The case became especially

worrying and complex when the patient discovered that she was 20 weeks pregnant. This caused huge dilemmas for the patient and the doctor. The patient desperately wanted a chance to have her own baby but Dr B felt caught in a terrible moral predicament. Medically, remaining pregnant was totally inadvisable for both the mother and the baby, but this woman was clinging to hope and it was painful to disappoint her so fundamentally. The patient decided to have a termination, which was medically complex and emotionally traumatic for her. Dr B increasingly struggled to draw clear professional boundaries, visiting her on his day off, giving out his personal phone number and even leaving a family gathering to take the patient to hospital.

As Dr B presented his case to the group, I noticed that the doctors began to reflect these difficulties in their emotional responses. When he complained about feeling unsupported and 'dismissed' by his colleagues, the emotional atmosphere became increasingly stressed. It was as though the group were determined to show that they were not 'dismissive' – that they too would put themselves out as he had done. When I warned the group that we were approaching the time we had set for the next presentation, there was great resistance and a sense of urgency to help Dr B 'find answers' before we could move on. Dr C was particularly insistent, suggesting that we should forego the next presentation. The group seemed to readily agree. I felt uncomfortable and under pressure, realising that the doctors were reflecting Dr B's inability to draw effective boundaries; that they were being unconsciously seduced by Dr B's vulnerability, just as he had been by his patient. We were also modelling allowing ourselves to change our plans, which did not seem safe. Against the wishes of the group, I said that I felt strongly that we should give Dr D the space that we had allocated for her. Dr C was clearly angry with me, which felt uncomfortable, but I knew that maintaining group discipline at this moment was essential.

Although not explicitly expressed, the group was reflecting the powerful response that can be evoked by very needy and damaged patients, and I realised afterwards how important it was to model an ability to contain this. This had been a big challenge for the group and to my role within it, but I think it was an important test of the group's resilience. Such situations are typical of this 'Storming' stage and are part of the growth and development of a strong, healthy and functioning group.

At our session the following month Dr D commented on my intervention, saying that she had been grateful to have been able to present her case. She also realised that the firm boundary keeping had been a helpful model. This was very affirming.

Performing

The group met five times before the summer break. Eventually four GPs left the original group – three clearly felt that it wasn't for them and the fourth could no longer make the time. We agreed that six members was too few, and invited one new GP to join us. Two members missed the final sessions before the summer due to sabbaticals, and so it was not until we resumed meetings in September that I began to feel that we were becoming a coherent group.

Despite two members being absent, there was clearly a different quality to the September meeting. I noticed that I felt more relaxed and confident, and it seemed much less urgent to impose a strict structure to the evening. For the first hour, the doctors reported back on their recent progress with patients whom we had discussed earlier in the year. Before the summer break, Dr E and Dr F had been encouraged by the group to resist some entrenched situations where patients had become over-reliant on them. Dr E was persuaded to try to break a cycle of dependency with an alcoholic patient, by using his imminent sabbatical as an opportunity to confront her and end the patient's reliance on very frequent consultations. Dr F decided that she would more assertively resist being sucked into a negative spiral of being persuaded by a patient to keep changing her medication. In the September meeting both doctors reported back very positively and expressed surprise at the ease with which their patients accepted their stance when previously they had been so resistant. It was as though the pressure had disappeared. In the discussion that followed the GPs began to realise that the change in their own resolve, reinforced by the support from the group, had provoked a change in the patient's response. Dr D commented: 'It seems as though what we bring massively dictates how the patient responds.' There followed a discussion about whether the GPs bring their own needs into their consultations – perhaps a need to be relied on, to be empathic or particularly caring. They talked about handing out the tissues as 'doing the solemn "I care" thing' and were astonished to realise how much their attitude might affect the patient's behaviour.

I found myself able to sit back and observe their process of enquiry, reflection and understanding. It did not seem necessary to intervene or comment, and it was moving to observe the creativity that was beginning to emerge. Afterwards I wondered whether my own shift in perspective and deepening confidence in the group had influenced the unconscious group dynamics. Had my own development affected the group process, enabling me to subtly let go of my need to be recognised, so that I could allow things to proceed with their own momentum? I am mindful of Winnicott's wise words in Playing and Reality (1971):

If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever. I think I interpret

mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers.

As we approach the end of a year of work together, I am aware that this has been an enlightening journey for us all. It takes great courage for GPs to be prepared to open up to one another and reflect so deeply on their work and relationships. I have grown in confidence as a group facilitator during the year, and am learning the value of trusting the group process.

In these times of target setting and accountability, doctors are expected to cope, keep going and know the answers. Traditionally, cases are discussed briefly in the corridor or over coffee, and there is a culture of self-sufficiency and autonomous practice that does not encourage enquiry or exposure of vulnerability. As a result doctors develop ways of 'cutting off' (Burton and Launer 2003) by splitting their needs onto their patients and ignoring themselves, resulting in cases of burn-out and stress. Currently there is growing concern about the lack of provision and opportunity for reflective practice and support for GPs in Britain (Launer 2007). As a result Balint Groups seem to be undergoing a revival. It is a great privilege to be part of this process.

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The Importance of Strong Working Alliances in Balint Group Development

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One of the passions in my professional life since I've been at the Santa Rosa Family Medicine Residency over the last 27 years has been leading Balint groups and other reflective group experiences. One of the main reasons we have created the American Balint Society, the International Balint Federation and other Balint societies, is the promotion and furtherance of Balint work. This includes the expansion of Balint work to those not currently participating in groups, as well as the care and maintenance of those already existing groups. Unless we pay attention to how best to maintain the quality of the groups we are currently leading, and develop new groups, Balint will not grow and flourish. This is a problem that we've been grappling with for a while.

The first part of my argument is that it is not enough to be an accomplished Balint leader; not only do we need to be excellent leaders, we need to actively work to develop new groups, and sustain those groups over time. (I won't continue on this point, as I'm fairly confident I would only be preaching to the choir.) And here is the second and most central part of my argument and the one I'll be focusing on today – the crucial importance of the working alliance for the future of Balint work. There is a great deal of very good research coming out of psychotherapy that is quite germane to the purpose of promoting and sustaining productive groups. This body of research looks at the working alliance. A good strong working alliance is defined as 'the degree to which the therapy dyad is engaged in collaborative, purposive work.'[1] They find that the quality of the working alliance is by far the best predictor of a successful outcome in psychotherapy –more important than patient characteristics, psychotherapist characteristics, psychotherapist technique, attitudes or theoretical orientation. I believe that this is also the case in primary care medicine. And I believe it is also the case in Balint groups. Therefore, what I'm going to focus on today is an expansion of the definition of the working alliance to include not only physician and patient, not only leader and group, but also, and perhaps most importantly, leader and organization. I am arguing that the development and maintenance of a good working alliance must include relationships with individuals, groups, and the organizations within which these groups take place, in order to optimize the possibilities of successful, long-standing Balint groups. To this end, I'm briefly going to trace the developmental process and challenges of the three Balint groups I currently lead, highlighting the problems that arose, threats to the formation and continuance of the groups, and how I am addressing those problems, all with an eye to the importance of creating and maintaining good working alliances so that Balint group work can continue to grow.

Resident Balint groups

How did the Santa Rosa (California) Resident Balint group experience come to its current form? We had resident groups about 25 years ago when Frank Dornfest came for eight years' tenure as our residency director. When he left, the groups disappeared. The subsequent director (whose tenure was about 12 years) couldn't understand Balint (he stormed out of the room during one demonstration Balint).

All this time, we had Professional and Personal Development (PP and D) groups, which addressed many of the residents' needs for support and group affiliation and were very popular. However, I kept looking for an opportunity to reinstitute resident Balint. It turned out that the director of our outpatient family medicine center had participated in a previous Balint group and was willing to excuse R2s (second year residents) from clinic for one hour twice a month for a Balint experience. I remember attending a harvest party at his home after he told me that almost no faculty member ever attended any of his functions outside the residency. I think this helped our working alliance. He later told me that he had noticed that patient complaints decreased dramatically when residents began doing Balint. I told him how much I appreciated his creative problem solving that freed the R2s to form a Balint group.

The group was well-liked and got very positive feedback on the year-end evaluation. This allowed me to think about expanding from a one-year experience for just R2s to a two-year experience that included R2s and R3s. In order to get the support from other faculty members to expand the group, I knew I had to rebuild the entire Balint infrastructure at the residency. By this time, I had the Faculty Balint Group going again. We also had the ABS (American Balint Society) credentialing initiative going strong. I encouraged a few other faculty members to attend Leadership Training Intensives and to become credentialed leaders. I also had been at the residency for 20 years and had developed good working relationships with most of the faculty. With this support among the faculty, I proposed taking over a precious dedicated conference hour twice a month, where residents got credit for

attendance and did not have competing clinic pressures. Even though the residency director couldn't stand the Balint process and didn't understand it, we had a good enough relationship that he trusted my judgment that it would be a worthwhile educational experience for the residents. I had a similar relationship with the residency administrator, who, at a critical meeting, in the face of opposition to Balint, came up with the compromise idea of trying the Balint groups for a two-year trial. That was about four years ago.

Residents spend two years in Balint now, a year with each of two leader pairs, two of the non-faculty leaders volunteer their time without pay, and one of them drives over an hour twice a month to co-lead his group. In terms of maintaining the group, all leaders (including one trainee) meet after the groups for 30-45 minutes where we present our groups, and discuss group development, leadership, and threats to the group, co-leader relationships and other such issues. The group takes place at the end of the day on Thursday, a time when most residents would rather be going home to their families or going out to exercise. The residents are required to sign in for Balint, just as they are required to sign in for all the other Thursday afternoon conferences. As a member of the faculty who tries to attend to their well-being and long-term development, I hope the residents know I am there for them, that I try to understand how their lives as residents are not easy. I cut them slack if they are late for the start of group. I try to end on time, believing it is more likely that they will attend if they are confident that we will be done on time. I try to understand when they use the group to complain about how difficult they have it with patients. I try to make the atmosphere of the group stimulating and energizing, especially since it takes place at the end of the day. I try to come to the group with a generous, optimistic attitude. I honestly look forward to spending time with the residents and their cases. (They love to hear updates on the cases previously presented, since many of them know the patients being presented by other residents.) I try to understand the stress they hold as residents at different developmental levels of their training.

(The beauty of a vertical group that contains residents who have never experienced Balint as well as residents who have a year of experience is that the experienced residents help train up the inexperienced ones. The inexperienced ones look forward to being with the class ahead of them in the Balint group.) In other contexts, I mention that their difficult cases might be possible Balint presentations. I want them to graduate knowing what the Balint process is and to feel it as familiar, to miss it, and band together with their colleagues to request a Balint group from their employer. More about this later.

To summarize, in order to develop and maintain a successful Balint experience during Residency, I had and have to attend to my working alliances with the residency director, the family practice center director, the residency administrator, my co-leaders, the individual residents, and the organizational needs of the residency curriculum.

The Faculty Balint group

This is a group that began over 25 years ago, although only two of us were members back in the day. It had a long hiatus during very dark financial times. I reconstituted the group about eight years ago. In its current form, we meet twice a month. It is led by myself and another credentialed physician co-leader. The largest challenge for Faculty Balint is numbers; this group is always on the edge in terms of having enough members to make it feel like it is a solid group. It currently has five or six participant-members, plus the two leaders. Competing demands for faculty time always threaten having enough bodies in group to make for a lively discussion. I send the members reminders about a week in advance of the group, requesting regrets only, assuming they will attend. I also ask them to block their schedule for the second and fourth Thursday of each month from 3 to 4 p.m. I invite them to bring in new faculty members, as I do; I emphasize the team building and connective benefits of group – that they not only come for themselves, but they come to support each other as well. I try to look forward out loud at being able to spend reflective time with them at the group. We joke and have fun with each other, most of us believing that education, at best, should also be an enjoyable experience.

Cases come from either the members' (or occasionally the leaders') patient or teaching population. Nearly everyone looks forward to presenting cases. The members are very considerate and tend to take turns doing so; it is rare that one person will dominate with frequent presentations. My co-leader and I meet briefly at the end of the day to check in about anything we need to attend to. I write up the case at the end of the day. I occasionally remind them of the patients and residents they have presented over the years.

My role is far less traditional in this group. Again, I struggle against scheduling threats to member attendance, such as faculty presentations at the resident conferences. (I have even asked the conference coordinator to try not to schedule faculty who are Faculty Balint participants to present during the time that Faculty Balint is held. Since he happens to be a member of Faculty Balint, this sometimes works.) Unfortunately, the group is sometimes quite small: only three or four members plus two leaders on occasion. At these times, when the presenter pushes back, one or both of the leaders will participate more with the group in speculating about the case. Also, on occasion, both of the leaders have presented their own cases.

Most of the participants are my

colleagues; some were my residents whom I've recruited to be faculty, and recruited to be in the Faculty Balint group. They each take an hour out of their administrative time to attend. One is a former interim residency director who saved my job during dire financial cutbacks. So my relationship to the members of this group is much more complex and multidimensional than in the resident group: instead of being just a leader to the group members, I am also a colleague, former teacher, friend, and consultant to the members at various times. The most striking difference in my leadership of the Faculty group is my (and my co-leader's) availability to participate fluidly in a member-like role, while still maintaining ultimate responsibility for the group. Because of the size, the leaders move back and forth between member-like and leader-like interventions. This is sometime referred to as 'leading from within.'[2] Not to do so, would not fit with our Faculty Balint group. Over the years, I've evolved to this style of leading the group, and it seems to work. Now if we can just secure the funds to hire additional faculty who want to part of the group...

To summarize, for the ongoing success of the Faculty Balint group, I again have to attend to my working alliances with the residency director, my volunteer co-leader, the conference coordinator, the faculty members, and other faculty, who might become members at some time in the future.

Balint for practicing physicians

I have just begun a group for physicians practicing in a local Health Maintenance organization (HMO). I co-lead this group with another credentialed leader, a physician, who also co-leads the other resident Balint group. The HMO group has about nine possible attendees, five of whom usually can attend at any one group. The participants are primary care physicians, either family physicians or internists, who expressed interest in this group after I was invited to give a talk on burnout, meaning in medicine and sustainability of practice. I was invited by a graduate of the program who missed having a group reflective experience and wanted the HMO to institute one. Primary care physicians in this organization were under tremendous stress. Some had left, many were depressed. They decided something was needed. The department planned a day off-site, part of which was my talk. At the end of the talk, I suggested possible actions both individuals and organizations might take to address the problem. I recommended Balint and Professional and Personal Development groups as two important organizational interventions to address burnout and promote sustainability of practice. From that talk and their fear of an impending shortage of primary care physicians and concern for others becoming burned out, the HMO committed to three groups for a year, each meeting twice a month. Some physicians chose to attend the Balint Group, others chose the P&PD group, and a few are choosing both.

The participants include: newly hired physicians having difficulty acclimating to the HMO, since they receive the most difficult patients for the first two years until they have established their own, familiar patient panel; physicians who know me from another context – either they were former residents I taught, or physicians who had been at one of my talks or workshops; physicians who had previous Balint experience; physicians who desperately needed to talk about troubling cases in a non-judgmental format; physicians who were isolated and wanted to connect with their colleagues; or physicians who were on the edge of quitting or falling apart. I still think it an unbelievably propitious opportunity to run such a group for such a productivity-driven organization. At a time when physicians in such an organization come under scrutiny for ordering more tests and lab work than their peers, when physicians are asked to see more and more patients, for physicians who are inundated with charting and other desk medicine requirements, I think it somewhat extraordinary that the organization is willing to pay for two leaders to hold a Balint group for interested physicians, and, that physicians are willing to take an hour out of their busy day (which will likely result in them working an hour later that evening). It seems in this local context a type of 'tipping point' was reached, allowing everything to come together so that the group could begin and people could experience the benefits.

Because of the relationship many of them have had with me over the years when they were residents, they trust that a confidential group reflective experience might again be helpful to them. One of them missed his group experience so much that he asked me to give the talk, and asked the HMO to institute the groups for the physicians. Without the good working alliance he and I had developed during his residency, I'm not sure either the opportunity to speak to the department or the opportunity to lead groups for the HMO would have occurred. The largest difference in my leadership of this group is probably my intense efforts at establishing the safety of the group in the face of constant threats to that safety: For example, the group felt threatened that the department chair wanted to participate, since he evaluated them and granted them their end of year bonuses. Also, there is no dedicated room for this group, except for one that contains the refrigerator and microwave that other staff use for their lunches. Even though I place a sign on the door asking them to wait until the group is over (a somewhat unrealistic request on my part), we are often interrupted by someone needing something from the refrigerator. Also the room is separated from the health educator's office by an accordion divider, which is unsatisfactory in terms of confidentiality. For the small price of a sandwich and soft drink, the health educator has offered to lunch elsewhere and try to schedule appointments around our group time. I want the members to feel safe

presenting cases of great vulnerability in a confidential format. The tremendously painful cases they present (e.g., a frustrated physician presented his relationship with an eating disordered patient refusing all entreaties to eat; a shocked and surprised physician presented one of his patients, who worked at the medical center, who carefully and privately planned her own successful suicide; and others). These are evidence that they can allow themselves to share very vulnerable feelings and situations with each other.

I promised to supply the HMO with a group evaluation by the group members in the late fall. I don't know if the HMO will be able to afford or choose to continue the group past the end of the year (or even to the end of the year, considering the current economic challenges). So far, the participants have been incredibly enthusiastic and appreciative of the opportunity. I hope the organization will find the resources so that the group can continue.

To summarize: for the practicing physician group I had and have to attend to nurturing strong working alliances with former residents, the department chief (and his administrative assistant who arranges the rooms and the lunches), as well as the individual physicians in the group. As the year comes to a close, I imagine my working alliances with others will also become important in regard to the potential continuation of the group.

In conclusion, I am convinced that without the good relationships or working alliances that I developed over the years, with individuals, with the groups, and with organizations, the continued existence and the ongoing viability of all of these groups would not be possible. I hope that these three tales will stimulate you to go out and examine the nature and quality of the working alliances you have now; I also hope you will look at potential alliances that may either positively affect the longevity of your existing groups or open up the possibilities of new groups. I hope that attention to the quality and strength of working alliances at all levels will only help us to promote Balint work further, work that we all have experienced as invaluable in improving the physician-patient relationship, the health and well-being of patients, and the satisfaction, sustainability and meaning of medical practice.

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Reflections on the Struggle between Altruism and Egoism and Parkinson's Disease

Dr. Ariel Arieli (Israel)

Introduction

In one of our Parkinson's support group meetings in Israel, a public figure bitterly remarked that we live in a 'dog eat dog world.' He complained that since he had contracted Parkinson's, his old friends treated him with disdain and seemed to take vicious pleasure in his deterioration. This comment provoked debate amongst members of the group. They reported that, while they also felt mistreated on rare occasions, in general, they had the opposite experience. Contrary to his opinion, the other members of the group claimed that people regarded them with the utmost compassion, empathy, willingness to help and generosity of spirit. This discussion motivated me to investigate deeper, and thus I turned to the professional literature. Around the same time, I happened to watch a documentary about a related topic. In the film, a helpless man was trapped in a car, which was engulfed in flames. Another driver came down the road and saw the victim's plight; without a moment's hesitation, he hurled himself into the burning vehicle and dragged the man to safety. Only later, when he arrived home, did the driver realize how he had jeopardized his own life for the sake of a perfect stranger, and he became stricken by anxiety.

The purpose of this article is to describe the various perspectives regarding the conflict between altruistic and egoistic behavior, according to the following professionals: philosophers, psychiatrists and psychologists, and neuroscientists. Finally, it is my aim to connect these points of view with the typical characteristics of a Parkinson's patient, and to draw conclusions about the influence of such traits on this conflict.

Philosophical Perspective

Ever since Rabbi Akiba decreed, 'Love thy neighbor as thyself', philosophers have struggled with this concept up until modern times. Two basic questions emerge regarding this matter. First, does altruistic behavior actually exist, or is it just a lofty ideal or wishful thinking, something that is impossible to realize? Second, is altruistic behavior is learned or inherent in our species? The term 'altruism', first coined by Auguste Comte in the 19th century, is defined as 'excessive love of the other, willingness to sacrifice one's own well-being and happiness, even one's own life, for the sake of someone else, or the benefit of one's fellow man'.

There are two philosophical camps, namely, optimism and pessimism, regarding these questions. Jean-Jacques Rousseau, and all the French utopians who followed him in the eighteenth century, were apparently the most optimistic of all the philosophers. They claimed that a child is born innately good, that his soul is a tabula rasa, or 'blank slate', and therefore an education based on helping others in distress, empathy and humanitarian values, could transform him into an empathic individual. Rousseau's disciples also claimed that a child should be educated in a natural, free and harmonious environment, in contrast to urban scholastic education. Thus, Rousseau proposed the concept of the 'noble savage', which described how the natural purity and innocence of primitive man had been corrupted by human civilization and government.

Across the Channel however, philosophers were less romantic and more pragmatic. Thomas Hobbes of the eighteenth century, Herbert Spencer of the mid-nineteenth century (a contemporary of Darwin), and other notable British philosophers, argued that the world was designed solely for Man's benefit and self-interests. They claimed that Man was therefore justified in exploiting it to maximize his own betterment, and that it was morally acceptable to do so. Hobbes refuted the entire notion of the existence of pure altruism, divorced from egoistic motives, in our actions, and even in our thoughts. 'When I give a miserable beggar a shilling,' he once exclaimed,' that is a selfish act, because it makes me feel good!' This principle is applicable to acts of giving charity in general, and volunteering in particular, which can be considered a form of egoism, by virtue of the fact that they elicit a sense of satisfaction in the one who gives (as will be discussed later).

It is interesting to note Darwin's opinion about this matter, for as father of the theory of Natural Selection, he focused on animal evolution, including Man. This theory determined that Nature governs by the principle of survival of the fittest, so that the strongest individuals must kill their weaker competitors in order to transfer their successful genes to their offspring. Darwin, an exceptionally moral man, felt repulsed by these brutal laws of Nature he himself had described.[1] This fact drove him to publish an additional article entitled 'The Expression of Emotions in Man and Animals'[2], in which he claimed that altruistic feelings exist in the animal kingdom, as well as in mankind, and are inherent in the species. Darwin wrote that altruism has existed in Man since the dawn of history, and has aided in his survival; this occurred through the formation of unified bands, which could collectively grapple with large dangerous beasts and other natural hazards. Even today, untiring optimists such as Matt Ridley and Daniel Goleman struggle to prove their theories about altruistic human behavior, and have written books demonstrating that 'the human heart is innately good'[3,4].

Psychiatric and Psychological Perspectives

There is also controversy amongst the leading theorists in psychology and psychiatry on this matter. Bleuler, one of the great minds in modern psychiatric medicine, who first described and defined schizophrenia, also claimed that there are ethical (altruistic) instincts in every human being[5]. In contrast, Freud[6] was much more pessimistic. In his opinion, a child is born totally egoistic, and feels the urge for instant self-gratification; altruism is something that is acquired only through societal pressure. As a result, any altruistic behavior on his part is always secondary to his selfish behavior. In actuality, there are two powerful opposing forces, or vectors, which are constantly at war within every person's psyche. This comes as no surprise, as all human behavior is derived from contrasting tensions, which can be described as the fierce battle between the individual and his conscience (or what is referred to in psychiatric jargon as the struggle between the ego and the super-ego). The intensity of this conflict is manifested according to his personality: if he has obsessive-compulsive traits, or is anxiety-prone, then the struggle is even more traumatic. This is highly subjective, and can range from a slight feeling of discomfort, as in a sense of 'something is rotten in the state of Denmark,' to clinical depression, with all the accompanying symptoms of sleep disturbances, strong guilt feelings, and even contemplation of suicide.

It is not only those with depressive tendencies or a strong super-ego who find themselves engaged in this conflict. As the Chinese sage Mang-tze stated over 2400 years ago, everyone is given a soul, which cannot bear the suffering of others, and thus when we hear the cries of a young child we instantly rush over to help him. That is to say, compassionate feelings are built in, and thus upon receiving a stimulus that someone is in trouble, a network of emotional reactions triggers the motor system (notice the connection between the words *emotion and motion*).

To illustrate further the extent to which altruism is an integral part of human behavior, let us look at an intriguing study conducted at Princeton University, known as the 'The Good Samaritan' experiment[7]:

As the story goes, a Samaritan was riding along on his donkey when he spied an old man on the roadside, pleading for help with his hand outstretched. The rider immediately pulled his donkey to a halt in order to assist the elderly man...

A group of 40 students, men and women, sat together revising for a test on The Good Samaritan. Their examiners were waiting for them in another building, and the students had to go down a long corridor to get to them. A pitiful old man sat in one of the rooms they passed, with the door open, crying out to passers-by. Only 16 out of the 40 students paused to help the poor old man, the other 24 simply ignored him and continued on their way. When asked why they did not stop to help him, they came up with many reasons; most of them explained that they did not have time, because they were worried about arriving late to their exam...

Neuroscientific Perspectives

Remarkable discoveries have been made over the last two decades in the field of brain research, especially since the beginning of the twenty-first century. Thanks to the widespread use and technological advances in neuroimaging techniques with high spatial resolution, and the courageous collaborative efforts of neurologists and psychologists, some revolutionary contributions to brain research have been made. These advances have had a major impact on the insights and perspectives of a vast majority of scientists. For the purposes of this article, I will touch only upon those discoveries that are relevant to our topic, that is, the conflict between altruism and egoism. For those readers who wish to obtain a more detailed explanation about these advancements, I highly recommend three published works by Daniel Goleman. These books are: *Emotional Intelligence*[4], *Social Intelligence: the New Science of Human Relationships*[7] and lastly, *Destructive Emotions: How Can We Overcome Them?*, an account of an exciting seminar that took place in India in the year 2000, based upon dialogue between the Dalai Lama and his disciples, and some of the world's foremost authorities on neuroscience. Discoveries related to this article, are as follows:

1. Integrative Functioning in All Areas of the Brain

Until a few years ago, anatomically well-defined regions of the brain were known to be responsible for particular mental functions, and were said to work in exclusion from the other areas. Take, for example, the prefrontal cortex, considered to be central to thought processes – cognition – such as wisdom, judgment, memory and so on. The regions located more internally in the brain (the limbic area containing the hypothalamus, the amygdala, the hippocampus, and other important sections), are said to be solely responsible for the regulation of sensory and emotional processes. Research in recent times has raised some questions about the validity of this theory. First, it was demonstrated that cerebral activity involves the entire brain, and spreads out to all regions through nervous-electrical cycles, even to the most remote areas (in varying degrees of intensity).

2. The prefrontal cortex is imperative to sensory responses, and the limbic area plays a crucial role in cognitive processes.

Recent studies have demonstrated that the limbic area and the pre-frontal cortex are intricately woven into a circuitry of hundreds of millions of

neurons, which simultaneously link together thoughts, feelings, conscience and sensory perceptions. Daniel Goleman points out how the invincible determination of Professor Richard Davidson caused a revolutionary change in perspective among neuroscientists concerning cerebral processes. As a junior researcher in the 1970s, Dr. Davidson was interested in the brain's influence on the processing of emotion. He went on to claim that the prefrontal cortex played a central role in the regulation of feelings. That was the era of 'Cognitive Behaviorism' in psychology. Everyone was interested in the workings of cognition, and they pushed aside anyone who focused on emotional processes. Dr. Davidson was also unpopular because he greatly emphasized the information stemming from subjective experience, while other researchers claimed that only objective facts had any scientific value. His approach was like a lone 'voice crying in the wilderness' for more than ten years, until he ultimately managed to convince his colleagues of the validity of his work. Today, Professor Davidson oversees one of the most important neuroscience laboratories in the world, located in the state of Wisconsin, which is funded with a research budget of tens of millions of dollars.

3. The Brain's Flexibility – Neuroplasticity

One of the most amazing discoveries of recent years is how brain tissues are able to change, not only in response to different physical factors, but to altered emotional states as well. The limbic region is the most flexible area of the brain. When we feel good, the amygdala expands from its normal size of 1.5 centimeters, and it contracts when we are depressed. The amygdala becomes enlarged once again after an appropriate treatment regimen of anti-depressant drugs[7]. Some scientists emphasize the influence of mood on the hippocampus, a slender, horn-shaped region of the brain, approximately one centimeter long, which is located directly behind the amygdala. The hippocampus is responsible for our active memory, and its close proximity to the amygdala enables these two interconnected organs to work in tandem in memory-related functions. For example, let's say I am walking down the street, and I unexpectedly bump into an old acquaintance. My hippocampus immediately begins registering all kinds of stored details about this person. While my hippocampus is busy retrieving these facts, my amygdala draws upon my previous feelings about him. It warns me that our last meeting had been tense and upsetting, and urges me to hurry along in order to avoid any further confrontation with him. In other words, the amygdala provides an emotional context to the event[9].

4. In Search of an Altruistic Gene

The fact that altruistic behavior is inherent in both animals and humans perplexes neuroscientists, particularly developmental biologists, for it contradicts the fundamental laws of evolution based on the principles of aggression and competition. Currently, extensive studies are being carried out by numerous groups of neuroscience researchers[10,11] in search of an altruistic gene. Yet despite their collective efforts to unravel this seeming paradox, it remains unsolved. What they have been able to find, however, is a partial answer: they have identified two genes, involved in the neural signaling mechanisms relating to altruistic behavior, that are located on the D4 and D5 dopamine receptors. The neuroscientist R. Bacher-Mekman[10] and her colleagues in Israel found clear statistical evidence demonstrating a correlation between generous behavior and what is known as the 'reward and pleasure system' (see 13 for more details about this process). This explains the sense of elation felt by the person who performs an 'act of kindness'.

5. 'The Social Mind'

One of the most outstanding recent discoveries in the field of neuroscience is the concept of the 'social mind'. Apparently, the human brain is naturally primed towards collaboration – in other words, our minds are functionally tied to our fellow man. This mental interconnectedness between humans is made possible through specialized cells known as 'mirror neurons'[12]. The larger size and shape of these neurons are distinguishable from regular brain cells, and their role is to facilitate communication and bonding between two individuals. This is especially true when two people have a sense of 'good chemistry'; they unconsciously mimic each other's vocal tone and body language without noticing what they are doing, thus enhancing their positive interactions. Furthermore, these mirror neurons are present in all regions of the brain, and they not only enable us to imitate the gestures of the other, but also to 'walk a mile in his shoes'. Thus, we are motivated to interpret the meaning of our fellow man's actions, to empathize with his feelings and perceptions, and to attempt to identify with his life experiences as if they were our own.

6. On a Personal Note

As stated earlier, Professor Richard Davidson paid serious attention to the subjective perceptions of his patients. Many neurologists today also attribute great importance to these feelings, among them, Professor Nir Giladi. In private conversations with him, I promised that I would write something about some of my own subjective feelings. I am 77 years old and have had Parkinson's for about twenty years. The major symptoms I experience are rigidity and slowness of movement. I suffer from episodes of 'on-off' practically every day, and the 'off' periods last from one to four hours, often accompanied by stages of freezing. Like many of my friends with Parkinson's, the slightest unexpected emotional trigger, be it irritability or

excitement, can exacerbate the severity of these symptoms. On the other hand, my peers in the support group and I are aware of a pleasant phenomenon which we have discovered in our daily lives. Whenever we experience deep satisfaction, something that gives us a special sense of purpose and fulfilment, then our familiar physical symptoms temporarily disappear, even for several days. In my case, this sense of contentment can be elicited from various experiences, for example: the company of good friends who accept me as I am, overcoming my perfectionist tendencies so that I can write something worthy, a pleasant excursion, or the uplifting feeling I get after performing a good deed.

An additional comment I would like to make is that I have always been a highly-strung individual, long before I contracted Parkinson's disease. My work as the head of a clinic, and above all, as a psychotherapist, helped to diminish my anxiousness. I was able to overcome this further and to regain a greater sense of equilibrium through many years of volunteer work. For instance, following the 1974 massacre of schoolchildren in the northern development town of Ma'alot, I established a psychiatric counseling center to aid people in dealing with the terrorist attack. I volunteered my time in this clinic, which was located several hours' drive from my home, once a fortnight for seven years. I admit that courage is not one of my personal strengths, yet during the Yom Kippur war in 1973, I worked around the clock with soldiers suffering from post-traumatic stress disorder (PTSD). Completely absorbed in helping these young men to cope with the impact of battle, I fearlessly ignored the danger I was in. This was in spite of the fact that the site where I was treating them was within extremely close shooting range of the enemy.

7. The Struggle between Egoism and Altruism and Parkinson's Disease: the role of volunteer work

This article has frequently touched upon the relationship between Parkinson's and the conflict between egoism and altruism. As I mentioned previously, the typical traits of a Parkinson's patient are those of an obsessive, perfectionist personality, often plagued by excessive feelings of guilt and a need to clear one's own conscience. One of the ways he can allay these negative emotions and pacify his own conscience is to do volunteer work. Yet many such people can become overly self-sacrificing in order to feel better, to the extent that they neglect their own needs. The uplifting aspects of volunteering are far more than simply enabling someone to feel less guilt-ridden, for benevolent acts are highly commended by society. Beyond the praise he earns from others, the volunteer perceives an internalized sense of satisfaction and self-worth that are intrinsically related to the 'pleasure and reward' system. This process is enabled through the increased secretion of dopamine, for positive, enriching experiences stimulate dopaminergic activity in the brain.

In truth, someone who volunteers 'kills two birds with one stone': not only does he feel he has received more than he has given, and is elated by his efforts, but he also enjoys a sense of renewed control as his physical symptoms subside (if he has them). This is especially noticeable in Parkinson's patients, who can be freed from their 'off episodes' for a number of days by doing volunteer work; what a tremendous sense of relief this brings them! Even if it is true that every act of giving is characterized by an element of egoism, who cares? As long as everyone is happy, what difference does it make if the volunteer's benevolence contains some degree of self-interest?

Due to its plasticity, tissues in the brain are transformed through the sense of accomplishment in an altruistic deed. This significant fact demonstrates that dopamine-secreting cells are not actually destroyed, but rather are capable of continual and renewed secretion of this hormone. This supports the notion that human behavior is learned, not innate, and therefore, can be instilled through proper education. Kindness is a trait that can be taught, provided the learner is motivated. (Incidentally, motivation is also related to the secretion of dopamine!) The most admirable example of altruism and generosity of spirit can be seen in the partners of Parkinson's patients. This is particularly true of the partners who share their lives with them, and whose untiring support is often giving at the expense of their own personal goals, careers, quality of life, and sometimes, even their health.

Conclusion

How can we respond to the member of our support group who claims that we live in a 'dog-eat-dog world'? After delving into the evidence presented herein, we can tell him that he is only partially correct. His comment can be compared to the person who can only see the cold, dark side of the moon, when in fact, the other side, which is warm and radiant, is also apparent. Even on the dark side of the moon, we can sometimes detect tiny beams of light...

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The Art of Professionalism: Being in Role as the Fundamental Skill

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Overview

In the past several years, the concept of professionalism has become a focal point within medical education and the medical community.[1-7] All definitions of professionalism share a common understanding that professionalism is not a single construct but defined by a constellation of components. While some definitions, such as the Accreditation Council for Graduate Medical Education (ACGME1) and Physician Charter[7], are statements of principles or outcomes, those by Swick[6] and National Board of Medical Examiners Center for Innovation (NBME:CI[5]) are based in behaviors. For example, Swick's definition includes behaviors such as subordinate one's self-interest to the interest of others, adhere to high ethical and moral standards, evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others, and trustworthiness, exercise accountability for oneself and for others, and incorporate self-reflection about one's actions and decisions.

As medical educators, it appears to us that a central, integrative theme has been overlooked in existing concepts of medical professionalism. We call this core integrative theme the concept of "staying in role". We believe that the initial steps in professional development must involve developing and understanding the expectations of being and staying in the culturally defined role of physician.

Our goal in this commentary is to discuss the elements that we use in our efforts to promote medical professionalism among undergraduate medical students. While we agree with the idea that "...teaching professionalism begins with the first-year medical student...and continues as the student progresses into the clinical arena..." we believe it is particularly important to use experiential methods to instruct medical students as early as possible in their training[3,4]. The idea is to "lay a solid foundation" that can be built upon throughout medical school, residency training, and in professional practice. As we present our instructional method, we will focus on three explicit areas:

1. The professional role;
2. The potential impact of transference and countertransference; and,
3. How medical students can learn the importance of remaining in their professional role while recognizing and managing both transference and countertransference.

The Professional Role

Many future physicians begin medical school with some interest in both medical humanities and better understanding the doctor-patient relationship and the role of empathy.[8,9] However, most medical students are somewhat lost when it comes to having a mature appreciation of the role of doctor in western society. It is up to us as their faculty to promote the nurturance and development of medical student curiosity in this direction.

In our work with medical students, we explain that the essence of medical professionalism requires "staying in role" with their patients. While meeting this challenge requires attention to various elements of professionalism (e.g., integrity, accountability, competence), we believe that empathy is of particular importance in understanding the doctor-patient relationship, and in turn, staying in role. Empathy is an imaginative appreciation of the patient's state of mind and ways of interacting with others. The product of empathy is emotional understanding. Physicians who are viewed as excellent doctors by both peers and patients tend to use empathy to help establish the reason for the patient's visit and to implement a management plan based on best practices coupled with an approach which is most suitable for the particular patient.[10,11]

Through fostering a professional doctor-patient relationship that helps patients present their story in their own ways, the physician in role can use empathy to respond in an effective manner. Empathy is inherent in creating this atmosphere, and is the skill for maintaining the integrity of a professional relationship. The empathic doctor is an active listener both to the patient's story and to the thoughts, feelings and actions the patient's presentation engenders. Such a doctor is able to differentiate thoughts and feelings belonging to one's self from those of the patient; knowing the difference involves self reflection and introspection.

Transference and Countertransference

Patient-centered medical care is now advocated as a fundamental building block for meaningful healthcare reform. In this regard, it has been argued that quality of medical care must be evaluated (at least in part) in terms of the quality of patient experiences with the health care system including the quality of the doctor-patient relationship.[12] On this basis, we believe that the psychodynamic concepts of transference and

countertransference provide a heuristic model for understanding and managing the doctor-patient relationship in an empathic fashion.

Transference describes the process whereby the patient unconsciously projects thoughts, feelings, and wishes from their past onto the doctor. Similarly countertransference refers to the process whereby the doctor may unconsciously project thoughts, feelings, or wishes onto his or her patient. The term *projective identification* describes a process whereby the physician temporarily indentifies with the patient's thoughts, feelings, and wishes. It is the conscious recognition of projective identification that allows the physician (or other authoritative health professional) to refrain from actions (e.g., topic avoidance, blame, inducement of shame, etc.) that serve a primarily defensive function for the physician (to protect the physician from uncomfortable feelings such as vulnerability, loss, or sadness).[13] As the goal within the doctor-patient relationship is to always serve the best-interests of the patient, failure to recognize and manage transference-countertransference reactions can produce harm in providing the best care for our patients.

A few simple examples of transference and countertransference may be helpful. For example, the patient may use the defense mechanism of projection to accuse the doctor of being unsympathetic. An alternative explanation may be that the patient has experienced past authority figures to be unsympathetic and is indirectly expressing this fear to the current doctor. If the doctor becomes annoyed at this (inaccurate) accusation, he or she may be picking up on the patient's own low-self esteem (involves the doctor changing their thought of "I don't like this patient" to "maybe the patient is acting this way because authority figures have taught them to not like themselves").

Another transference-countertransference dynamic may involve what can be termed a parallel process. In other words, the patient may through thoughts, feelings, and actions influence the physician to play a familiar (but self-defeating) role in the patient's life. Such parallel process scenarios may take various forms (rescuing the patient, punishing the patient, reinforcing guilt within the patient, etc.). The doctor who learns to "stay in role" develops the capacity to empathically understand doctor-patient dynamics such as parallel process. This doctor attempts to avoid reenacting this parallel process with the patient while still providing appropriately for their medical needs.

A final example of transference-countertransference reactions includes triangulation. In this example, the doctor might be induced into playing the emotional role of a family member who is not present ("doctor, you be the authority in controlling these children, because I don't know how to do it"). The doctor is implicitly if not explicitly pressured to take sides with regard to some long-standing intrafamilial conflict. As with other forms of transference-countertransference, the responsibility of the physician is to recognize the interpersonal dynamic that is being displayed and to use it for diagnostic purposes and treatment planning. In the example given, the doctor may need to offer several interventions (e.g., express empathy for the parent who feels overwhelmed, negotiate with the parent an agreement that the goal is to empower the parent towards more effective parenting skills, etc.).

The recognition and derivation of meaning from transference and countertransference is a product of empathy. *The empathic process is facilitated by the doctor understanding and managing their own projective identification with the patient's style (e.g., my irritation may reflect the patient's own low self-esteem).* The empathic process allows the doctor to remain professionally rooted in the role of physician. When empathy is impaired it is difficult to make sense of professional relationships and use these kinds of interpersonal understanding therapeutically. Fundamental to learning professionalism, is for the student to receive training in ways to manage the subjective experience of being and staying in the role of physician.

Teaching Role Maintenance

Accepting the argument that staying in role is a necessary component of professionalism, and that empathic recognition of transferences and countertranferences is a basic skill for remaining in role, it is important to discuss how this skill can be transmitted to medical students.

We have been working with first year medical students for nearly a decade in a communication and medical interviewing course, and have found that students as early in their first year of training are receptive to learning how to recognize and make clinical sense of projection, parallel process and triangulation in clinical situations. Through the use of standardized patient (SP) encounters in the course, we have been able to instruct students experientially about transference-countertransference issues and the need for staying in role. During the SP encounters, students take individual turns interviewing the SP, and taking "time outs" to obtain advice and where to go next in an interview is permitted (encouraged) during class. The SPs are paid actors who have been trained to portray a particular complaint commonly seen in primary care. As the course progresses, these patient complaints become more complex in nature, providing students with the opportunity to develop more advanced interviewing and communication skills.

We will now present case examples from our first year communication and medical interviewing course that illustrate our approach to teaching students how to manage the subjective experience of being and staying in the role of physician.

Projection. Patients bring to the encounter feelings that are often "caught" or engendered by the physician. The patient with an upbeat, positive attitude during a visit may have the clinician feeling refreshed and invigorated after the encounter. Based on counter-transference, this good feeling may distract the doctor from being sufficiently medically vigilant (e.g. the doctor indulges in feeling good, based on dependency needs for reassurance or narcissistic needs for approval). Similarly, a patient who is depressed may temporarily induce feelings of sadness in the clinician (such "bad feelings" can induce feelings such as vulnerability, impotence, or incompetence in the physician leading to either topic avoidance by the doctor or premature and "superficial" reassurance, again not serving the best-interests of the patient). We encourage students to reflect on the feelings that patients engender in them, and use the group's work with the SPs as a learning opportunity.

Example:
A standardized patient was scripted to present a chief complaint of chronic back pain after a work related injury several years previously. The actual actor was a man in his mid thirties who had himself suffered a disabling stroke as a complication of diabetes (his left arm was limp). The student group was overcome with a sense of sadness which made it difficult for the designated student interviewers to function without calling repeatedly for a "time out". In the time out periods they acknowledged the sadness and were able to imagine that this feeling belonged to the patient and could imagine letting go of it.

Parallel process. During the encounter, patients may reenact a troubled personal relationship, inducing the physician into a "complimentary role" similar to the person(s) within the relationship. Recognizing when one has been placed in a role other than physician is important for diagnostic and therapeutic purposes.

Example
A standardized patient was scripted to present a chief complaint of a sleep disturbance which began 4 years earlier, coinciding with her divorce. Her son who lives in the same town blames his mother for the breakup and remains alienated from her. Her daughter who lives 400 miles away, is sympathetic but rarely sees her mother. A male and female student was asked to play the role of physician and interview the standardized patient. The female was induced into the role of "good daughter" while the male could "do no good". The patient stated to the male student, while in role, "you guys wouldn't understand" when explaining about her feelings. In the debriefing the student group was able to see how the patient's trouble with her children was dramatically reenacted in the two interviews. This also allowed a discussion of how a male or female doctor might most effectively manage interactions with this patient.

Triangulation. Triangulation can be a subtext during a clinical encounter. We refer to triangulation as the instance "when the doctor and patient have in common a relation to a third person or issue that colors the quality of their contact."14 In the example that follows it will be seen that the burning emotional issues associated with nursing home placement are sidestepped by trying to "help out" the patient or her daughter (i.e., through projective identification the doctor either overidentifies with the patient or the daughter leading to an unsatisfactory outcome for the patient and her family) .

Example
Two standardized patients were scripted to play the parts of mother and daughter presenting a chief complaint of memory loss. The daughter wanted her mother to be placed in a nursing home while the mother wanted to remain in the daughter's house. The students asked to interview the mother and daughter struggled to remain above the fray. Each took sides with either mother or daughter and ended the interview feeling unsatisfied with their performance. In feedback the standardized patients felt that their concerns were not addressed. This information allowed the students to explore how their personal opinions distracted them from fulfilling the professional role of the doctor. Faculty were then able to model potentially more effective responses with real-time feedback from the standardized patient (e.g., "this must be a difficult decision for both of you", "both of you are struggling to do what you consider to be best", etc.).

Conclusions

Professionalism is an essential attribute of the physician's work. While ethical and moral standards, honesty, integrity, compassion, respect and other attributes are encompassed within definitions of professionalism, the need for the physician to be mindful of his or her role is fundamental. Recognition of transference and countertransference issues during the patient encounter facilitates staying in the physician role and maintaining professionalism. *In particular, the empathic process is facilitated by the doctor understanding and managing their own projective identification towards the patient.* Empathy becomes an essential tool in understanding and managing transference-countertransference reactions. We have described a way in which three common modes of transference can be introduced to first year medical students using standardized patients. We observed that the students grasped the concept of transference-countertransference and its relationship to staying in the professional role of the doctor.

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A short report of the experience of a Balint group with medical students in Peru

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This is a short report on an experience of training medical students in the Balint Group Methodology, at the Universidad Nacional Mayor de San Marcos, in Lima, Perú. Peruvian medical studies last seven years, and our experience was performed with sixth year medical students, meaning they were almost ready for their Internship: therefore, they had already finished the whole medical training. Peruvian medical training comprises direct patient care starting at the fourth year, meaning that a sixth year medical student has already had two years of experience in interviewing, examining, and suggesting therapeutic approaches.

The group consisted of six medical students. The professor acted as facilitator, after having been trained in the Peter C. Alderman Masterclass of the Harvard Programme on Refugee Trauma (Mollica and Lavelle, 2008). As the group was formally part of a course of the Medical School, the facilitator asked them if they were willing to be trained in a method for a more comprehensive handling of their patients and their own emotional reactions to them. The group agreed to devote a one-hour session every week, for 10 weeks, from May to June 2008. The first session was devoted to explaining the methodology and operative principles of Balint Groups (Elder, 2007). All the remaining sessions were basically typical Balint group sessions.

In an open evaluation, after the ten sessions, they all agreed on the following:

- The Balint Group method was found very useful in improving understanding of the emotional dimension of illness and health care.
- They all felt highly confident in their competence to share the emotional charge after difficult cases.
- They all felt more empathic with the patients.
- They all felt the training gave them an "inner peace".
- They felt a clear "evolution" in the perspective of how the health care team actually works.
- They all felt that sharing their emotions made the group more cohesive.
- They all agreed that this was a very useful approach, and that it should be introduced in the medical curriculum as a regular component of the training.

In my personal evaluation, at the beginning (first three sessions) they were quite amazed by the insight into their own emotions. Sometimes they would volunteer to share some personal experiences, as for example the personal involvement and related feelings in the loss of a relative, or some of their own experiences as patients and how this shaped their expectations for their career. After this, they were more open to discussing the emotional dimensions of their cases, and I would say that the openness, the active listening and concentration required for good group dynamics, were easily developed by the students.

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What Lord Darzi doesn't know: the role of psychodynamic factors in health

Richard Stevens

(Joint winner of the 2009 Balint Society Essay Prize)

This essay addresses the way intrapsychic factors affect healthcare through being ever present in every consultation, interaction and exchange. These can occur between and within groups or individuals of patients, doctors, other staff and even between institutions and organisations. Yet because these factors are difficult to see and quantify – a difficulty in part because their irrationality challenges our psychic defences – they tend to be ignored in all forms of health care planning. Because the soft stuff is hard to measure it is ignored. Nevertheless I believe that ignoring factors that contribute to the way patients and doctors behave, for example through transference, counter transference and primitive attachment drives, prevents a full understanding of health and wellbeing. Lord Darzi, until recently a minister in the Department of Health, has published a document to reform primary care (2008). This has become known colloquially as the Darzi report, and one of the recommendations contained within it, for polyclinics of primary health care services, has also taken his name and these structures are referred to as Darzi centres. The tenor of this report is of logical, evidence-based and rational progression. The left brain rules and market forces are dominant. I am, therefore, taking Lord Darzi's name to represent and characterise an approach to medicine; one that sees similarities between a broken car and a broken person, and that both can be fixed by suitably trained mechanics working from appropriately sited repair shops. I recognise I may be splitting off a number of features and projecting them into figure of the noble lord to whom I apologise if I do him a disservice.

Lord Darzi and Michael Balint both lived and trained in different healthcare systems before coming to the United Kingdom to leave indelible marks on British general practice. An outsider may have advantages and find it easier to have an unencumbered vision free of the histories, experiences and baggage that weigh down those who have always been within the system. A fresh eye can be used without expectations or projections. The fact that Lord Darzi continues with clinical work, where he develops minimally-invasive techniques and use of robots in surgery, may in fact obscure his view rather than keep him in touch with workings of the NHS. Balint came from Hungary after initially training as a biochemist. After re-training in psychoanalysis, he famously worked with British general practitioners and explored the doctor-patient relationship. His view of the central role of the family doctor led him, when considering the places of generalists and specialists, to write:

'[Moreover], for the general practitioner the patient is not only a patient but someone well known, including his family background, all his relatives, his past, his disappointments, success and quite often also his whole neighbourhood. The consultant, however sympathetic, is hardly ever involved to such an extent. Moreover, by forgoing the not fully justified role of a mentor equipped with overall superior knowledge and wisdom, the burden carried by the specialist will be lightened, and the weight of his opinion in his specialised field enhanced. So perhaps it is not entirely unrealistic to hope that it will be the specialists who first realise the advantages of openly accepting the role of expert assistants to the general practitioner.' (M. Balint 1957 pp100).

Today between 80 and 90% of consultations within the NHS are in primary care and the relationship between the patient and *their* doctor remains central. These encounters are the bedrock of healthcare in this country and the transactions occurring within them still need full exploration. It is widely quoted that 90% of communication is unconscious so it probably holds that the vast majority of interchanges of information, wishes, wants, fears and expectations are being communicated in a way that is unseen and unacknowledged. The unconscious mind is a key concept in psychodynamic thinking. Thoughts, feelings and emotions that are too difficult to bear are pushed from the conscious mind but this pushing is an active (a "dynamic") process and leaks and spillages occur. The most easily describable illustrations of repressed material being spilt are slips of the tongue, the Freudian slip. For example when describing the behaviour of a patient with a history of erratic behaviour and multiple episodes of self-harm, I reported that she "slut her wrists". On reflection I suspect that I prefer to see myself as a caring and non-judgemental doctor and as such I found I could vent my feelings of frustration and irritation at the patient's behaviour which nevertheless found a way of being expressed. Similarly when the wife of a patient consulting her general practitioner ruefully recounts the delay between her husband taking a Viagra tablet for his erectile dysfunction and the onset of the medication's action in error and embarrassment speaks of "cock watching" instead of "clock watching". Both are examples of the unconscious speaking "in humiliating mockery of our illusions of conscious awareness and control over our desires and intentions" (Mollon 2000 pp 4).

Unconscious factors are in play at other levels too. In an article that examines the general practice in terms of attachment theory, Elder

muses "when I was working for Central Relief Service, as a young doctor, I remember being surprised by the quasi-parental loyalty patients seemed to feel towards apparently 'bad' practices and their reluctance to change their registration" (A. Elder 2008 pp19). This resonates with:

"A young boy lies in a hospital bed. He is frightened and in pain. Burns cover 40 per cent of his small body. Someone has doused him in alcohol and then, unimaginably, set him on fire. He cries for his mother.

His mother has set him on fire.

It doesn't matter what kind of mother a child has lost, or how perilous it may be to dwell in her presence. ... the presence of the mother – our mother - stands for safety. Fear of her loss is the earliest terror we know." (J. Viorst 2002 pp22)

In both examples, their primitive pull is towards the attachment to the secure base – the mother, or the organisation that should fulfil the care-giving and nurturing role of the mother. In both cases this pull is more powerful than the consciously logical urge to pull away. This makes perfect sense to anyone familiar with attachment theory (Bowlby 1988) but represents a serious case of "market failure" to most healthcare planners. The practice, or even NHS, is often the recipient of attributes that are projected onto it by patients. These are illustrations of the transference phenomenon. Transference is a frequently occurring psychic event whereby aspects of the self, which can be seen as residue from inner world models and templates of relationships, are projected onto another. Seen originally as a contaminant to the psychoanalytic process by Freud, he later appreciated the central place of transference in exploring the patients unconscious and his resistances. Transference is recognised to occur outside the analyst's consulting room and can be broadly defined as the experiencing of a range of feelings, drives, attitudes, fantasies and defences towards a person in the present that are derived from significant persons in childhood. Key features are that these are unconscious, inappropriate for the present setting and tend to be repeated. This wider definition allows even for transference reactions towards inanimate objects, animals and institutions, but will always be anchored by feelings towards important people in childhood. Strangers, too, attract the reaction and "lovers, leaders, authorities, physicians, teachers, performers, and celebrities are particularly prone to activate transference reactions". (Greenson 2000 p154).

Transferences can be complex and entwined and are not always restricted to the therapeutic dyad. Consider for example the following case history from my practice: Y is a thirty-year-old man who is single and lives with his parents. I have known him and his parents for many years. His father, though physically small and unimposing, clearly wields great power in the home. He comes across as strong, silent and moody. In contrast his mother is a "little woman" who twitters at her husband's side and seems subservient to him. I formed the opinion that in the household Y's father controlled most things and Y and his mother formed a subversive alliance against him. I referred Y to the practice counsellor when he presented in crisis as a result of problems with his work. After he had been seeing the counsellor for a while I was approached by her. Y had asked her to speak to me in advance of his seeing me for an extension of his sick note. He was getting anxious about asking me and was insistent that the counsellor approach me about it. I had been aware that Y was consulting with me in different manner by bringing only mostly administrative issues (such as the sick note) but I assumed his other issues were being dealt with by the counsellor. When we were discussing this case it dawned on us that Y had reproduced the situation at home onto the counsellor and me. The same relationships seemed to be played out between us. I was being cast as the dominant and powerful father figure (it was in my gift to provide a sick note or not) and the counsellor had been recruited as his ally against me. Unusually the counsellor felt she had succumbed to his request to petition me on his behalf. In this case it seems the transference involved transplanting an entire scenario onto another arena. This interaction had the hallmarks of the process, as it was unconscious, intense and inappropriate.

Counter-transference - the feelings and emotions engendered in the therapist, analyst, doctor or helper, towards the client - has a similar history to that of transference. Freud originally noted that the transference a patient projected onto the therapist could be mirrored by a reciprocal reaction from therapist to patient. If the original transference was seen as a hindrance to analytic progress how much more so counter-transference was, containing as it did all the blind spots and material that should belong to the analyst. This view reappears in recent times in discussions about the ethics and moral hazards of over valuing counter-transference effects (Holmes and Lindley 1989). In contrast to counter-transference merely being reciprocal transference from therapist to client is the view that it incorporates all the thoughts, feelings and emotions stirred in the therapist. Influential in this view is Heimann who states:

"... I am using the term 'counter-transference' to cover all the feelings which the analyst experiences towards his patient. It may be argued that this use of the term is not correct, and that counter-transference simply means transference on the part of the analyst. I would suggest that the prefix 'counter' implies additional factors". (Heimann 1950).

These additional factors can include communications between the patient's and therapist's unconscious. The positive value of counter-transference is also stressed:

"My thesis is that the analyst's emotional response to his patient within the analytic

situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious." (Heimann ibid).

An illustration of this type of unconscious communication occurring is contained in the following case history: W is in her late twenties and I have known her since she was six years old. When she was a little girl her father died of a congenital brain tumour after years of being at home ill. Her mother clung on to W for comfort to the extent of keeping her at home rather than allowing her to go school. Her mother remarried but her stepfather died soon afterwards. She now lives in poor-standard accommodation with her partner and two small children. She uses marihuana heavily. Although her mother and siblings consult with me W prefers to see the doctors in training, especially male ones, with whom she forms close attachments. A characteristic of these doctors is that they leave the practice at the end of their training. W is always 'being left' by a succession of young male authority figures. This seems to be a re-enactment of her early life. Unusually, she did see me recently and in the course of the consultation I needed to examine her abdomen. Afterwards she sat on the side of couch while I stood nearby. This seemed an unusual and oddly intimate configuration and I was aware of experiencing a benign feeling of wanting to take care of her and that she had 'come home' by consulting me, the permanent male, again. If it had been permissible I would have put an arm around her. After the consultation she rang me and over the telephone was able to say what she had not been able to say in person. She wanted to ask about breast enhancing surgery but was shy as I was 'too old'. On reflection I think I felt like a father to her within the consultation. This may have unconsciously communicated itself to her and made it inappropriate for her to ask her question. Daughters simply do not discuss their breasts with fathers. Outside the room she felt somewhat free of these constraints and was able to raise the issue over the telephone. My reaction to her may have contained some elements of my transference reaction but I feel also incorporated her feelings aroused in part by the reworking of a father figure who was not going to leave her.

The mechanisms of transference and counter-transference are principally those of projection and introjection. There are occasions however when the primitive process of projective identification described by Klein (1946) is evoked. In this process some thought, feeling or emotion that is perceived as too anxiety-provoking or painful is projected onto another who becomes influenced by the projection and begins to behave as though he or she is in fact actually characterized by the projected thoughts or beliefs. An illustration would be when I was consulted by Mr C., a Pakistani man, whom I had always thought to be a gentle and honest person. His family seemed tightly knit and collectively cared for one of his daughters who was severely disabled. Mr C. and his other sons drove a taxi in shifts. The car was in use twenty-four hours a day. A few days earlier Mr C. had been the victim of a racially motivated attack while working. He had suffered a broken arm and would not be able to drive for some weeks. He recounted what had happened to him in the assault in an even and measured way with no apparent sense of rancour or injustice. While I was hearing this I felt consumed with intense feelings of anger and barely containable rage. While I would expect to feel some sense of empathic aggravation in this case I think the disparity between my barely containable sense of outrage and his equanimity provided an important clue. Mr C. was not able to own the feelings of murderous anger and desire for revenge and they were projected onto me. I was experiencing his rage in a case of projective identification. This can be seen as falling within the all-encompassing use of counter-transference as covering 'all the feelings experienced towards the patient'.

From these simple illustrations I have tried to demonstrate that psychodynamic models of thinking are as relevant in medicine today as they were when Balint stated "by far the most frequently used drug in general practice was the doctor himself" (Balint 1957 pp.1). Since its iteration there have been many wonderful and beneficial advances in medicine and, by some measures at least, we have never been in better health. I doubt that the patient experience of their current health status is very different from that which they experienced fifty years ago. No one can oppose the concrete thinking that logically plans the siting of new healthcare facilities or makes other such rational decisions. The difficulty is that unless the full range of messages being communicated, conscious and unconscious, are at least acknowledged then the public may not feel "better". Rational thinking needs to be accompanied by the magical thinking that patients are bringing to their doctors every day. Concrete thinking gives you concrete buildings but real healthcare is about what happens inside.

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Balint Groups and the Doctor-Patient Relationship

Noah Moran, fourth year medical student
(Joint winner of the 2009 Balint Society Essay prize)

Medical training seems to revel in pushing students into the 'clinical deep end'. The burden of acquiring medical knowledge coupled with achieving clinical competence leaves little room for personal reflection and, at times, even less for the patient. My Balint group provided a venue where these shortcomings in my training could be overcome, but more then this it enabled me to gain an insight into the bigger picture and, as a consequence, change my approach to patients and their families.

Joining my Balint Group shortly after finishing my surgical firm I was still immersed in a world of the acute abdomen - where surgical acumen outranks bedside manner and the all the stereotypes from years of watching medical dramas were confirmed. To my amazement, I loved it. I enjoyed the camaraderie and felt my induction into the medical tribe complete as I followed behind my consultant in matching scrubs, listening to him regale the functions of his new mobile phone.

Three years of pre-clinical training hadn't prepared me for life on the wards. My nervousness and anxiety found a hiding place within this surgical world; attending theatre most days allowed me to avoid the ward. Alongside the bonus of not running into the formidable ward sister, whose hatred for medical students was notorious, this strategy allowed me to avoid the patients. I knew each of my consultants' patients, not by name but by case; I had scrubbed in on many of their operations. Before long I was fully indoctrinated into the surgical world, with this came bravado, shortly followed by my ever-increasing ego, which swelled with each operation I assisted with. I was diligent; I took time to read notes, watch everything from the induction of anesthesia to the patient's return to the recovery suite. I would clerk patients mostly just before their procedure. Minutes before they were due to be walked around to the anesthetic room, I was there detailing presenting complaints, listing differentials and ensuring that in the quiet time before an operation I was there asking questions.

Joining my Balint group, I had little idea of what to expect. The introductory talk had covered the logistics and basic concepts but I still had little idea what it was about. I had opted to enroll in a Balint group truthfully to avoid writing a reflective essay. I resented my feelings and ideas being subjectively assessed and arbitrarily given a grade. I was a good talker so the opportunity of having a captive audience to listen to me was not one I was going to pass up. Most meetings would begin in the same way. As people arrived, we would exchange stories of various firms and placements, chatting happily away until we were invited to begin the session by the leader inviting someone to share a patient with the group. A silence would fall across the group as our eyes fell to the floor avoiding eye contact until someone would break the silence; "I have a patient". We shared a common nervousness; this environment was totally alien to us. Although we had been together for three years, it was commonplace to turn up to a tutorial and meet people for the first time. Unsurprising in a year with 400 students.

As someone shared we would listen and learn about a troublesome patient or situation. The presenting student was given time before we would explore further the elements of the story that had struck a chord with us or where we needed clarification. After this, the person who presented would step back while the rest of the group discussed the patient, before moving on to another case. This was the first time I had heard a case-presentation without thinking about the surgical sieve determining a differential diagnosis. As people explained their case, they painted a picture of the patient; we all added to the image with our questions as we hypothesized the patient's agenda and motivations. This patient-centered approach was new to me and I reveled in exploring the patient's perspective without considering their medical programme.

I found myself revisiting patients I had meet during my surgical attachment. One patient repeatedly returned to my mind. James was a 32-year-old, medically well man except that his weight in stones matched his age. He was admitted electively for a Roux-en-Y gastric bypass. The hospital I was attached to had recently invested heavily (pardon the pun) in new bariatric facilities so as to start to offer weight-loss surgery. Obesity, despite affecting one in four people, is still a source of great stigma making it an easy target for hospital gallows humour.

James underwent his surgery without complication. I was on intensive care when he woke following anaesthetic. James's bulky frame filled the extra-large, reinforced bed specially purchased to accommodate bariatric patients. I visited him most days on one ward round or another. I had spoken to him before his operation, I remember thinking his history was boring – '32-year-old failed dieter, father of two, presents for Roux-en-Y gastric bypass with banding, medically stable with Type 2 diabetes and hypertension, no previous surgeries'.

James struggled to leave intensive care. Post operatively, he developed a pulmonary embolus and later a chest infection. When he did

find his way to the surgical ward, he managed to pick up a MRSA infection, giving his wound very little chance to heal, and eventually he developed cellulitis. This latest infection brought him back to intensive care, where he stayed for the next three weeks. His five-day post-operative stay had turned into five weeks. James became a regular fixture on the ward round. At times I would see him two or three times a day, always with his phone in his hand punching in texts. You could hear the vibration tone of the phone against his bedside table across the ward when he received messages. When he died over the weekend just before Christmas I wasn't there. I found out the following Monday.

I found myself going over his history again and again. How old were his two children? Why had I not seen them at some point during his prolonged stay? Why did he never complain? Everything that could have gone wrong did and he said never complained. I could get the image of him texting continuously out of my mind - who was he messaging? Alongside these questions I found myself feeling profoundly guilty about making jokes about him. At one point he needed a CT scan and he would not fit in hospitals scanner. When the zoo was contacted to utilize their extra large machine I made sure to pass this on to my colleagues.

I brought James's case to a Balint session. As I told his story I realized how little I knew about him, I felt ashamed when I explained the jokes I had made. Discussing his case the group demonstrated a concern for him I had failed to do when he was alive. They asked about his motivation to undergo the surgery? Thinking about it he had struggled all his life with obesity and this operation must have represented hope to him. Sharing my feelings about James I recognised, that having struggled with my own weight, I could have used this shared experience to facilitate a better relationship. Instead I used our common values to make jokes. This experience, alongside others from the Balint group, have shaped my future patient interactions. I recognised that, as a student, I benefit from the luxury of time. I can explore non-clinical areas with patients whilst at the same formulating a good differential diagnosis. The benefit of this approach being a better relationship between me and the patient, a relationship based on a mutual dialogue where we both shared experiences and find common values.

My patient histories now are unrecognizable from those of my first surgical firm, not only because of my clinical training, but because of the insight I have gained through completing the Balint group. Discussing the alternative agenda of consultation opens up a world beyond the differential diagnosis and examination findings. I have learnt to think more about my patient as a person rather then a disease or presentation. My interactions with patients now follow a far less regimented approach. Whilst ascertaining the 'History of Presenting Complaint' I now have the confidence to explore less traditional medical subjects. Exploring my patient's ideas and concerns. I avoid the overly-structured suggested models from the medical school and opt for my own strategies where my initial approach is aimed at establishing a relationship - reaffirming trust. Not just building rapport, but more. Focusing on contextual questions rather then asking 'How bad is the pain on a scale from one to ten?' I ask 'How does this impact on your daily life? What does this pain stop you from doing?' This allows for a greater insight into the patient perspective. My experience within the Balint environment has taught me to appreciate the patient's agenda during a consultation. Taking time to find out what is important to the patient reveals that their perspective may not tally with your own values and acknowledging and exploring these difference allows for better trust and mutual respect. This allows for a better exchange of information and knowledge.

Reflecting on my experience within the Balint group, I am grateful for the opportunity to share and learn. I gained an insight not only into my own patients and those of my colleagues but also an appreciation of the patient agenda that can has changed my approach to patients. For me involvement within a Balint group gave me space to reflect, to appreciate the subtleties of consultations and apply these lessons into my clinical practice.

18th Michael Balint Memorial Lecture 'Balint at the Edge'

given by Dr Paul Julian, retired family doctor, GP teacher on 7 April 2009 at the Royal College of General Practitioners

But let's all be clear where we are starting from: at the heart of general practice. Iona Heath[1] reminded me of where that is when she wrote in the BMJ about making clinical choices. It was the title which caught my attention: *Dare to use your own intelligence*! This she explained was Kant's battle cry of the Enlightenment and she concluded by saying that it should be the battle cry of every physician. That is my starting point, but how should we use our intelligence in the uncertain world of the consulting room, where reason fails often enough? 'With the courage of our own stupidity' Balint replies.

This is Kant à la Balint, making a humorous allegiance between intelligence and stupidity. But the intention is serious. This stupidity is not something to be dispensed lightly or without the supervision of a group. It is an understanding that arises in a group if the atmosphere is right so that,

> ... the doctor feels free enough to be himself with his patient –that is, to use all his past experiences and present skills without much inhibition. At the same time he is prepared to face severe objections by the group and occasionally even searching criticism of what we call his "stupidity.[2]

The atmosphere that permits this to happen is provided by the support and identification between group members who are enabled to accept and use their own shortcomings to help the doctor understand the patient better. Let's put aside the notion of a battle cry, but hold in mind these ideas about Balint groups. What follows is a description of a personal journey and my connection with Balint work. It looks at the influences that Balint's ideas and the work has had on me; and on three different types of groups; medical students; second year qualified doctors [FY2s] and finally a fully-fledged GP group. My guiding theme of 'Balint at the edge' occurs in all these areas. This theme contains two paradoxical ideas; at the edge of normal practice *being marginalised*, rather static; but it can also mean pushing at the leading edge, about carrying the work forward, something more dynamic. There is also a subtext to the title: an acknowledgement to the society of my sporadic attendance over the last ten years, thank you for noticing me; at the edge; and for asking me to speak.

Fifty years ago Lord Moran[3] in his evidence before the Royal Commission on Doctors' and Dentists' Remuneration, referred to his infamous ladder, off which failed specialists fell, presumably into the pit of despair of general practice. Not a very edifying view but the goad that prompted a very skilful and thoughtful group of GPs to negotiate our 1966 contract. It broke through to a quite new terrain where many young doctors wanted to spend their working lives. Unimaginable changes have occurred since then in health promotion and prevention, in evidence based medicine and in general practice; yet Balint remains, as ever, at the edge. Those of us who hold Balint firmly at the centre of medicine may find this marginal position difficult to bear, but that is probably where it will always be; the number of doctors who are interested in joining a Balint group now remains the same as it was in the 1950s. A place at the edge does not seem to have decreased Balint's influence in medicine.[4] But this influence is slightly tricky and beguiling, rather like I assume Michael Balint must have been, although I never met him. His knack of summarising complex concepts into aphorisms with great wit; the *apostolic function*, the '*mutual investment company*, the *collusion of anonymity*, and the *drug doctor*' has led to their incorporation into the language of general practice but, and here is the rub, while the wit dazzles, the true meaning of these ideas is often misunderstood or misapplied outside the context of a working seminar. Many grasp that the doctor is indeed the most commonly prescribed drug in general practice, but can miss the tacit caveat: but not necessarily administered appropriately or correctly.

The *drug-doctor* is at the heart of the doctor-patient relationship, and although 'the doctor-patient relationship' is not one of his aphorisms, it is indelibly linked to his name. There are some snags here too. The doctor-patient relationship means many things to a wide variety of disciplines but even within general practice its use can be confusing. The RCGP has a checklist in the syllabus for their membership exam called *The doctor-patient relationship, communication and consulting skills*"[5] which is exemplary, and I am completely signed up to it, but it describes behaviours to be learnt. Balint work is about describing and exploring actual behaviour, warts and all including omissions and errors; not with a view to correcting them, but to explore them as part of the manifestation of the patient as well as the doctor, and then use them for the benefit of the patient. Of course this endeavour is played out against the understanding that the doctor has met the criteria of the RCGP syllabus, and is clinically competent. It is not about teaching but *training* the doctor to observe in a particular way; to be a participant observer who then goes a stage further and aims to help change what he observes. This

then is the aim of Balint work. The aim may be simple but its execution is not. Working in partnership with patients should be the intention.

That the patient can be a partner in the relationship with the doctor came as a surprise to me as a young medical Senior House Officer when working for the late John Paulley. A Suffolk farmer in his forties was admitted with an exacerbation of ulcerative colitis. A searching history revealed nothing of special note to explain this flare-up, and the patient appeared generally untroubled. At the end of his weekly ward round, Paulley asked me to go back to find out more about the patient's social circumstances. The farmer, it turned out, had his mother-in-law living in a caravan in his front garden. Whether or not this had a bearing on the state of the farmer's bowels was not the issue for me. Much more important was the understanding that a patient could withhold information from me. It was a surprise that this patient might not feel fully engaged in an endeavour to get better at all costs. Furthermore until then it had seemed to me to be solely the doctor's responsibility to unravel the patient's story. When asked why he had not mentioned the mother-in-law and the caravan, the farmer said in a rather truculent manner, he couldn't see the need to tell me that. Further surprises lay in store when discussing this man again with Paulley. He explained he did not believe that the farmer was trying to hide either his domestic arrangements or his feelings about them. But he did wonder if it was possible that feelings just by-passed the farmer's mind and he expressed them directly through his body. Once again, whether this intriguing hypothesis was correct was not the issue. What impressed me was, first, the pleasure and satisfaction that Paulley took in sitting down with his SHO to discuss his ideas; second, having already understood that patients might chose what they tell you, it left me free to conceive that patients might actually be quite unaware of what is going on inside themselves.

Medicine suddenly seemed an intriguing place to be and put me in touch with my own stupidity. Looking back now it resonates perfectly with Enid Balint's elegantly simple intention for Balint groups when she says ... *its essential nature is to add to the pleasure, satisfaction and competence of doctors in their ordinary work*.[6] There seems to be something about learning by discovery like this that places it at the edge of medical education. There are so many important facts to learn first. Learning by discovery is also difficult to set up, either squashed by financial imperative or easily subverted by those who don't understand its aim. This sort of learning is about developing a personal relationship with a teacher who by dint of circumstances can only engage with relatively small numbers. Being at the edge, in the relative shade, where those who look will find it, is where Balint work prospers. Its value continues to be recognised by teachers and supported by the establishment, with the acknowledgement that Balint work helps doctors bear the burden of clinical work. It also develops the skills in doctors to make personal choices with their patients about what might be useful and reject what is irrelevant. Making choices needs emotional awareness. John Paulley drew my attention to that.

Jumping off the ladder

In 1973, with what in retrospect seems like my first courageously stupid act, I jumped rather than fell from Lord Moran's ladder, not into the pit of despair but with great delight into the seventh heaven of general practice. A half-day course at St Thomas's revealed a whole new medical world where I first saw the Robertsons' film *A Two-Year-Old Goes to Hospital*. It resonated with my jump from the ladder because as a paediatric registrar I saw my one-year-old daughter every other weekend. It also evoked memories of my own stay in hospital as a four-year-old. Allowed to see me once a week, my parents devised a special system for staying in contact; a string and small basket lowered from the window by my bed was filled with cakes from my mother and plastic figures of wild animals from my father. They were hauled up and either eaten or added to the jungle constructed in the bedclothes. Outwitting authority remains important to making life possible (bearable?). Memories and discoveries of this sort are powerful stuff and they continued through that year. Mike Courtenay gave us a brief, but irresistible taster of a Balint group. I joined his and Mary Hare's group the next year.

These first steps into the new world of general practice had been ushered in by the publication of *The Future General Practitioner*[7] in September 1972. Several of its authors had been in Balint seminars. This book was rather dry stuff until it was illuminated in 1977 by the Nuffield Course[8] which had an impact on my medical education, parallel to and as long lasting as that of Balint. They have been intertwined ever since, drawing me simultaneously into vocational training and to establishing the Department of General Practice at Barts. Working in small groups was the *metier* of the Nuffield course which, unlike Balint seminars, explored the process of small groups in detail, both theoretically and experientially. The difference between task and process in group work became clear; no more so than in a group led by Alexis Brook, where the task was to focus on the group process, during which I became the group's 'emotional sink' while they discussed, rather lightly, a particularly distressing event. Alexis noticed my sadness and helped us see what was happening. Self-discovery was part of the agenda of that course, which was not about revealing and anguishing on personal hang-ups (although it was an inevitable side effect) but was about things which release you to behave differently and more helpfully. Like discovering a preference for spatial thinking through an IQ test which changed my style of lecturing.

Nuffield, first and foremost though, gave me a preference for teaching through small groups. Balint, however, remained at the edge of my teaching in the department of general practice except in some small but important respects. In our research seminar with Enid from 1984 to 1992 we presented and discussed cases that surprised us. Selecting a case to present using the criteria of a surprise was clear and releasing. It worked well, moving us into interesting and useful discussion. This idea of surprises came to mind with a group of final year medical students who got stuck in a debriefing session. Five of them had been with the practice for a week, 'sitting-in' with the doctors and nurses. Students often looked shell-shocked at the end of the week. We managed this usually in a debriefing session when they role-played a patient they had seen who had touched them in some way, while they were sitting-in; one of the other students played the doctor, while the rest watched. This usually worked well. In one particular group, unusually, no one found a patient who fitted the bill. Their resistance seemed to be a normal defence to being pushed to where they didn't want to go. Feelings it seemed were not on their agenda, just not their cup of tea, believing perhaps that they disrupt rational thought. Not an unreasonable proposition; we have all seen misdirected feelings cause irrational behaviour. A cool head is needed to direct the emotion, not deny it but to understand it. If the students had missed the chance to share their feelings then their time with the practice might have been wasted. But why had this impasse arisen now? We realised that there had been a curricular change. The general practice attachment had been moved from the fourth to the fifth year. These fifth years were much less relaxed and more focused on facts and finals, than the fourth years had been. Feelings, it seemed, should be kept at bay.

Damasio has explored these ideas[9] about engaging feelings in decision making, or rather recognising them, for they are always engaged, whether we like it or not. The task is to understand how to use them appropriately. They make sense of our experience and enable us to make decisions. Our dilemma with the subsequent fifth years was resolved by asking them to role-play a surprise they had witnessed, which held the advantage that it was not obviously touchy or feely; it allowed the students a more free and immediate response. Their 'resistance-to-learning' became more appropriate, rather than a blanket embargo. This worked; the discussions became easier, ranged more widely, with the students using and valuing their subjective experience. This small 'cross-over' idea, between Balint and undergraduate teaching, was helpful. There have been others. For example if as the leader you feel rather pleased about what has happened in a group, it can be a danger signal, so that the more self-satisfied you feel the more likely it is that you have missed something in the group. It is a similar process to that which happened to me in Alexis Brook's group when I had all the sadness dumped on me, but in this case the leader grasps all the good feelings leaving the group empty. What the leader has missed is that he has stolen something from the group. This sort of connection can just as easily happen between doctor and patient.

Here is an example from general practice that illustrates the problem of both feeling smug and stealing an understanding, two sides of the same coin. They came up in a consultation that recalls Cyril Gill and his paper about cystitis . He recorded one hundred patients with cystitis; half had an infection; half, spread equally between the infected and uninfected, were *bursting* to say something. The issues they wanted to discuss fell into four categories; the first, and the one of interest to this account, was a group of women who had problems *to do with having babies, or not having them...*

With that in mind, this is what happened in a surgery with a newly appointed registrar sitting in. She was keen and eager; the patient was welcoming and interested. Balint was not on my shoulder, so could not warn me that the presence of a third person in the consultation *however tactful and objective, would inevitably destroy the ease and intimacy of the atmosphere*. The patient, a woman in her mid thirties, was relaxed and easy with the registrar. She told us about yet another attack of cystitis and in obvious discomfort quickly asked if she could go to pass a urine specimen. While she was out of the room we discussed cystitis, the cause and treatment. We wondered if it might be associated with intercourse. The patient was still not back. I shared my understanding of Cyril's paper. The registrar thought these ideas were a bit far-fetched. The patient returned, apologising for her delay. The bottle was labelled, the form filled and we continued the consultation. She too thought it might be associated with intercourse. We established that she had a new partner; also a teenage son by her first partner. The registrar caught my eye with interest at this point. I said to the patient, 'While you were out of the room we have had time to discuss cystitis and this odd idea has come up that it might be related to an ambivalence about having babies or not.' The patient looked quite shocked and said, 'How could you ever have guessed that?' It transpired she was about to go back to work, but was in two minds about having another child. She accepted my routine instructions and prescription for cystitis and said she would phone for the result of the MSU. She left the room as quickly as she decently could. It felt as if I have stolen something from her. There was no significant growth in her urine culture and I never saw her again. Being right does not necessarily help, far better to let the patient lead and remain alert to follow offers the patient might make.

Groups for medical students

Turning once more to teaching medical students; why has Balint remained at the very edge of my

teaching practice in the undergraduate curriculum? Thoughts about Balint and students have been in and out of my mind since beginning work in the department of general practice at Barts in 1977? Students attend the annual Oxford Balint conference; some at least want the experience. There have been seismic changes in the undergraduate curriculum in the last fifteen years, although the true depth and impact may have been obscured in general practice by our own upheavals. These changes in the undergraduate curriculum were sparked initially by concern about factual overload but spurred on by the need to produce doctors who were fit for purpose in the twenty-first century.

Tomorrow's Doctors[11] which details these changes has two important elements that may support a higher profile for Balint work. These are Problem Based Learning [PBL] and the requirement that students must make a personal selection of part of their curriculum, the so-called 'Student Selected Component' [SSC]. Both need describing to explore their potential to support Balint work. Problem Based Learning was pioneered at McMaster University in the mid 1960s where they set out to construct a medical school that was more humane than one based on a traditional approach. It was endorsed by the General Medical Council in 1995 and is now in the majority of medical schools in the UK. It was introduced at Barts and The Royal London in 2000. In the new millennium PBL has been judged, in the light of its original aim, an unqualified success.[12] It initiates the students into a way of working which is sympathetic to Balint methods. Here in précis is what happens. The students work in small groups on a clinical problem; they determine through structured discussion what they need to learn to solve the problem; once they are agreed, they adjourn to do private study; they meet again to share their findings. It is the *process-of-finding* the solution which is as important as the solution itself. A member of staff attends the group not to provide answers but to oversee the process. The students are introduced to the idea of working in small groups, appointing a chair and scribe, they learn to negotiate and listen to each other, taking responsibility for making it work. The students have accepted it. So too have Barts and the Royal London, who also saw the importance of establishing an assessment of this curricular change. They asked me, as head of assessment, to do that.

I was given a completely free hand and permission to collaborate with a third-year medical student. We agreed that we didn't want to measure the course's outcome, and would leave that to the assessment already in place. We both believed that assessment drives the curriculum and that it is '*the process*-of-finding-the-solution' which is essential to PBL. We devised, after consultation with the students in the first year, an assessment of the PBL *process*. This was constructed so that it not only assessed but also clearly explained the behaviour that was expected in a PBL group, why it was being assessed and how it helped learning. It encouraged appropriate work and behaviour in the group. It gave the student a written record of both their achievement and a record of what they had done.

The support and backing the Medical School gave to this task was not lip service but showed they had grasped the importance of working in small groups, confirming a sea change in medical education. While PBL is not learning by discovery as propounded by the Balints, it is learner centred and moreover it is learning that the-way-you-learn is as important as what you learn. It is now an established part of medical education. The new climate in medical schools is also felt in their SSCs already referred to. The curriculum has two components; one is the so called 'core curriculum' and the other is the student-selected component [SSC] which make up between a quarter to a third of a five year course, in which the students must choose what to do. It must be sanctioned by the medical school. Might the students choose a Balint group? Assuming the proportion of them opting for a Balint seminar would be equivalent to the proportion of GPs who seek it [1% – 2%], an average medical school might expect five or six applicants each year. UCL are running groups for more than seventy at the moment.

Balint said that his seminars were probably inappropriate for medical students; a position I had supported until recently, which in the light of the ideas outlined above, needs to be qualified. Balint qualified his position later in the light of his experience with medical students in his own department at University College London.[13] His work continues there today and is expanding.[14] Outside that privileged place it is more challenging. Balint groups need a security which allows them to relax enough to have the freedom to explore their ideas and feelings. Just as my exploits at the age of four in hospital with the basket and the jungle in the bedclothes were undoubtedly overseen by caring young nurses and doctors, who kept secure the boundaries around the world on my bed, where I could safely play; so too Balint groups need clear and secure boundaries within which they can be free and safe to learn. The boundaries are temporal, geographical, spatial, and internal. It is the leader's task to be clear about the boundaries and contain them. But the real world always impinges; it can be kept better at bay if the time, duration and place of meeting are clear and constant. These are not always under the control of the leader. Compromises have to be made. An hour-and-a-half seminar is good, but some work can be done in an hour; in today's busy world even an hour is difficult to find. Nevertheless the group should begin and end on time and meet in the same room, without interruption, with phones and bleeps switched off. The leader must agree these boundaries not only with the group but also the host institution.

There are other boundaries, best left until discussing the groups for qualified doctors. But there is one that needs mentioning in this context because the students do not fulfil it. Group members should have a therapeutic responsibility for their patients. Heather Suckling and Peter Schoenberg have got round this at UCL by encouraging the students to believe that they can make a difference to the patient's hospital stay. Their invitation to students to *discuss encounters with patients who continued to occupy their minds*, is a helpful variant to the traditional 'Who has a case'. Several other medical schools are now offering Balint groups to students. Sue Gelding at Newham University Hospital is doing so. She has just persuaded David Watt and me to lead a group of eleven volunteer third year medical students attached to a variety of firms for ten weeks. This falls far short of Balint's recommendation. Nevertheless, it felt like an offer impossible to refuse, a warning perhaps to be very careful. Prepared with Heather Suckling's description of the themes that medical students have discussed in her groups[15] and the other publications from UCL, we met our first student Balint group last week.

Recently qualified doctors

Moving on from student groups to those for recently qualified doctors, I lead one of two groups that run in parallel with David Watt at Newham University Hospital. We meet to supervise each other every two months or so. The groups, conscripts not volunteers, are for doctors in their second foundation year. Their position is different to a student's and other boundaries come into play. It is easier to reach agreement with a traditional group of eight to twelve volunteer established GPs than it is with a group of fifteen conscripted Foundation Year Two(FY2) doctors, competing with their peers and seniors for educational space, and learning not only how to behave as doctors but also how to manage their time. Easier also to get unconditional agreement from the seniors the host institution who understand and support the effort, than it is from junior administrative staff, who have to juggle with the reality of putting on a range of educational activities, some of which will inevitably take precedence. There are two recent reports about leading groups for doctors at a comparable stage, one from Sweden and the other from America. They both describe groups that I recognise. Both report the group's strong desire to move the focus of the discussion from the doctor-patient relationship onto the doctor's world. They have both made some accommodation for this on the grounds that recently qualified doctors need to struggle with themselves before they can get a deeper insight of their patients; they are in a phase where they are seeking their professional identity. I understand this and have made similar allowances for a discussion group of Foundation Year One doctors [FY1] that I lead, but have tried to keep the focus of FY2 group discussions on the doctor-patient relationship. It is hard to keep on course. If the leader can contain the group's desire to shift the focus they may find a way through. It is an important internal boundary of the group's work.

There are other boundaries and other problems. These can be illustrated by extending the description of the differences between Balint groups for GPs and for FY2s with some examples. Working with GPs *doing their everyday work, undisturbed and unhampered, sovereign masters of their own surgeries*, is a long way from working with foundation year two doctors who do their everyday work, constantly disturbed and hampered by lack of privacy, queuing for an opportunity to get onto a computer, feeling like masters of nothing, in a hospital hierarchy, near the bottom of the pile. Furthermore, when a GP is 'asked for a case' in a seminar the expectations are clear; it will be about a patient for whom the GP is solely responsible, with consequences for the future, describing what happened between them, and what the doctor felt about it, with a view to helping the patient. FY2s on the other hand do not have overall responsibility and may never see the patient again. The relationships which do have future consequences for the FY2 are those with their working colleagues. In a group of FY2s which is confidential and has been given permission to discuss feelings but also makes them a focus of discussion, relationships in the workplace come to the front of their minds. How should the leader cope with bids for this sort of discussion?

The answer would be straightforward in a group of established GPs but FY2s are in a different place and witness the patient's relationship with other members of staff and things done to the patient of which they disapprove. Declaring such powerful feelings as off limits may not help. The leader is trying to build a relationship with the group members. A more appropriate strategy would be to contain it, protect the presenting doctor and try to bring the focus back to the patient. But this is hard work; what hampers the leader? Similar personal experiences as a young doctor can make the leader identify too strongly with the presenting doctor. Who hasn't had a tough time in the fiery-furnace of the first year as a doctor? My life was made hell as a preregistration house officer in thoracic surgery by a very strange senior registrar, completely out of touch with reality, who imagined he was a match for Christian Barnard. So it helps me to know that I am a soft touch for such woes.

In one group an FY2 came in bursting to tell how the red mist descended and he nearly hit a consultant. He was incandescent and unstoppable, the rest of the group needed to be held in check, wanting to have a go too, egging him on to reveal more and more. But he is a good doctor and cares about his patients. It was easy to bring into focus the patient behind these feelings, on whose behalf the doctor was outraged;

although in his initial story it had seemed like a response to a personal slight. But the leader had positive feelings about the group and the doctor; it was obvious how to manage it. It is not so easy to retrieve things when the leader's negative feelings about group members get the upper hand. A mutual learning experience can become didactic teaching or an exclusive discussion between leader and presenter. A co-leader would make this easier. It does underline, however, that the FY2 has a relationship not only with the patient, but also with the team, who in their turn have a relationship with the patient.

Another issue that has arisen, since the European working directive, which has lead to doctors looking after each other's patients much more than they did before, is that at some case presentations it quickly becomes clear the patient is known to several in the group. This often prompts them to retreat into a clinical discussion. It can happen in any group, but here the impetus is greater, because they really have seen the patient and must have their say. The leader's job is to keep the discussion of the patient *with* the presenting doctor. Often hard work but easier than when the patient has a notoriety in the hospital. Then it is a real task to help the group see the uniqueness of the patient, and a real danger that they will collude to see the patient as a stereotypical monster. It is as if the patient has been overexposed. The patient needs protecting from the group, and the group needs protecting from themselves. The final boundary that I want to discuss in FY2 groups is attendance. This is always a problem when members are conscripted. Dealing with this is part of the leader's job. The real world always impinges. The learners are adults and there are many calls on them and, unlike volunteers, they are less likely to have the freedom to set aside a specified time for the group. There is always one person on nights and one person starting at 4 p.m. There is usually someone on holiday, and the possible attendees drop by three. The unexpected and unavoidable can always arise. The group can easily drop down by five. One group member who came early enough to help me set up the room one week expressed his incredulity as I put out a chair for everyone in the group. I explained if there are not enough chairs and everyone turns up it is disruption for any latecomers who may feel shut out. It was a serendipitous moment when the last chair was filled, the only time that year. The student looked across at me and smiled. Looking back through my records I see that negative feelings about the group can be projected irritably onto attendance. Low attendance seems containable when the group are doing some work. My sessional notes back this up. The group know that I use these for supervision but that otherwise the details of our discussions are confidential. At the end of the year they will get an anonymised, factual summary of each case and a record of their attendance which they can put in their personal portfolio; while this is not a requirement they can use it as an extra piece of evidence of personal reflection about their work.

A group for established GPs

Finally I would like to turn to a group of established GPs at Well Street, my old practice. It is an unusual group, the background is important. Gaby Tobias asked me shortly before I retired in the autumn of 2006 to come back once a month to lead a Balint seminar. She reminded me of the pleasure and satisfaction we got from our weekly clinical meetings in the past, before the current climate in the NHS eroded them. These discussions were loosely based on Balint principles, and although we had no nominated leader, five out of six of us had had experience of Balint seminars. She wanted to share this with her colleagues and remind them of the essence of general practice which she was concerned was getting smothered or just ignored. She had already discussed this with the other doctors who were all in favour. This felt like a tricky proposition but it seemed worth it, both for the practice but also, rather selfishly, to help me let go and retire. Gaby did not want to be co-leader. Andrew Elder agreed to supervise me. I will go into some detail to illustrate some aspects of the special nature of running a Balint group in one practice. There must have been Balint seminars for the doctors in one practice run elsewhere, but I could find nothing in the literature, so we were going into uncharted waters, exploring as it were 'at the edge'. But this was complicated by Gaby's and my relation to the practice. This felt 'at the edge' in a completely different sense; breaking all the rules; starting a group with whom I already had a pre-established relationship and it was possibly beyond 'stupidity'. But Gaby gave us the courage. Then a month after my retirement Gaby was diagnosed with liver secondaries from a colon cancer. Her prognosis at that time was six months at the most. This commission started to feel even trickier than anticipated. Gaby stopped consulting in April 2007 but remained very active until the end. She died at home in August 2008 and is greatly missed.

We started out with 10 doctors in January 2007. Half the doctors were principal GPs and half non-principals and one doctor was on maternity leave. Gaby was on holiday. She came to the next three meetings before she stopped clinical work and withdrew from the group. She was replaced by another non-principal. At the tenth meeting the doctor on maternity leave returned. At the 18th meeting the registrar left. At the 19th a new registrar joined. At the 20th another doctor went on maternity leave and the first registrar rejoined as a locum. We have been stable since then. We have had two FY2 doctors join us, each for two months. About nine doctors come to each meeting held on the first Wednesday of the month at 8.30am for an hour around the common room table. We have had twenty-six meetings in which thirty new cases and fourteen follow-ups have been presented.

There has usually been a queue to present a case. The presenters have been spread fairly evenly between principals and non-principals. Most in the group have now presented; some less than others and on several occasions, as you might guess, patients presented by one doctor had also been seen by more than one doctor in the group, more of which in a moment.

My supervision has been every other month and is essential. Each seminar is written up, usually on the same or the next day. The write-up records date, attendees and their status; with a rolling one-line record of the cases presented. The current case is written-up in parallel columns showing factual recall of the discussion in one column and in the other my emotional response and thoughts about the group behaviour and our relationship. Gaby's original aim, to establish a forum to share with her colleagues the essence of general practice and rediscover the pleasure and satisfaction of our work, has been realised. The attendance attests this. The group has gone on to do useful work with their patients. They have matured from the initial position of deferring to me, saying, 'Here's a patient, you will know all about', and implying I had all the answers, which of course I didn't. They have matured and cut their apron strings. Someone said the sessions help them step back a little and view their patients differently. The secondary aims have also been achieved. It has helped me step away from the practice and we came to terms with Gaby's prognosis. The two meetings we had either side of her death show something of this. I give them now.

Gaby had taken a turn for the worse. She was in hospital, very unwell. I had been unable to see her and was worrying about her. Our group was due to meet the next day. I had failed to prepare my papers the night before and having slept poorly, overslept. I was woken by a concerned phone call from one of the partners. Dressing very quickly and dashing into the practice I arrived with about twenty-five minutes to go and crept in with apologies. They had given the floor to the new registrar who was reassuring them about the current good progress in uterine cancer screening; he had been involved in this in his final hospital post. The patient they had been discussing was having domiciliary palliative care through a new initiative just set up by the practice with St. Joseph's hospice. As is so often the case, relations with centres of excellence can be awkward for those on their doorstep; it is difficult to get the distance right.

This new arrangement had been brokered by one of the doctors in the practice, who had worked at St Joseph's before coming to us as a registrar. It was working well. It was good to hear that things had changed and were moving; ironic that it was on the deathbed of such an important member of the practice. However, it felt that the practice was moving on properly, disentangling itself from the old, and moving into new and very appropriate waters. Listening to this discussion it seemed obvious that they were also talking about Gaby and that it was time to do that. Of course we had had brief updates about her at the beginning or end of the sessions, but until then as leader, partly reflecting Gaby's wishes and determination, I had kept the group to task with a focus on their relationship with patients. Now that she was at the end it seemed easier to interrupt to ask if we could talk about her. With relief they did. Oversleeping had knocked me out of the leader's chair and allowed me to see the group from a different position. It was then quite appropriate that we shared our thoughts and feelings in a different way; a necessary discussion. Gaby died two weeks later.

Patients too had been grieving. It can be seen here in a consultation presented to the group. The doctor told us that about a month after the funeral, a special patient of Gaby's complained that the whole practice was going to pot and that the reception staff and two other doctors had been unsympathetic to her daughter. I too knew this mother and was worried the discussion might pit the doctors unhelpfully against each other. I was in two minds whether to say that I knew her, when a group member, who may well have had similar fears to my own, revealed that I had also looked after this patient. I then explained the patient had been quite challenging. The group focused the discussion on the patient, which seemed appropriate, and on her hidden anger at Gaby for being there no longer. On reflection, tensions between the doctors on this occasion were not handled well, complicated by my own relationship to this patient. My knowledge of patients and relationships with patients presented to the group which was extensive to start with, and although only rarely declared, was not helpful or easy. My familiarity with the patients presented has diminished over time, freeing me to get a clearer perception of what is happening in the group and to behave more helpfully. However, the doctors continue to present patients who may also have consulted their colleagues. The group see how each of them relates to the same patient and the discussion can too easily focus on clinical decision making, and they may fail to listen with due attention to the presenting doctor's narrative. Moreover, because the other doctors know the patient, then the fantasies and ideas, which members are permitted to have in a Balint group, may be thwarted. We are learning together how to pick our way through this new territory, negotiating the potential obstacles that may block the freedom to become *more sensitive to what might be going on in the patient's mind when the doctor and patient are together*.

We continue to meet once a month to look at our work guided by the experience of those that have gone before. Together we are beginning to flex the muscles of 'the courage our own stupidity'. With that as our battle cry and the Balint Society's standard planted firmly 'at the edge', as the clamour and confusion settles at the centre of the melee over the NHS, the work we

are all doing today will be clearly seen and a fitting memorial to Michael and Enid Balint.

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Personal Care in Primary Care
Keynote address to the Balint Society Oxford Weekend, September 2008

Caroline Palmer

I'd like to thank the members of the Balint Society council for their kind invitation to give this keynote address on the subject of 'Personal Care in Primary Care'.

This subject lies at or indeed is the very heart of general practice. It is based on the idea of the development of a relationship that allows a patient to seek help from a doctor whom they have grown to know and trust. It engenders the growth of mutual respect and freer communication; it helps establish resilience in the relationship, so that minor upsets and difficulties are tolerated by both parties, and that times of crisis in a patient's life are faced with the support of the doctor and recognized as often pivotal and meaningful. In other words, knowing our patients allows us to give them better care.

I can't really talk about personal care in primary care without making it personal' i.e. talking about a real person, and so I would like to tell you about a patient Harry (not his real name), whom I have got to know over the last 20 years at the practice, to illustrate the point. It was at the end of my first week working as a 'locum with a view (to partnership)' in May 1989, that Harry appeared at lunchtime at the reception window, with diffident sad eyes, and asked if he could 'have a word?' I agreed and he came and sat down on the edge of his seat, clutching and wringing at his cloth cap with his big mechanic's hands. He explained that his wife Elsie, (also not her real name) had been diagnosed with lung cancer earlier that week, and he didn't want her to be told, as 'She couldn't take it', and that she had an appointment to see me that very afternoon. I listened, acknowledged his feelings, sympathized and then explained that I wouldn't inflict information on her, but that I was duty-bound to answer any questions she asked me, as honestly, but as tactfully as I could. After several minutes he left looking forlorn, head bowed under the weight of his sorrowful burden.

That afternoon, a wiry, spirited woman, came into the room, introduced herself as Elsie, and told me she'd been to the hospital; that they'd beaten around the bush, told her a lot of mumbo-jumbo, but that she guessed she had lung cancer, and was she right? I explained that I still only had rather limited information in the paper notes, but that all the tests done so far pointed to the possibility and even likelihood of that as a diagnosis. I assured her of the practice's support, and said I'd like to see her again in a couple of weeks when she and I might both know more.

She duly came to her next appointment, and then, as her illness progressed, came with her doting husband Harry. I started visiting her at home regularly, involved the district nursing team in her care and she died peacefully about six months later, at home, comfortable in her marital bed with Harry holding her hand.

I visited Harry once at home following his bereavement. We talked about his fears about Elsie knowing her diagnosis, and how really she'd already known what was wrong, but I acknowledged that his concern and love for her, as well as his wish and will to protect her had been paramount in his own mind. I then suggested he came to see me at the surgery if he felt the need and if he thought he would find it helpful.

Well, Harry did come and see me, at the surgery... and then elsewhere! His walks always seemed to bring him up the lane, towards my house, to my allotment, his large head with the sad eyes becoming more animated as he bobbed up over a hedge. On one occasion he leaned on the gate talking to me for nearly half an hour, so that I felt effectively trapped. One weekend when I was on call he phoned me at home and told me he'd baked me a cake, and asked how he could he get it to me. I gulped, expressed my surprise at such an unusually kind gesture, but suggested that perhaps it would be best if he dropped it off at the surgery on Monday, and that he make an appointment to see me there sometime in the next few weeks.

By this stage, as you might imagine, I was becoming quite perturbed by the situation; but by good fortune there was a Balint Society Oxford weekend the following week, so Harry made his first appearance in a Balint group there. The group allowed me to voice my feelings and face the uncomfortable closeness of the relationship, and gave me courage to consider gently confronting rather than rejecting him as a patient outright, so that a supportive professional relationship could be re-established. When he next attended, about two weeks later, I explained that I knew he'd suffered a dreadful loss, that we had established a meaningful relationship as doctor/patient forged during Elsie's terminal illness, I had a duty of care towards him which I still wanted to fulfill but that it was a professional concern, and that his walks, cakes etc. made me feel uncomfortable. I recognized that as an important person during Elsie's last illness and death, he may have invested me with some of the feelings he felt for his wife, (had experienced a transference, to use the psychotherapeutic jargon), and made me a living receptacle for his emotions that had nowhere else to be directed now that Elsie had gone. He shed a quiet tear when I mentioned Elsie.

Things settled down, Harry still came to

see me in surgery, but gradually less and less. One day, about eight years ago, he presented with haematuria. Investigations were organized, and he was diagnosed with a low grade bladder cancer, which he calls, and was told are his 'bladder warts'. He remains under the care of the urologists to this day.

I hadn't seen Harry for about a year, when he attended in March this year, saying he'd lost weight, felt tired all the time, had aching in his shoulders and upper chest, was more short of breath, and had a persistent cough. I knew that despite my best efforts to encourage him to stop smoking, he was still smoking his roll-ups. Examination showed him to have lost weight, but there were no discernable chest signs. Blood tests and a chest X-ray were ordered. I was due to go on holiday, and he would see me on my return for the results. His ESR result, sent down the computer line from the lab, arrived the last evening before my holiday, and was raised at about 10 times the normal level. I phoned him, explained that he might have polymyalgia rheumatica, amongst other possibilities, and that either I could admit him to hospital that evening, or I could start him on a trial of high dose steroids, and see him on my return from holiday as planned. He chose the latter course. He was also going for his chest x ray the next day.

On my return to work, he came to see me saying he felt so much better, that the tablets were wonderful, that he was eating like a horse, had put on weight, was less short of breath and was even coughing less. On my return to work however, I'd also received the report on his chest x ray, which was suggestive of a mass in his left lung field, and probably a carcinoma. I had wondered if he and his beloved Elsie would be ironically reunited in this diagnosis, and eventual demise. But how could I burst Harry's excited up-beat bubble, which was, no doubt, fuelled by the steroids I'd prescribed? I then remembered him coming to the surgery nearly 20 years ago, worried about Elsie, and how 'she couldn't take it', and realized in a flash, that it was *he* who couldn't take it. I explained that we'd received his X-ray report, that it showed a possible small 'spot of bother', and that one of my partners in his efficiency had already referred him to see a chest physician while I was away on holiday.

A couple of weeks later, Harry returned to see me. He explained in a deflated way that the dratted consultant had taken him off those wonderful red pills that had made him feel so well, as they thought the 'spot of bother' in his chest that I'd told him about, was TB! He asked if I could just prescribe them for him again. He would prefer not to travel up to the hospital regularly to be seen, and he would much rather just take the shiny red pills and pop along to the health centre and see me instead! I had to explain to him that the steroids had seemed a good idea at the time; that they had helped him feel better; that they might have been exactly the right treatment if he'd actually had polymyalgia, and probably would also have helped his symptoms if he had had a lung cancer, but that actually in truth they would make the underlying disease process of the TB, that he turned out in fact to have, worse. I entreated him to keep his appointments at the hospital and take the treatment offered and stay the course, and since then he has.

So things with Harry have gone quiet again, for the moment, and it seems that we haven't yet arrived at the last chapter in our relationship. The neat but feared book-end of a second lung cancer diagnosis isn't in place, but the familiar mess of general practice with its loose ends continues. As you have heard in this story we have had ups and downs – differences of opinion e.g. about broaching diagnoses, mismatched expectations (his walks, the cake), treatments given with the best of intentions that have proved to be less appropriate in the end, but the relationship has continued, and become resilient and strong, since we have both invested time, effort and perseverance in it.

I would claim that his treatment has been enhanced, by the degree of personal knowledge and care that I could offer, just through knowing him over time. I can also claim conversely that my working life has been enhanced and made meaningful by knowing patients like Harry over time. To any GP this story will be familiar, and bring similar stories of their own to mind. It embodies the daily role of the GP as confidante, mentor and advocate, as well as trusted source of knowledge and advice, reliever of suffering, and privileged witness to the patient's life. How different this experience of the patient's actual life and journey is from the neat world of the health care planners who now apparently call doctors, nurses, and allied health professionals 'Units of Care Delivery' and who seem to see general practice as an industrial process driven by competitive targets and market share and think that any old, or preferably young, worker can plug the gap on the assembly line! An increasing number of mainly younger patients brought up in this consumer society, aided and abetted by government health ministers who should know better, seem to treat me like a check-out 'operative' at Tesco's, choosing the one with the shortest queue that day, and expecting me to metaphorically read their bar codes, and perform a diagnosis in seconds, not recognizing that symptoms, and even results need interpreting in the context of a personal medical history, family history, and some knowledge of their life. How many of us doctors are feeling like I do, feeling increasingly like a refugee, marginalized, dispossessed of my work homeland and virtually feeling forced to travel abroad to other medical disciplines in search of a sense of belonging? My natural medical home has been increasingly usurped by the computer, quantitative targets, QOF points, and bureaucrats who have never sat at my desk with the continually depleting box of tissues, nor witnessed the extraordinary heroic and titanic struggles of the very ordinary people

who process through our surgeries.

How many QOF points is 20 years of personal care, of continuing curiosity and concern, witnessing, accompanying and 'seeing through life' worth I wonder? And thank God for the Balint Society which offers refuge for these ideas and ideals, comradely astute support and emotional sustenance to the weary GP fugitive, and thereby their patients. Long may the Society continue to flourish!

Why Balint?

Michael Courtenay

Keynote address at the Northumberland Balint weekend held at Longhirst Hall, 19-21 June 2009

I am very pleased to have been invited to give this introductory talk to a Balint-work weekend in glorious Northumberland, where I spent a memorable holiday some forty years ago, but only hope I am not such a dinosaur as to be of no relevance to your work. I entered general practice in London in 1952. Entry into a practice at that time was difficult, as elderly GPs were postponing retirement in order to get a good pension, which meant having to work for 10 years in the NHS. Being married with two children and virtually broke, when I was offered a partnership it was an offer I couldn't refuse, in spite of having done insufficient postgraduate training. I was very keen to get started, having spent four and a half years in the army, where I had seen men maimed and killed, and later at the concentration camp at Bergen-Belsen in April 1945, where I saw horrors which live with me still. NHS general practice was in a parlous state. The number of patients to see every day was never less than sixty per doctor, and the only investigation available without referring the patient to hospital outpatients was a chest X-ray! We did do simple tests on blood and urine, but that was all. That was bad enough, but what was worse was that what my patients complained of rarely seemed to have been described in the textbooks I had studied as a medical student. There was almost a sense of relief when a urine sample tested positive for glucose! I did twig that many patients had an emotional problem, and a funny little book on anxiety symptoms by a Dr Ross became my vade mecum, but only filled a pothole in a bumpy road. It also became clear that many specialists could not put a diagnostic label on my undiagnosed patients either, so that referring them to one specialist after another only produced a fat-folder of notes and no light at all.

I struggled for five long years before reading Balints' *The Doctor, his Patient and the Illness*. You may be amused to hear that I read it while hospitalized for epididymitis! I wrote immediately to the Tavistock Clinic to enquire whether I could join a group. I was summoned for an interview by Michael Balint, which was the most searching one I have ever had, though I cannot explain to you quite why. Having told him in response to a question that I had four children, he said, 'You're not afraid of responsibility then'. Shortly afterwards he wrote to say I could join his group in September. That was 1957.

The group met at Michael and Enid Balints' house in Park Square West. The imposing front door was up a few steps, and the hall was rather dark. Stairs led up to the first floor which consisted of a large L-shaped drawing room The deep sash windows looked out onto the trees in the square, and above the mantelpiece there was placed a long medieval carving. We met in the larger part of the room, but my curiosity drew me to peep in the lesser part, where there was a caricature of Michael Balint adorned with horns! Enid was there as she was to co-lead the group with Michael, and there were eight of us to constitute the group, six men and two women. All but one of us were practising in or close to London, the exception came from rural Gloucestershire. He was obviously an innovator, as he told us he had a radio in the boot of his car so he could receive and transmit messages on his rounds. (There were no transistors then!) He had to take a whole day off to attend the group, which he did regularly for three years. He was a very calm and thoughtful doctor and presented cases regularly. Although many of his patients lived and worked on farms, their complaints seemed to differ little from the urban ones of the rest of us. Then there was the Superior Doctor. He was not slow to tell the rest of us what to do! Later he left general practice to run a drug-dependency clinic, which was new aspect of life in those days. Next came a rather motherly woman who presented cases mainly involving family problems. Then there was a young doctor who had joined a practice just outside London in which the other partners were a father and son. He was very likeable, but I think the rest of us thought he was bullied and exploited by his partners, who were also relatives. Next was an older man who practised to the west of London and seemed less disorientated than most in the new setting. Then there was me, practising in south London and totally bewildered. I found it quite testing to take the tube to Regent's Park Station on the underground to be there by two p.m. and get back for evening surgery at five. The other woman was young and dynamic, married with young children, with a loud voice. At first I found this disconcerting. I offer you as evidence that Balint-work does what it says on the tin that we later became good friends. And then there was the Pole. He told us his name and where he worked, and those were the only words I heard him utter before he left the group at Christmas time. He never presented a case.

In those days group members were expected to have a case ready every week, and to have seen the patient for one or more long interviews, as the initial idea was to turn us all into quasi-psychotherapists. Michael Balint was active and forceful in his leadership, and not afraid to inject little paragraphs of teaching. Enid was relaxed and quiet and would intervene to protect a group member who was being pressured by her husband. I slowly began to see what we

were being asked to do, but even when the Pole had left, things were far from clear. Gradually I began to see forward, the focus on the doctor-patient relationship opened a door to understanding patients whose problems had previously been intractable. At the same time I think my family found me less of a pain.

But I do not wish to depress you before you start, things have changed! It is because of the past experience that the Balint Society has introduced such weekend workshops in which we are now engaged. John Salinsky's short introduction proves it.

As a psychoanalyst Balint was used to seeing patients five times a week, and time constraints were rather ignored. For instance, once in my first group Michael Balint suggested we put the spotlight on the sex-life of every patient we saw during a single surgery. The surgery I chose became very long, even though I had tried to choose a quiet day! I still remember that one patient, who had come for a final certificate to return to work, remarked, 'And I thought I should be out of the surgery in no time'. I think that Michael Balint had been prompted to give us this task as in 1960 the Family Planning Association approached him because there had been a lot of feedback from the doctors working in birth control clinics that showed that many of the patients coming had sex problems, sometimes cryptic, sometimes overt. This led to the formation of a group to study the nature and treatment of common sexual problems, the first one studied being non-consummation in marriage. Later groups attempted to use brief psychotherapy for sexual problems. While considerable success was achieved, it became clear that some patients were not being treated with adequate skill by semi-trained 'psychotherapeutic' doctors.

Michael Balint came to realize this was also relevant to the way the GP groups operated, and the product of another group, of which I was a member, was the book *Six Minutes for the Patient*. The focus of this group was the exploration of what was possible in the average GP consultation, and I believe that this still continues to be the case in most groups today.

Interestingly in view of the fact we are enjoying a weekend Balint meeting, the tide turned for the new approach at a similar weekend in Aberdeen, having been invited there by a local psychiatrist, who wished to observe the Balint approach. For the first time 'ordinary' cases in general practice were presented, and it proved a breakthrough for the group. However, I would like to say that, initially, this change was not readily accepted by some of the doctors who had been members of the very first group. For instance, Philip Hopkins, the man responsible for the birth of the Balint Society, its first President and editor of the Balint Society Journal for 25 years, was one such, and had even altered his mode of working by seeing four patients for long interviews in the afternoon for four days a week, so maintaining a caseload of 16 patients at a time. But he was altogether an exceptional man.

So what is the relevance of doing Balint-work in general practice as it is today? One of the insights that emerged from Balint's first group was his concept of what he called 'the drug doctor', the idea that each doctor has a personal therapeutic potential for his/her patients. The consultation could no longer be seen as an objective process where the doctor listens to the patient's story, brings his/her intellect to bear on it and then tells the patient the diagnosis and outlines the treatment. The consultation is thus transformed into a subjective experience for both doctor and patient, which then goes beyond the classical medical history, taking everything relevant from the personalities of each of them into account. The reflections by the doctor on what appears to be happening between him/herself and the patient then stand side by side with both the way the complaint is presented and its impact on what the doctor feels as a result. Recently, neuroscientists have made us aware that thought and feeling are inseparably bound in our consciousness, and that the idea of rigorous objectivity is probably a mythical state.

Balint noticed that the doctor presenting a case in the group often appeared to be acting out aspects of a patient's story, apparently unconsciously, and that often gave a clue as to how the patient viewed the world. At the same time the doctor's attitude seemed to stem from hidden factor in the doctor's make-up, being a personal response to the patient as a person. This idea led to another of Balint's concepts, that of the 'apostolic function'. It seemed to him that every doctor had a clear, though unconscious, view as to how a patient should properly behave vis-à-vis the doctor. Does this have echoes for you? And I do not exclude my colleagues or myself even after many years of Balint-work; for I have observed that we all tend to develop alterations to our apostolic function, rather than lay it to rest! Evidence for this may be found in the book *What are you feeling, doctor?* which was an attempt to understand which factors in a doctor's personality might have a bearing on his/her clinical work. Another of Balint's ideas was the need to develop 'a third ear'. By this he meant that we should develop a sensitivity towards matters in the process of communication between patient and doctor beyond ordinary verbal exchange. The image of the patient with his hand on the handle of the door as he is on the point of leaving the consulting room, who then says 'By the way, doctor', is an iconic example. Beyond that Balint always stressed that what the patient didn't say was often more important than what he did. If there is an area of life which could be presumed to be relevant, but about which the patient remains silent, that may point the way for the doctor's further line of enquiry.

But I will (in the words of business-speak), push the envelope; I think the aim of Balint-work is also to provide the doctor with a

'*third eye*'. By this I mean, when you feel entirely at a loss with the patient in front of you, either because the diagnostic process seems to lead nowhere, or because the patient pisses you off by his attitude or consulting pattern, perhaps it is time to figuratively take a deep breath and imagine that you are now somewhere up near the ceiling (an image akin to some reported near-death experiences), looking down on the patient and yourself getting precisely nowhere and from this imaginary increased over-arching distance in the consultation process, try to take a detached view of how you got there. It is a way of '*earthing*' one's emotional overload to mobilize a new perception on what has been going on between you and the patient. Try it; you may be surprised!

Turning from questions of personality to the milieu of general practice as it is today, though I am only a grateful patient of my splendid GP, in talking to her and reading the BMJ I sense that some of the stresses I experienced in 1952 have re-surfaced in a different guise. I note the difficulty in getting a partnership, the demands of new generations of patients whose expectations are now much more sophisticated, and who have access to a lot of information on the internet, much of it of dubious validity. The Balint group provides a little space and time without the day-to-day pressures of modern life, encouraging the sharing of problems by allowing a number of other perspectives to be set beside your own, as well as the freedom to share flights of imagination however wild, to be used or rejected by the presenting doctor. This is a healthy exercise, it is freedom to speak one's mind about important things without fear of being bullied or belittled. It is way of getting unstuck.

In my first draft for this introductory talk my mind turned towards thinking of an illustrative case, in spite of the fact that I have not seen a patient for 20 years. But while illustrative cases have been the bedrock of writing about Balint work, I think it would be wrong to introduce one now, even though several unreported cases still lie bright in my memory. The essence of Balint-work is experiential, and you have already tasted the process yesterday evening. Anyway to talk about a case here would be worse than useless, in that any single case would bear too heavy a burden of importance at the beginning of this weekend which is designed to be a door into a new way of learning. So I will urge you to take a deep breath and walk out into a new landscape of medical practice, where the air is bright with the brainstorming of your own *feelings*. Take courage! Although you do not yet know your fellow group members and the *animateurs* of your group, be bold to trust their goodwill towards you, seeing that all of us are vulnerable human beings who need all the help we can get. Let your gut feelings fly and do not be afraid to look stupid. We are all stupid some of the time, and Balint urges us to 'have the courage of our stupidity.'

If we have reached a point where understanding the patient seems beyond us, we must try a different path towards that understanding, by letting our imagination rip. Visualize yourself with the patient and observe your interaction up to the point you have reached, with the thought that there is something on your side of the interaction that is somehow interfering with your wish to reach the goal of understanding the suffering person who sits in the other chair. He/she may appear difficult, demanding or downright impossible. What is it about the patient that makes that true? Especially to you!

From the Annual Dinner 24 June 2009

Address by Dr Iona Heath

It is a great pleasure to be invited to speak to you tonight. No-one can possibly describe me as an active Balintian but my extraordinarily privileged experience of Balint groups has been extremely important to me. When I was still a trainee, I participated in a group led by Mike Courtenay and Enid Balint and then, after I had completed my trainee year, I joined an established group whose members included such luminaries as John Salinsky, Paul Julian and Lesley Southgate. These experiences are, I am sure, responsible for much of the joy that I have found in my consultations with patients.

Tonight, I want to discuss two issues:

- my view that within an increasingly hostile and reductive policy environment, Balint approaches have never been more needed.
- and then something about the need for change and development within the Balint approach itself.

I have had two opportunities to listen to Barbara Starfield over recent months and to hear her wonderfully heartening finding that an increase of one trained family doctor per 10,000 persons was associated with a decrease of about 70 deaths per 100,000; whereas an increase of one specialty physician per 10,000 population was associated with approximately 15 additional deaths per 100,000. And it seems increasingly clear that general practice improves health outcomes in this way because of our capacity to integrate care around each different and very particular individual and family context. This, in turn, makes it easier to understand why the imperatives and coercion of the Quality and Outcomes framework (QOF) feel so wrong – because the targets inevitably shift our focus away from the person and towards the disease.

As soon as you look at the disease, you are looking at what the patient has in common with other patients – using a normative biomedical gaze – seeing the body as a standardised object – within an I-it rather than an I-Thou relationship as defined by Martin Buber. In the language of the World Health Organisation, care becomes vertical rather than horizontal.

Thinking and listening and speaking within Balint groups is a hugely needed counter-balance and will always bring the focus back to the unique human individual – to the human subject – to what is unique for this particular person – to an intersubjective dialogical relationship between doctor and patient. As Boris Pasternak wrote in *Dr Zhivago*: '- the mystery of the individual is precisely what must be put into the facts to make them meaningful'.

And of course, the body is – almost miraculously – both an object and a subject. During a consultation, the gaze of both the doctor and the patient needs to oscillate between the body as an object of scientific study or as an object impeding the will and aspiration of the patient – and as a unique suffering subject. If the QOF really does succeed in shifting the balance of that crucial oscillation it will prove very destructive.

But, moving to my second point – is there anything really special about a Balint group? Why are groups led by a GP and a psychotherapist? Does it matter that many no longer have a psychotherapist? It seems to me reminiscent of the evidence around psychotherapy and counselling techniques: the theoretical basis of the therapy makes no difference to the outcome and seems simply to serve to make the therapist feel secure by providing a structure within which to work.

Is a Balint group any different from any other form of reflective group learning? Is it simply the reflection – the space and time for thought – that matters? Is there a danger in a purist tradition? Why do people always seem to be trying to reinvent the wheel – most recently, perhaps, with mentalization groups which I heard about at the recent Nordic Congress of General Practice? 'Mentalization' is defined as the capacity to reflect on one's own mental state and to attribute mental states to others as an explanation of their behaviour. Mentalization-based therapy is defined as a therapeutic process in which the mind of the patient becomes the focus for treatment.

I find myself wondering whether this kind of reinvention happens because the original wheel has not changed. Is there a danger in a purist tradition? Should the Balint tradition now be embracing different humanist disciplines and other perspectives? For me, the dual leadership of the groups is crucial. Clearly, there must be a GP leader – someone who understands and has experience of the constraints and privileges and opportunities of the consultation – but why always a psychotherapist? For me, the role of the second leader is to bring a different approach – a tangential perspective – the ability to pose unexpected questions – so why not a group led by a GP and a poet – or a historian, a novelist, a philosopher, a journalist, a geographer, a theologian, a photographer or even a mentalization therapist?

My understanding is that the original specification of a psychotherapist was driven by the very real and important need to reunite the body and the mind within the practice of medicine and Balint made a huge contribution to this – but it seems to me that this argument is now sufficiently established, at least within general practice.

As Laurence Sterne wrote in *Tristram Shandy* 250 years ago: 'A man's body and his mind, with the utmost reverence to both I speak it, are exactly like a jerkin, and a jerkin's lining; -

rumple the one, - you rumple the other.'

Perhaps it is now time to look to different humanist perspectives that may offer new insights with the potential to enrich general practice just as much as the psychoanalytic approach has done since Michael Balint first began working with GPs all those years ago.

Secretary's Report 2008-2009

2008-9 again showed a general expansion of the Society's activities, with the reintroduction of a study day in London in February, receipt of new charitable funding to expand Balint work in the Northwest of England, and also interest from a small group, the Harvard Program for Refugee Trauma, in using Balint group work to help local health workers in the third world.

The Oxford weekend ran from 5 to 7 September at Exeter College. 43 people attended forming four groups. There were three medical students who enjoyed the experience, and 20 guests from Iceland. Just before the economic collapse of their currency the whole of the current Icelandic GP training course was able to attend. There was no linguistic problem, and a lot of singing on Saturday night when we found that one of their bedrooms had a piano in it!

The lecture series at the RCGP continues as a seminar style meeting to which guest speakers are happy to be invited, meeting on Tuesday evenings. Attendance varied between 10 and 25 in the past year, with about 50 people attending the Balint Memorial Lecture, given by Dr Paul Julian. The text is printed in this edition of the Journal. The group leaders workshop, once a term at the Tavistock Clinic, continues and many more people are currently interested in training for leadership. There are also leadership training opportunities at some weekend meetings. In 2009 both the Northumberland (Longhirst) and Oxford weekends offer a leadership group.

The new event of the year was held on 19 February at the Canonbury academy, a very pleasant old house, providing a warm atmosphere for Balint group work. About 30 delegates attended. It had been envisaged as a meeting to attract young GPs, and was jointly promoted with the London Deanery. In fact it was a good mix of young GPs and programme directors. Two kinds of experience/learning were thus catered for. The event, organized by Dr Andrew Dicker, will be continued next year along the same lines. The Whalley Abbey weekend, organised by Dr Caroline Palmer, had two groups. We are hoping that this event may continue to grow as there is finding for more work in the Northwest. There will be a day meeting on 14 November 2009 in Manchester to try to set the ball rolling, organised by Dr Ceri Dornan. The Longhirst weekend was again a great success at midsummer. Three groups, including a group leadership one, led by John Salinsky and Esti Rimmer, enjoyed a beach barbecue on the Saturday night.

The President , Dr Andrew Elder, and I travelled to Boston in early June to consult with the Harvard Program for Refugee Trauma, a second meeting. We hope to continue working with them on a consultancy basis, trying to train leaders in distant, traumatized countries, provide ongoing supervision, and a training structure, applicable to such conditions.

The last event of the year was a very successful Annual Dinner at the Royal Society of Medicine with Dr Iona Heath, president elect of the Royal College of General Practitioners, as speaker. 35 people attended. Dr Heath spoke of how much she for Balint work, but wondered about how it might change and improve in the coming years. The Balint Essay Prize was awarded at the dinner jointly to Dr Richard Stevens and a medical student from University College, London, Noah Moran.

We are looking forward to the International Congress in Romania from 5-9 September and also the Oxford weekend, this year at a new venue at Lincoln College, from 25 to 27 September.

David Watt

British Balint Society Day Conference, February 2009

Andrew Dicker

During the depth of the February gloom of 2009, the Balint Society held an all-day meeting of Balint groups and discussion about the purpose and value of the work. This was the first of what will hopefully become a regular occasion in the Balint Society calendar. The meeting was designed in the context of the need for a move away from the traditional winter evening meetings held at the RCGP and a more modern approach to day time meetings relevant to all GPs.

Following the inclusion of Balint work in the national curriculum for GP training, it has become more relevant both to GP trainees and to those who train them. The target audience was the training 'community' in London, to whom the meeting was publicised through the medium of the London Deanery database of trainees, trainers and Programme Directors. The meeting was held at the Canonbury Centre which lent itself admirably to the purpose. The meeting attracted an eclectic group of about twenty doctors both from London and elsewhere, all of whom were closely involved in training. The experience of Balint work among the participants varied from none at all to a great deal.

After introductions and a brief explanation of the intended purpose of the meeting, the rest of the day was devoted to Balint group work lead by four experienced leaders. The day was concluded with a semi-structured discussion by the whole group about what had been achieved. This included written feedback where everyone had an opportunity to record the highlights of the day and observation about what could have been done differently. The discussion and feedback evoked a uniformly appreciative account of the day which reflected the intrinsic reward of involvement in an authentic Balint group. There evidently continues to be a need for opportunities to discuss the process of the consultation in general practice in a safe, non-judgemental, target-free environment.

Whalley Abbey Weekend Workshop, March 2009

Caroline Palmer

It was a blustery March weekend, with daffodils blown by the wind, when 20 of us met together in the old but comfortable, conference house in the grounds of the ruined abbey at Whalley in Lancashire. Once through the ancient abbey gates, there was a sense of withdrawal from the material world and yet a paradoxical engagement with the patients and clients with whom we share our working lives. The luxury of protected reflective time, focused thoughtful work by all in the groups, and a shared commitment allowed us perspective on our problems with patients, and thereby a vision or a path towards their resolution.

Both groups worked hard on the cases, and interestingly seemed to cover similar thematic areas; cases that made us ask what is tolerable for us: be it tolerating patient demand; tolerating risk, uneasiness and insecurity; or tolerating biding our time and being patient. We also pondered on how we could tolerate our medical system, our colleagues, teams and their way of working sometimes, ultimately perhaps recognizing our own idealism, resilience and inner strength. We also acknowledged that while systems may feel inhibiting, stultifying, or even at times corrupt, they could also be protective and supportive, allowing us to operate and survive.

We were perturbed at times by our need to label people, with emotional problems in particular, with a diagnosis, but recognised that while it might sometimes help us understand the person, their problem and our relationship difficulty, at other times it may hinder us from seeing them as a complete human being. Thinking about labelling also led us on to cases which challenged social and professional boundaries and roles, which became a recurrent theme developed in both groups. We were able to explore situations when patients overstep the usual boundaries of a doctor-patient relationship, and when doctors also uncomfortably verge on allowing that to happen, and we tried to consider and understand why this might happen.

The intensity of the group work was balanced through comfortable surroundings, plenty of wholesome Northern nourishment and hospitality, as well as a well-stocked bar! The opportunity for further withdrawal and perspective was taken by some on a breezy bracing walk along the lofty edge of Pendle Hill, in the footsteps of the renowned reflective thinker George Fox, (founder of the Quakers), and also the non-conformist healers of their time, the so-called Pendle witches.

The next Whalley Abbey Balint Society weekend dates for your diaries are May14th to 16th 2010, and again May 20th to 22nd 2011, to which all reflective thinking healers are welcome!

Northumberland Balint Weekend and Leaders' Workshop Longhirst Hotel and Conference Centre June 2009

Jane Dammers for the staff group in Tyneside

This was the third Balint weekend we have held in the North East and it is now set to become a yearly late spring or early summer event. We again had nearly thirty participants, this time an almost equal mix of GPs, therapists and psychiatrists and we all got on extremely well.

The weekend started with a dialogue between two GPs about a 'surgery' - a real surgery of patients seen in the previous week. The first patient was a gift, telling the doctor 'you are the sister I never had' and giving her a big hug as she left. The dialogue revealed the diversity of problems brought to the GP, the very common emotional and psychological presentations, and some patterns in consultations. We used this last year and it seems to be a very good way to bring everybody quite quickly into the world of general practice.

John Salinsky had kindly agreed to come up and work with Esti Rimmer from our staff group to run a Leaders' Workshop. This was a big mixed group with eleven participants, including three GPs and there was some anxiety about how this would be managed. John had very helpfully written basic documents about Balint work and leading groups which were circulated to everyone before the conference. We felt this was very useful for especially as we had people from several different disciplines. The larger group gave opportunities for people to sit out and observe as well as participating in leading or being part of a Balint group - so the rather large group was not problematic.

Mike Courtenay gave a marvellous talk on Saturday morning detailing his involvement with Balint work – we were all spellbound. We can only thank him and Jane for coming all the

way from Oxford to be with us. His talk is printed in the journal and will also be posted on the website – it is a gem which everyone should read.

We had four groups through the weekend, one on Friday night, two on Saturday and one on Sunday morning following the well-established pattern at Oxford. The ordinary Balint groups

were quite small but worked well. On Saturday afternoon we also ran a goldfish bowl. We decided to offer the leadership of the goldfish bowl to anyone on the floor (not staff group members) and one or two staff group volunteered with others to be in the group. The goldfish bowl was facilitated from the outside by two of the staff group. This seemed to work well – avoiding any idea of being a demonstration of expert leadership or a 'good' group – just another group which we could observe and think about. The leaders did very well and it was a lively and very 'real' group which provoked plenty of discussion and seemed to be useful.

Saturday was Midsummer's Eve. We all went in a coach to Newton by the Sea, one of the most beautiful beaches in Northumberland. Mike and Jane remembered it from a holiday in the sixties as 'being just like the Mediterranean'

which it is with little islands off shore and a sandy bottom blue sea. The sun shone at the last minute and we had a lovely walk towards Dunstanburgh

castle followed by a Bar B Q on the beach – helped enormously by two dear friends from Hexham who set up before we arrived. The local pub had good beer and a few of us had a quick dip in the North Sea before the coach took us back to Longhirst after a long, quite tiring and very good day. Many people said how much more sociable and fun this had been than sitting down to a more formal dinner and spending the rest of the evening in the bar. We worked hard, we made friends and learned a lot. It was a very enjoyable weekend and we have had lots of good feedback. We have already booked Longhirst which is an excellent venue for July 2 – 4th 2010 and hope you will be able to join us then.

Pictures from the 16th International Balint Congress in Romania

The Balint Society Essay Prize 2010

The Council of the Balint Society awards a prize of £500 each year 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 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 2010 and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS.

Guidance for Contributors

All manuscripts for publication in the Journal should be submitted to the Editor, Dr John Salinsky by email: *JVSalinsky@aol.com* as a word file.

We welcome research papers, personal reflections, case studies, book reviews and reports of Balint events and ongoing groups.

References

References may be in the Harvard or Vancouver style. 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.

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