DEFINING BALINT WORK – IS THERE A HEARTLAND? AND WHICH ARE THE NEIGHBOURING COUNTRIES?

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I will firstly try to say something about Balint work in the 21st century as a part of a humanistic, holistic approach to the medical profession.

The ideas of Michael Balint for enhancing the professional capacity of the general practitioner have spread over the world during these 50 odd years since Balint met with his first groups of British GPs in the small conference rooms at 41, Portland Place off Oxford Circus in central London.

They have inspired many doctors both in the somatic and psychiatric fields and a lot of group activities have been set up - and also vanished - bearing the name of Balint. In this paper, I attempt to discuss the essential ingredients of a Balint group. I discuss these issues from various perspectives:

1. The general purpose of a Balint group - the explicit goal and its consequences for the practical contents of work.
2. Some aspects of the boundaries and the "work contract" of the group
3. Demands on the group members
4. Demands on the group leader

I propose a core definition:
A Balint group consists of clinicians who meet, as equals and because each of them wish to do so. They meet on a regular basis over a long period of time to discuss and come to a better understanding of their own clinical work, their own meetings with their patients. Within the group a mutual consultation is taking place.
To facilitate the working process the group members cooperate with an external consultant who also has the role of group leader. This person must be well acquainted with the working conditions of the group members (culturally attuned) and be able to add psychoanalytical/psychological aspects which are relevant for the purpose of Balint work.

I try to discuss the advantages and difficulties of Balint work and the adjacent territories of other kinds of group work, such as group therapy, educational groups, supervision groups for students and doctors-in -training, mentoring groups, other clinical conferences, other professional reflection groups, and team meetings, etc, etc.

I discuss various varieties of Balint-inspired groups and what modifications of the original framework that is demanded of such groups, its members and leader.

An English breakfast can consist of a large variety of dishes but the foundation is always ham and egg. Otherwise it is not an English breakfast.
In analogy Balint work must be based on the idea of mutual consultation for equals, focus on clinical work and a relevant psychological perspective brought into the group to promote the group members´ own reflective work.
I suggest that in Balint work it is not always easy to see the boundaries. We might rather speak of a shared border territory with other forms of group work. Still, I maintain that, to ensure the continuity and good work of the Balint group, it is important to stay within its defined territory. And yet good spin-off processes can start generating within the group members on a personal level, at their clinics etc though this is not the goal of Balint work itself.

It is very challenging to participate in an International Balint Congress in Berlin in this year of 2003. Even if the majority of the participants to this Congress were not born when the fateful processes started off, still the 20th century history of Berlin should be very tangible to every European and American. This city in the beginning of the 20th century was a centre of German culture and a great source of inspiration to Europe and the world, as well as an international cultural and scientific meeting place and a melting pot. It is now 70 years after the rise of National Socialism to power, a megalomaniac illusion that utterly destroyed this city. It was followed by forty-four years of division and a two-front civil struggle against totalitarianism on the one hand and the disillusionment of the past on the other. 70 years after 1933, Berlin again is a whole city and part of a challenging national and European context, and has once again recovered its former position. In this respect we may paraphrase JFK that we should all try to be Berliners.
It makes this city a good vantage point for looking back at the origins of Michael Balint´s ideas and the world he came from as well as looking for the future prospects of Balint work. We may recall the strong psychoanalytical links that existed between Berlin, Budapest and Vienna before the Hitler barbarism put a stop to it. The work of Sandor Ferenczi (the spiritual father of Michael Balint) in Budapest and Karl

Abraham in this city and Sigmund Freud in Vienna constituted the axis around which the psychoanalytical wheel started turning.

Some thoughts on the social and medical context for Balint work

Before starting my discussion about the aims and functioning of Balint work, I would like to say something about the context that the Balint group is intended to support - the world of the general practitioner and the outpatient clinic. I think we all agree on the extreme importance to the citizen of a secular and democratic society; of having access to an experienced and sensible doctor for his feeling of security and comfort. The need of the patient is twofold in an intertwined way:

The patient seeks to be the object of a good medical judgement and to have his concerns and anxieties about his condition reflected in the eyes of the doctor so that hopefully he will feel he is adequately seen and met with. In this way - no matter how serious his condition is - he will be helped in dealing with his medical condition as realistically as possible. But in a democratic and secularised society - whether we like it or not - the spiritual needs previously supplied by shamans, medicine men, magicians and priests since the dawn of civilisation, have, to a large extent, been transferred to the doctor. These demands will also be present in the consulting room - but in the modern society we have many competitors in this "marketplace", serious ones and frauds.

Still, subsidised medical health care with a general practitioner - whether privatised or public - is an important symbol of the safety and care provided by the modern civil society to its citizens. It seems to me that politicians, administrator and also the doctors themselves do not always fully recognise how important this function is for the cohesiveness of our society. The function of the Balint group is to support the doctor in doing this work as adequately as possible in line with the saying attributed to Hippocrates: "The most important thing? is not what disease the patient is suffering from, but who the patient is who is suffering from the disease." It is not enough that the doctor tries to exert his skills and medical techniques in a logical and rationalistic way and in accordance to science and proven clinical experience. That gives no guidance to the understanding of the meeting between the two persons in the consulting room. The Balint group may help the doctor to be more aware that the patient because of his demand-for-dependency and inner hopes and fears will not necessarily respond when talked to at a logical level. If the doctor does not take this into account something will be missing. The Balint approach could thus be seen as a way of recapturing and developing a humanistic clinical medical attitude.

From my position as a Balint group leader for 17 years, as a practising psychoanalyst and as an MD with some GP experience of my own, I am impressed by the personal qualities and training skills it takes to be a "good enough" general practitioner and by

many of the odd 70 colleagues, that I have had the privilege so far to work with over several years. The art of general practice requires an ability to improvise constantly according to the climate that is created between the doctor and the patient. This climate is tangible in the sensitive doctor and the doctor is acting in it - often without having a distinct consciously formulated idea of what kind of inner relation is going on in the patient or in the doctor himself. The purpose of the consultation is seldom clear (there is often a hidden agenda). The working conditions of the GP demand flexibility, good working capacity, professional integrity, tolerance, social competence, loving (I mean to use this word in a very unsentimental matter-of-fact sense) care and respect for the most varied expressions of life styles and demands, a good clinical intuition and a continuous up-grading of his medical training. This job is full of inner contradictions and, at the same time, a challenge and a possibility to be near life and people. It offers few opportunities to build ivory towers.

Michael Balint´s ideas were meant to enhance the professional capacity of the general practitioner. They have spread over the world during these 50 odd years since Balint met with his first groups of British GP-s in the small conference rooms at the CIBA Foundation at 41, Portland Place off Oxford Circus in central London.

In these years we have also witnessed a gradual shift in attitude inside the medical profession from a more or less pure organ-centred view to a rediscovery of a holistic and humanistic approach alongside the dominating medical natural science. General practice as a medical speciality in its own right has gained recognition against strong resistance from many representatives of hospital medical specialities. No doubt Balint´s book: *The Doctor, his Patient and the Illness* inspired general practitioners greatly in many countries asserting themselves. Also, many physicians both in the somatic and psychiatric fields set up a lot of group activities bearing the name of Balint. Some remain, many have vanished.

In this paper I attempt to discuss the essential ingredients of a Balint group. I discuss these issues from various perspectives:

1. The general purpose of a Balint group - the explicit goal and its consequences for the practical contents of work.
2. Some aspects of the boundaries and the "work contract" of the Balint group and the border territories to other kinds of groups with adjacent purposes.
3. Demands on the group members.
4. Demands on the group leader.

The aim of Balint work

Michael Balint described the gap between the regular medical training and the clinical working reality of the doctor as follows:

There are many fields in present-day medicine where science is of little help to the practitioner, and he has to rely chiefly on his common sense. (Balint: *The Doctor, his Patient and the Illness.",* 1957).

Balint aimed at "training the doctor in the psychological treatment of the patient". Still, this did not mean making the doctor a psychotherapist, but rather to make him psychologically adequate in his role as a GP. In the nineteen-fifties, Balint rightly could state that this would be a cultural breach with the expectations of both the patient and the doctor. Balint group work aims at gradually changing the definition of the relation to his patients by the doctor himself. It is achieved by making the interaction (the interplay is an even better word) between the doctor and the patient more visible as well as increasing both the medical and the psychological understanding of the situation of the patient.

Indeed, Balint, by working with the GP groups meant to help the doctor to develop his "common sense" so that the doctor would be able
- to apply his medical knowledge as judgementally as possible, and
- to use his "professional ego" in an optimal way educationally, psychotherapeutically and ethically.

The development of "the professional ego" is enhanced by
- examining in the group in which way the individual doctor is using "his apostolic function", that is how the doctor, so to speak, is preaching his particular medical gospel to his patients, and
- examining which are the difficulties and blocks in the doctor which prevent him from using his professional intuition and medical judgement in a good enough way.

Through Balint group work we become more aware of something we already in principle agree on - that there are feelings and thoughts in the doctor in clinical situations that are repressed (*verdrängt*) or disavowed (*verneinet*). Such impulses or uncanny premonitions might be turned into more or less pseudo-rationalistic counter-reactions, i.e. an extreme emotional distance to (objectification of) the patient, lack of distance, negligence, painful and unnecessary examinations and tests, a prolonged uncertainty about the results. Often the doctor will not be conscious of these processes. Like many of his patients he will experience a vague discomfort for which he will seek the advice of his colleagues in the Balint group. By means of a respectful discussion and reflection on these matters in the group the doctor may gain

insight into the situation and find he is no longer emotionally and intellectually imprisoned by his unawareness and his acting out.

In Balint work we also try to identify the extensions of what Balint called "the offer of the patient" - the outspoken and hidden demands and wishes that the doctor is charged with. I say extensions because in the modern society such demands do not only come from the patient. He may simultaneously be the messenger from the GP staff, colleagues, and neighbouring caregivers (hospitals, social welfare office), and also from the health insurance and the employer. There are many social and cultural conventions of our modern society that tend to be canalised into a call to the local GP just as in other eras people in distress used to turn to the church. I say this with no mocking or ironic tone. It is just a social and psychological fact and emphasises the responsibility of the doctor to consider this in an enlightened way, not to disregard it and not to exploit it, but to be a "good enough" shepherd to paraphrase the Good Book and Winnicott.

Useful psychoanalytical concepts

Let me firstly say, as a Balint group leader I prefer to talk Swedish rather than Psychoanalytish when I make my "apostolic" remarks in the group. But I find that psychoanalytical concepts do have a great heuristic value with regard to the understanding of what is going on in the group, between the doctor and the patient, and in the patient. If this kind of thinking is reasonably integrated in the group leader, and he appears in the eyes of the group members to come from a neighbouring country and not from psychoanalytical outer space, he will be able to provide the group with a very helpful way of thinking and with hypothetical models for understanding. But psychoanalytical thoughts are not the truth itself. Truth is for the case presenter to find However it happened many times over the years that the presenter came back and reported a dramatic change in his own attitude towards his problematic patient following such an "apostolic" psychoanalytical explanation. In this way the psychoanalytical clinical experience and thinking provides Balint work with a broadening and widening perspective on the doctor-patient relationship.

Those concepts I have found most useful are:
1. Conscious - preconscious - unconscious
2. Transference - counter-transference and projective identification
3. The aspect of unconscious meaning in the psychosomatic symptom
4. The psychic parallel processes

1 & 2: The conscious and unconscious interplay between the doctor and the patient is intimately linked with the concepts of transference and counter-transference - the communication between the various psychical levels or areas in the two of them. In a very simplified way we might say that the patient besides his outspoken requests may make the doctor the target of many inner representations (Vorvorstellungen),and the patient may be exposed to the doctor in a similar way (transference - *Uebertragung*). Also the doctor may find himself more or less affected by these tunes and also answering to them in ways somewhat alien to his usual professional self (counter-transference - *Gegenuebertragung*). The "symptoms" (resignation, irritation, anxiety, tiredness, irrational medical or non-medical acting out, various bodily manifestations i.e. head-ache, stomach troubles, muscular tensions etc) arising in the doctor from a meeting with a certain patient can be transformed to clinical signals, which the doctor could use to deal with the patient in a better way. A disregard for these signals will not make them disappear. Instead they may form the brick-stones of a burnt-out syndrome in the doctor. A word of warning: the distinction between the counter-transference and transference of the doctor versus the patient is not so easy to make. It is reasonable to think that it is also many times because of our own neurotic character and vulnerability that some patients can affect us so much. At least in the psychoanalytical sphere there is a bias - probably because of shame and preservation of a narcissistic equilibrium - towards assuming a counter-transference reaction in the doctor rather than talking about his own neurotic transference reaction onto the patient. This is a special issue that concerns the invasion of the private conflicts of the doctor into the consulting room, and I will discuss this further in the context of the limitations of Balint group work.

3: In the psychoanalytical conceptualisation you will find the ideas of the psychosomatic symptom as a formation of an unconscious concretistic expression of a hidden meaning, tragically often an aborted symbolical meaning. Such hypothetical ideas can be introduced into the discussions of a case in the Balint group in order to increase the understanding and the respect for the sufferings of a person, for the understanding of the communicative aspect of the symptom, and for finding the limits for intervention in spite of our preliminary understanding. Also, the concepts of conscious and unconscious are useful in discussing the primary and secondary gains of the patient from his illness. When such distinctions become less clouded to the doctor, it definitely affects his attitude to his patient.

4: It is not unusual that parallel psychical processes to the problematic situation in the consulting room of the presenting doctor emerge in the Balint group work on that very case. I will show it in an example soon.

I just first want to end up this brief survey by saying that the psychoanalytical formalised knowledge, which often helps clarifying and widening the understanding of an obscure clinical situation (also to a soundly sceptical mind) are constructions and auxiliary devices and nothing else. What is vital in the creative process in a Balint group I would put like this:
The successful participant of a Balint group will find and develop his own professional psychological concepts. Those will be a synthesis, a mixture of general concepts, private expressions (such as you experience in the involuntary poetic and withheld passionate quality of a good case presentation). In his unique way he will try to describe and analyse the elusive but nonetheless very real and tangible interplay between himself and his patients.

Now I will ask you to lend your ear to a presenting doctor in a Balint group. He will illustrate several of these issues that I have mentioned above, and also anticipate a discussion that will follow on the limitations of Balint work:

"Astrid was unmarried, childless and worked part-time in a school kitchen. She was sixtieth and had for a couple of years been with me for blood pressure checks and back pains. But mostly she seemed to consult me for ...yes, for what? She came more often than was necessary. First you´d think the call would be short, she had not much to say, only that she wanted a check on the blood pressure and that her back was aching. And usually the blood pressure was well adjusted, and her back was as usual. Astrid suffered from an old injury from childhood. It was as it was. From time to time she got analgesics, from time to time some physiotherapy. There was nothing else to do. At the same time it was like she always lingered in my office, as if something was waiting to be said. At times she would seem to try to say something but she interrupted herself, and I did not have much to add. It was because of this that I felt it was impossible to end our meetings."

There was a long silence in the group. Finally, when no-one else said anything, the group leader remarked that there seemed to be a boundary between the presenter and the group and that there was something lonely around him when he told about Astrid, something deserted even. There seemed to be something embarrassing about the situation when the presenter had nothing more to offer and the group in this situation seemed unable to receive and process anything from the presenter. Furthermore, the group leader did not recognise the usual professional self of the presenting doctor in

this case. Could the seeming sense of being lost of the doctor and his need for assertion also say something about Astrid?
These observations and questions immediately vitalised the presenter and made him curious about the patient and also about himself, and also the other group members woke up. An interchange of ideas started in the group while the difficult feeling in the presenting doctor started dissolving.
(Härdelin L, *Bulletin of The Swedish Psychoanalytical Society* 1997:22)

In this example the group leader is recognising the numbness of the group dynamics and in the presenter. He makes use of this observation to direct his torchlight to the clinical situation in the consulting room of the presenter. He remarks that the patient made the doctor loose his vitality and his regular "doctor self", and that the patient seems to have affected him on a deeply personal level. But he stops here and leaves this matter to the self-scrutiny of the doctor. This is the limit for Balint work and the beginning of psychotherapy. Instead the group leader points at the parallel process between the "doctor - Astrid" and "the group - the doctor". A transposition of affects seems to have taken place. He is as lost in the group as is Astrid in his office. Neither the leader nor the other members of the group try to supervise or educate the presenter, nor do they try to support or comfort him. They devote no further time to explore what kinds of processes that are taking place in the group itself. Furthermore, there is no administratively superior colleague in the group, whom the presenter may wish to prove something to, or who may pass judgement on the doctor silently or openly and thus influence his career positively or negatively. Such a situation is not free of "political" control and will affect the choice of case and the openness and sincerity of the presentation.
In this example the doctor-patient relation is in focus all the time. The leader is concentrating on clearing the way for a discussion on this issue and nothing else. Though he is touching on nearby issues he does not allow himself or the group members to get stuck on them. And the results of the discussion on this case was that the patient got a much better doctor who could gradually help her to live her life in a much better and richer way in spite of her symptoms. Her previously tormenting inner thoughts became less difficult and her need for frequent consultations diminished dramatically.

We may use this scheme to differentiate the task of the Balint group from other kinds of group work and non-work.

An attempt at defining the Balint group setting
In essence the Balint group should be a group of freedom, equality and brother- and sister-hood.
All other group settings constitute complications that have to be recognised and dealt with. I realise there are many "Balint cultures" all over the world and that my proposal for a definition might be a matter for a divergent opinion. This can be the subject of further discussion.
I would like to propose the following definition for a Balint group:

The Balint group consists of clinicians of equal standing who meet regularly by free will over a long period to discuss and better understand their own clinical work, their own meeting with their patients. In the group, a mutual consultation takes place, a mutual sharing of ideas. In order to facilitate their work the clinicians co-operate with an external consultant, whom they give the role of being the group leader. This person should be familiar with the working situation of his colleagues and be able when needed to add a psychoanalytical/psychological dimension to the group discussions.

One implication of the definition is that the leader of a Balint group does not - in contradistinction to a supervisor or clinical teacher - have an indirect treatment responsibility for those patients discussed in the group. Each participant has his own full responsibility for his medical action. He only uses the group to consult with equals. In this respect there is a greater resemblance between a Balint group of doctors and a group of equally experienced lawyers or physiotherapists discussing cases in strict confidentiality than a group consisting of medical students or inexperienced younger doctors in subordinate positions. With such participants the work must be modified to make up for the needs of group members who are not yet established as "professional egos" and who are dependent on others in their medical training and practice.

The Balint group member
I propose for didactic reasons to split the motives for joining a Balint group into "healthy" (=adequate professional and personal motives) and "neurotic" (=dysfunctional professional and personal motives) ones. The distinction is not so clear as it may seem. We should not underestimate that also certain kinds of unresolved neurotic tendencies in ourselves can help making us good doctors.

"Healthy" motives

- The doctor is mature and experienced enough to have some awareness of his shortcomings in various clinical situations.
- The doctor is sufficiently curious, honest with himself and has the moral courage to dare exploring how he feels, thinks and acts in the clinical situation, and
- He has sufficient empathy with, engagement in and sincerity towards his colleagues who are struggling with their difficulties
- The doctor feels a need to compensate for a deficit ("basic fault") in his medical training and in the ongoing practical work

"Neurotic" motives
- An open or hidden need for personal psychotherapy
- Conflicts and other problems with the staff. Sometimes starting a Balint group may define people as insiders or outsiders.
- The wish to use the Balint group as a substitute for the lack of other groups, other forums for solving clinical and administrative problems.

The Balint group leader - an external consultant
The task of the group leader is to protect the group and the individual group members from a number of pitfalls that are prone to appear in this kind of improvised work. In Balint work you are encouraged to associate freely. Members are encouraged to try to reach for issues, which are vague but often crucial for true understanding. There is a lot of insecurity in the individual during such a process.
As said above this requires an individual and group psychological competence from the leader who also has to have a good knowledge of fields that his colleagues are working in.
The first task for a leader is to make a work contract with the prospective group, to formulate the frame of work, the aims of work, the division of roles and work within the group and the limits for it.
I want to emphasise two crucial aspects:
- It is vital that what is said in the group stays in the group if a good working climate is to have a chance to develop
- The leader should carefully assess if the preconditions for work are reasonable. Is the working contract possible for the members to be able to comply with? If you have doubts, you had better discuss it with the group before you start. That might clarify matters that otherwise might haunt and frustrate you and the group for a long period. The assessment of a prospect group involves the motivation of its individual members, the impression of the group dynamics, the compatibility of the personalities of the members, and institutional aspects, i.e. will the participants be able to show up regularly? Do the other colleagues and staff members working with

the doctors accept that the group is formed? Will they respect that the doctor withdraws one and a half to two hours a fortnight?

Just like the group members, the leader has his set of motives. Some of them may seem self-evident, not even worth mentioning, but then again, if they miss, the Balint work will be impaired.

"Healthy" motives:
- In Swedish we say *klockarkärlek*- a true and longstanding love for clinical work is essential if the group leader is to be genuinely able to share the work of the group. The leader should have respect for, and a real interest in the clinical work of his colleagues. How else could he expect experienced general practitioners to integrate the knowledge from his own theories and clinical psychoanalytical practice?
- The leader must likewise stand up for his psychoanalytical competence, which for natural reasons is a minority position in the group. He must be prepared to try it out in a common-sense context. He may for instance have to argue against the general prejudices (*Vorstellungen*) and conventional patterns of adaptation held by the members of the group if he thinks that these stands diminish the professional freedom, the space in which sensible medical actions and decisions can take place.
- The leader must have an interest in exerting his leadership functions that the members have endowed him with, maintain the frame, the focus of work, the distribution of cases for presentation. The interventions will vary greatly depending on the group dynamics and the personality of the individual members these interventions. Bion´s thoughts about basic assumption group dynamics is helpful for understanding and guiding the leader in steering a group away from non-work.

"Neurotic" motives:
- Difficulties of the leader in maintaining the framework, i.e. keeping time and maintaining a good enough distribution and pace of cases in the group. But one also has to consider various forms of pseudo-functioning, i.e. the wish to be the therapist, guru, mentor, supervisor, sometimes even the general practitioner of the members.
- The leader may lack genuine presence, i.e. because he has locked himself up in a psychological ivory tower, or does not take his lack of knowledge about the clinical reality of the members of the group seriously, or is exerting his leadership under the illusion that his psychological knowledge is universally applicable. This may be connected to
- an unresolved "apostolic function" of the leader, i.e. that he knows the best and wishes others to know that as well. It seems Michael Balint himself was wrestling with this problem. A charismatic leader will affect the group process, but in the case of the original Balint group, its members proved their ability to make constructive

use of the impressive knowledge and clinical intelligence of Michael Balint. They were also able to continue their development and research in their own way after the sudden and premature death of Balint. When such apostolic pretensions come out in the open, you have a chance to deal with them while you are benefiting from what is useful in the gospel. It is far more difficult for a group to deal with a leader who is silent about his knowing best.... (see above: lack of genuine presence).

Which group leader will have a full clearance on this checklist? The important thing is that the leader with the critical help of the group is observant of his influence on the group process and makes adjustments to enhance the working process.

Balint-oriented groups for students and doctors-in-training
It goes without saying that medical students and young doctors who have not yet acquired a fairly stable and integrated professional identity and who do not yet have a permanent factual work in consequence also have other needs than the experienced doctor. In contradistinction to a regular Balint group, in such clinically oriented group discussions the demand for a mentor, supervision, professional and personal support and concrete guidance will be quite dominant.
Again, in such groups the leader has a supervisory function regardless of whether it is recognised or not. You cannot pretend running a consulting group whose members are not in the position of assuming full responsibility for their medical actions. There will be a gap between pretensions and reality and groups will make up for this gap in various ways. But it will be at the price of a somewhat hampered individual development compared to an adequate setting of a (Balint-) group for doctors-in-training. Again, having such a group usually make the members far better off than having none since it might help younger doctors and students to overcome feeling lonely and lost in their professional psychological development.
Then again, to repeat, on the other extreme you have groups led by a person on whom the members are dependent for their future career, so when presenting cases they are running the risk of disapproval and rejection, while hoping for approval and promotion. Such a politicised group is very remote from the free world of Balint.

The spin-off-effects of the Balint group
Stressing the necessity of a framework and the focus on the doctor-patient relation does not mean that the group will lead a life in a vacuum, separated from the reality of its members and the realities surrounding it. After all for several years the group members confide in each other, share thoughts - often personal and intelligent, emotionally dense and from time to time they are creating new perspectives. This kind of work offers some fringe benefits. After some time you dare to show yourself as a person more freely to your colleagues than before. You will risk a joke. You will

dare to confront one or all other members of the group with your own divergent opinion. And you will have faith that no one will take offence - well, at least faith that it will be possible to manage - and that something fruitful will emerge in the end. In short the members of a well-functioning Balint group will gain both an increased personal integrity and a sense of togetherness. No doubt those neurotic hang-ups of the individual doctor, which he brings to the group since they interfere with his clinical work, also have a connection to his private domains to a larger or smaller extent. Though those issues are not in focus for the group work the individual doctor stimulated by his committed colleagues and the psychoanalyst leader will have his personal self-reflection and self-analysis promoted as a side effect.

The purpose though is not to make the GP a psychotherapist - though one of the projects of Michael Balint indeed was to examine the possibilities of a certain kind of psychotherapy with the GP. It is rather to make the doctor more aware of the possibilities and limitations of his particular working situation. One side effect will be that the doctor will have a better eye for those patients that are accessible and motivated for some kind of psychological or psychiatric treatment. In this way his referrals will be more adequate. Those of us who have been or are working in psychiatric out patient clinics know how to appreciate that.

Also, the Balint group does not deal with solving administrative or organisational problems. Still some case presentations reveal problems of handling, of split treatment efforts, and of lack of communication within the staff. In combination with certain personalities in some patients (and in extreme cases without any such catalysing agent) such issues can erupt in the doctor-patient meeting. Some case presentations reveal a "home blindness" - the doctor is not seeing the essential dysfunctional dynamics at his own clinic. A limited discussion on such an issue may be beneficial as it could be brought "home" by the doctor and dealt with at the clinic in an adequate administrative forum. In other cases where circumstances remain dysfunctional, it is nevertheless often a relief for the doctor to see those issues more clearly, rather than feeling the victim of strange mental weather phenomena. It will help the doctor further to realise the limitations in his daily work. To some doctors I worked with, the Balint group was the only regular structure of their working week. Thus it may stand as a model for the necessity of a certain measure of structure to make working conditions more decent, efficient and agreeable. And this idea might spread within a clinic from the Balint doctor to the other members of the staff and inspire them to start structuring their work in a beneficial way. And on this note of well being emerging from the Balint group work into the outpatient clinic as a whole I will end my discussion and thank you for your attention.