Balint seminars and vocational training in general practice*

MARSHALL MARINKER, M.B., B.S, M.R.C.G.P.
Grays

POSTGRADUATE education for the general practitioner, notwithstanding the continuing attempts to delineate general practice as a discipline in its own right, is still largely conceived as the instruction of the generalist by the specialist. In this, postgraduate mirrors undergraduate education, which is still largely carried out by institutions where research in depth on narrow fronts of clinical interest takes precedence over the study of the medical care of the individual in his community. Richard Magraw[1] says, "The medical student enters practice, to some degree making his practice conform to his medical training rather than vice versa. Goethe's saying 'One sees what one knows' may be paraphrased to 'One does what one knows' ". To an extent, as general practitioners we remain lifelong prisoners of our early medical education and perhaps our postgraduate training should therefore be conceived as a process of liberation and unlearning, as well as a re-discovery of what we know that we see.

The argument that in every clinical field, general medicine, paediatrics, psychiatry, dermatology, and so on, there is a specialist more expert than he, has been met by the general practitioner with the reply that alone among doctors he deals with the whole man, and the whole man in the framework of his environment. But even this special area, which seemed inviolate, is now invaded by specialists in other fields. Professor Margot Jefferys[2] says, " . . . the treatment of illness or disability, especially in the chronic form which it is increasingly taking, whether episodic, static or progressive, cannot be left to the general practitioner". In describing how the specialist in behavioural sciences can contribute to the training of general practitioners, she makes the point that social workers in a multi-disciplinary team are specialists in their own right. "But in much of the (team) work with the elderly, the handicapped, the neurotic and the feckless, the social aspects of the sociomedical problem may be the most significant, *and in these instances it may be more appropriate for the social worker to lead, or to take decisions, if it is impossible to reach agreement*", (my italics).

What then is the core content of general practice, that part of general practice which is not a lesser order of specialist knowledge but a unique province that gives general practice the status of an academic discipline? The task of defining this province and of spelling out the detailed curriculum which gives body to the definition is already being undertaken by the College and by the new university departments of general practice. The background to much of this work is contained in the growing number of research papers into the content of general practice, the patterns of morbidity, the studies of work load and practice management and the studies of the psychodynamics of the doctor-patient relationship which have multiplied over recent years. Two articles by Lees and Cooper[3] [4] (are landmarks in the critical analysis of 37 such studies and a most comprehensive account of this whole field of work is contained in a review article by Zabarenko, Pittenger and Zabarenko[5]. What emerges from the work of these writers is the uniqueness of general practice as a subject for research, not only in

*Upjohn travelling fellowship (1969) report.

the field of epidemiology but in the fields of clinical medicine and the behavioural sciences.

Holistic Medicine

> Clinical medicine should be regarded neither as an art nor as a science in itself, but as a special kind of relationship between two persons, a doctor and a patient...
> *Ashley Montague*[6]

It seems that there is a consensus of opinion among general practitioners that the totality of their field of work is greater than the sum of its parts, even though the nature of this totality evades definition. This paper is concerned with one major attempt at such definition, which has been undertaken over the past 20 years, and with its implications for the whole field of continuing vocational training in general practice.

To quote from the paper by Zabarenko *et al*, "Among contemporary scientists writing on the psychodynamics of the doctor-patient relationship the name of Michael Balint must be in the forefront . . ." Although it is no part of my intention here to give a comprehensive history of the work that Balint started at the Tavistock Clinic in the early 1950s, the investigation of the nature of general practice by case-discussions between a psychoanalyst (Balint himself) and a group of general practitioners produced a new vocabulary with which it became possible to express something of the unique professional commerce between doctor and patient which is now recognized as an essential part of the core content of general practice. It may be helpful therefore, at this stage, to review in outline some of the basic concepts that emerge from Balint's[7] early work.

Illness, as it is first presented to the doctor, is seen as 'unorganized' and the mechanisms by which this unorganized situation is 'organized' into traditional diagnosis are examined. The consultation, although it functions in terms of history taking, examinations, investigations, treatment and so on, is also seen as a system of negotiations between two people in which the patient makes 'offers' of illness, and the doctor makes 'responses' in terms of treatment, good advice, sympathy and so on. The most important factor in organizing the illness is the way in which the doctor views his own professional activity, what Balint calls the doctor's apostolic function. It will be clear that this function is not only shaped by the current mores of medical school training, but also by the doctor's personality. It is not *only* disease, therefore, that is seen as the proper study of medicine, and not only the patient, but also the doctor himself. We are introduced to the concept of 'the doctor as a drug', a drug which is studied in terms of pharmacological action, optimum dose, signs of overdosage, side effects and allergic reactions.

The seminar method is based on case discussion with serial follow-ups often over a period of years. The whole world of general practice therefore comes under the closest scrutiny from the first presentation of the illness and the response and 'organization' of the doctor, to the results of laboratory examinations, the reports of hospital specialists and so on. It is difficult to convey to those who have not had this kind of group experience over a number of years, the extraordinary clarity of the picture that emerges of the doctors' and the patients' worlds. All general practitioners may experience it, but the process of the seminar in examining not only the patient as a person but the doctor as a person, throws light on areas of our knowledge, skills and attitudes where light is not always welcome and is often painful.

Seminars today

My original intention in taking the opportunity provided by an Upjohn Travelling Fellowship was to look at the work of other seminars, similar to the one led by Balint himself of which I have been a member for five years. I wanted to indulge my curiosity by looking over my own garden wall, and perhaps to organize that curiosity to the point

of assessing some of the objectives that seminars set themselves and of making a comparative study of the ways in which they go about their tasks.

These intentions, in the fairly prolonged period of organizing my itinerary, inevitably changed. My first source was Playfair[8] whose study of the training group method resulted from his own Upjohn Travelling Fellowship. In comparing his report with my own enquiries about the extent of seminar training in 1969 it became clear that the number of doctors under training had dramatically declined. There were fewer ongoing seminars at the main centres (the Tavistock Clinic and Cassel Hospital) and fewer seminars in the provinces. My enquiries extended no further from London than Plymouth in the west and Birmingham to the north. Outside the London area I discovered one seminar in Cambridge, another in Oxford, another in Coventry which was about to terminate, and in Birmingham a short-term seminar (lasting some six weeks) whose methods and objectives were quite different from the Balint seminars. At the London Hospital there was a group run by a senior member of the psychiatric staff for doctors in practice in Tower Hamlets. There were, in addition, two groups at University College Hospital, London, led by Balint himself, one of six years duration, and another composed of senior colleagues who had been working with him on and off for the past 15 years. Both of these groups were now largely concerned with research projects. At the Cassel Hospital, Richmond, there was now only one group serving doctors from the immediate neighbourhood.

This apparent loss of impetus in the seminar movement contrasting so sharply with my own high valuation of the training, worried me and needed thinking about. Accordingly, I changed my objective for the period of the travelling fellowship. I decided to spend my time talking to seminar leaders about their experiences of groups and their views on the future development of seminars and to take time to reflect on the possible causes of the present set-back and on the remedies which might be applied in the future.

A sort of psychiatry

> During the past seven or eight years I have been asked many times by my friends, my patients, and my colleagues, what kind of a doctor I now am. The other day when a patient asked, I found myself saying, 'I am, now, a non-psychiatrist'. To this the very kind patient replied, 'Well, I knew you had something to do with psychiatry'.
>
> *Ray S. Greco*[9]

From the start, Balint's work highlighted the hierarchy of diagnoses that was part of the assumptive world of medical teachers: a hierarchy in which physical diagnosis was considered 'superior' to psychological diagnosis. Moreover he showed how the diagnosis of an organic pathology, once confirmed, precluded an attempt to make a concurrent psychological diagnosis of the patient's condition. It was this other diagnosis, what Balint eventually came to call 'the overall diagnosis' which the seminar doctors tried to uncover in their patients. To do this they used the technique of the 'long interview'. Although the technique clearly derived from the world of psychiatry the vocabulary of the diagnosis certainly did not. Psychoanalytical jargon was eschewed, perhaps because Balint saw early on that jargon depersonalizes the patient. To talk of a man as 'full of anger that he cannot show' is so much more real then describing his 'repressed aggression'.

I found when I talked to members and leaders of other seminars that my own experience of seminar training had been quite typical. In the early days, anxious to apply newly learnt psychotherapeutic techniques, seminar members tended to report the most complicated and severe psychiatric problems from their practices and to undertake psychotherapeutic tasks which would have daunted the most senior and experienced of analysts. 'Long appointments' multiplied and choked up the practice appointment books, spilling over into the evenings, the half days and the weekends. Seminar members

behaved very much in accordance with the fantasies of their sceptical non-seminar colleagues. In retrospect, this is hardly surprising. Although the work of the seminars is concentrated on the doctor-patient relationship, very little is said of the relationship between the seminar members and the seminar leader. He is, although he seeks to be a peer among colleagues, a model for them, and to one degree or another there is an unconscious drive to emulate. A few seminar members fail to survive this period and themselves become psychiatrists: they are considered by Balint to be failures of the training method.

Does the seminar doctor then become a general-practitioner psychiatrist? Although one would like to answer a categorical 'no' to this question, the truth is that he goes through a phase of behaving like one. But there are forces at work to change this. First there is the pressure of the ordinary workload of general practice. Second there is the wide span of ordinary illness that daily streams into the doctors consulting room. There is finally the aim of the group leader, and so of the group itself, to look not at psychiatric extremes but at the random illnesses that patients bring to their doctors. Max Clyne[10] says, "The patients whom we have pictured in our case reports are all ordinary daily run-of-the-mill people who presented with the ordinary complaints of routine general practice, and who would normally have been allotted the ordinary organic diagnoses of medicine". All sorts of techniques are used to bring everyday general practice into the orbit of seminar work. Pre-selection of cases (a doctor is asked to report the nth patient seen on a given day) is one such method. The study of night calls is another. More recently patients receiving repeat prescriptions, dying patients, women whose pregnancies are interrupted before term, are reported and discussed. The 'long interview' becomes a less frequent diagnostic and therapeutic tool, as the doctor comes to appreciate the potency of so large a dose of himself on the patient and the realities of workload restore his sense of balance. More recently one group has been studying the characteristics and possibilities of 'six-minute psychotherapy'.

K. Menninger[11] in an article on 'Changing concepts of disease' asks,

> What is the diagnosis in a patient who has coronary symptoms whenever he takes his wife to a party, or in a woman who has migraine on the weekends that her son is home from college? What kind of arthritis is it that becomes activated with each quarterly meeting of the board of directors?

To try to understand the psychodynamics of the anginal patient, is not to ignore the constitutional nature of atherosclerosis nor the haemodynamics of the coronary circulation. It would be ludicrous for the general practitioner to think in terms of giving either glyceryl trinitrate *or* psychotherapy. It is essential in the treatment of the 'whole person' for the physician to be a 'whole doctor'. From the beginning Balint realized the special nature of the general practice setting; the general practitioner alone may have to encompass with one patient at one time a consultation which includes both psychotherapy and a vaginal examination. In a recent article Balint[12] underlines the separateness of seminar training from psychiatry and restates the problem:

> After having acquired more knowledge and better skills, how can a practising doctor avoid a split in himself, to be a general practitioner to some of his patients and a competent psychotherapist to others? How can he avoid practising illness-oriented medicine with some and person-oriented medicine with others of his patients?

The opportunity

The advent of the report of the Royal Commission on Medical Education[13] at the very time when my immediate aims were under re-examination, catalysed a resolve to look at the place of seminar training in the framework of vocational training for general practice. The report recommends a three-year general professional training period following the first pre-registration year in hospital (which would continue substantially unchanged). After the period of general professional training it is envisaged that the young doctor should have two years further professional training as an assistant principal

in general practice and it is suggested that each of these two years should be spent in different contrasting practice environments.

These admirable proposals are marred by the statement (para. 121) that "We do not think that the posts or supervisors required in this period of further professional training could be or need be as highly selected as those appropriate for the trainee during his general professional training". Such a statement applied to the training of a surgeon or a general physician would seem incredible, and is surely no more acceptable in the context of training for general practice. It is during this period of further professional training that trainers of the highest calibre will be required.

To meet this formidable commitment, training practices will have to be selected and organized, and about 1,000 trainers identified and prepared for their rôle. Here surely was a golden opportunity to include seminar training as a major component in the new medical curriculum. But when, in the curriculum, should seminar training begin? How long should it last? What should be the membership of the seminars and who should lead them?

Present difficulties

Unlike Playfair I made no attempt to take comprehensive stock of the status of seminar training at the present time but my impression, that there has been a marked decline in the numbers undergoing training, was confirmed by the figures from the Cassel Hospital and the Tavistock Clinic (figures 1 and 2). Various theories were

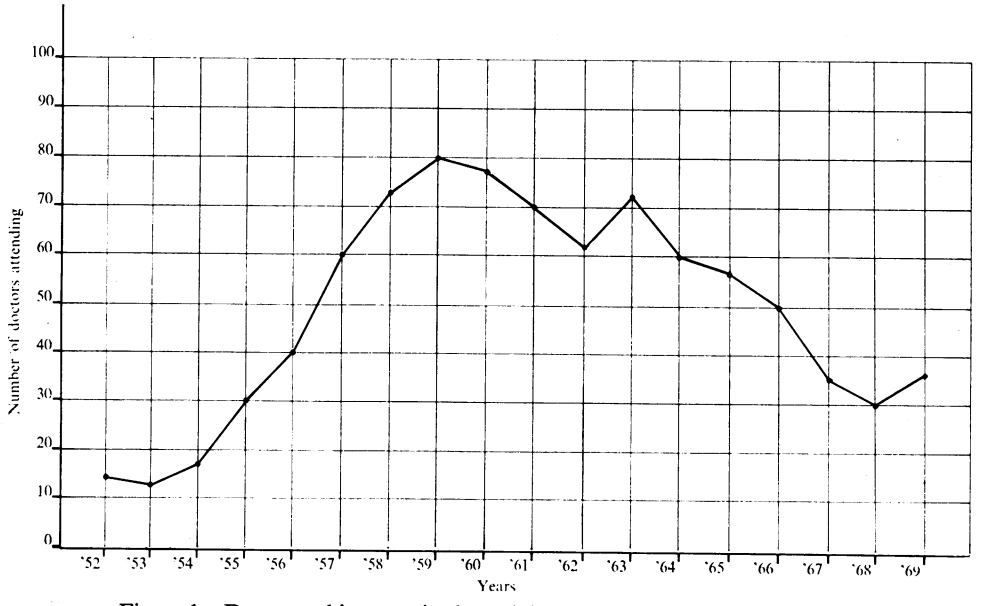

Figure 1. Doctors taking part in the training scheme at the Tavistock Clinic.

put forward to explain this. In the London area, it was argued, most of the doctors who wanted this sort of training had already been recruited and there now remained only a handful of doctors so motivated, who could from time to time be fitted into ongoing seminars. A failure of seminar training in the provinces was more simply explained. A map of the British Isles showing the presence of psychoanalytically-trained psychiatrists would reveal a relatively thick concentration around London and the Home Counties and vast areas of the provincial map left bare. Wales, apparently, boasts only one psychoanalyst, and no doubt psychoanalysts and Welshmen respectively place their own interpretations on this singular fact. Since Balint seminars are led by psychiatrists

who are either psychoanalysts or have been trained by psychoanalyst colleagues, the logistic difficulties of setting up provincial seminars are formidable. Doctors who are very strongly motivated to attend seminars find their own answers to these difficulties. For example, in the seminar run by Balint himself at University College Hospital, London, general practitioners attend from as far afield as Clacton-on-Sea, Bedford, and Liverpool—making the weekly journey to London over a period of years. Some-

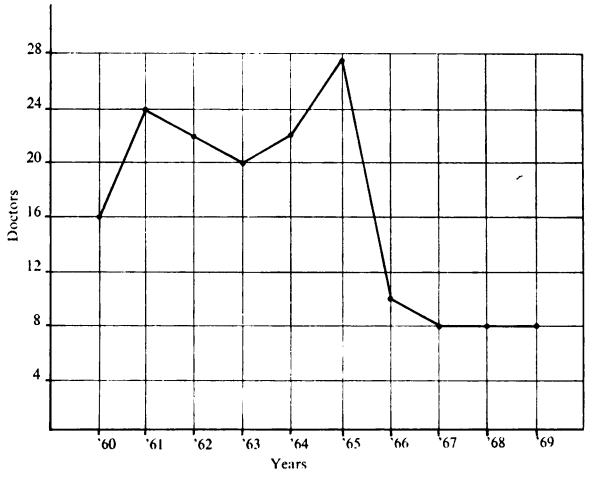

Figure 2. Doctors taking part in the training scheme at the Cassel Hospital.

times the group leader, rather than the group members, makes the journey. I attended a Monday evening seminar in Coventry run by Dr John Padel, who made the journey from his home near London. The seminar had been created as a result of the enthusiasm of a small group of general practitioners and was, after two years of successful work, in danger of closing down because the leader's other clinical commitments were such that the journey was becoming impracticable.

In 1964 Balint attempted a different solution to the problem[14]. He conducted a seminar with a group of nine doctors in Northampton, using a two-way telephone system from a room in University College Hospital, London. Although the use of this technique demanded a fairly strict discipline on the part of the members of the seminar, the Northampton doctors electing a chairman from among their number both to determine the order in which members spoke and to comment on the scene in the room at Northampton ("Dr X looks as though he will burst if he is not allowed to say something"), the experiment was a success.

It is not the logistic difficulties, but the massive psychological resistances that stands in the way of the growth of seminar training. The work involves doctors in exercises which have become alien to their habits of thought. Doctors, after all, are ordinary human beings whose professional work demands that they come face to face with an enormous amount of human misery and suffering. So much of what they see, the malformed infant, the ravages of old age, the inoperable carcinoma, the cripple from disseminated sclerosis, the neurotically unhappy, demands from them an endurance of misery which must be shared with the patient, and which they are helpless fundamentally to modify. The patient's expectations of the doctor, and the doctor's expectations of medicine, have to be disappointed in the light of reality. The young doctor as an essential part of his hospital training, develops two defences against the onslaught of all this suffering. He learns to put a distance between himself and his patient and he shifts his focus from the patient to the illness. It is the work of the seminar to return the doctor

as an individual to the doctor-patient relationship. But the relinquishing of hard-won defences, the uncovering of the doctor's feelings of disappointment and guilt, while it can liberate some to become more effective doctors both in diagnosis and treatment, may quite clearly threaten others with destruction. It is undoubtedly this threat that gives rise to the vehemence with which one sometimes hears opposition to seminar training voiced, and it poses a major problem for those who would like to see the gains of seminar training made available to general practitioners on a much more comprehensive scale.

Seminar training in the FPA

I was particularly interested in the development of seminars in the Family Planning Association, not only because they had so much in common with general-practitioner groups, but because both 'movements' had a common origin. Dr Tom Main, director of The Cassel Clinic, was concerned with FPA seminars almost from the beginning, and outlined the following history:

The first FPA seminar was formed when a number of clinic doctors approached Balint and asked him to form a group. The link between the first general-practitioner seminar and the FPA was probably one of the original seminar members, Dr Jean Pasmore, who was a general practitioner working in the FPA. Some time after its inception Main was invited to join Balint in order to study the techniques of group leadership. Later Balint resigned from the FPA seminar in order to concentrate on the then burgeoning field of general-practitioner seminars, and Main took over the FPA group. At first it was sponsored financially by the Cassel Hospital, but before long several influential lay workers in the Association became convinced of the importance of psychotherapeutic training for clinic doctors and undertook to sponsor the training schemes themselves. Within a short time requests were coming in from all over the country from clinic doctors who wanted to form groups. The problem was to recruit group leaders.

There were simply not enough psychoanalysts for the job. Many eclectic psychiatrists were keen to offer their services, but their lack of psychotherapeutic skill, which must be discussed later in another context, made them unsuitable. Main came to the conclusion that the only way to create seminar leaders, especially for the provinces, was to use those senior members of the first seminar ("the old guard") who had a particular flair for this work. A number were selected and groups were set up in several centres. Dr Michael Courtenay went to Plymouth, Dr Jean Pasmore to Bristol, Dr Sylvia Dawkins to Ongar, and others to Cardiff, Rugby, Birmingham, Oxford, St Albans, and to several parts of London itself. The net had been spread, though geographical limitations persisted because 'the old guard', like their psychoanalyst mentors, mostly lived in and around London.

The new leaders attended a workshop seminar which was run by Main himself. Here, just as in ordinary seminars the work of the doctor with his patient is examined in depth, so the work of the new leader with her junior group was examined and supervised. At first, workshop seminars were held at fortnightly intervals. It was found, however, that this produced too tight a supervision of the new group leaders, and they reacted to it by finding all sorts of excuses, pressure of work, domestic arrangements and so on, for not attending regularly. In the face of this resistance, it was decided to meet only at monthly intervals, and now, with some months omitted because of school holidays, they meet about nine times a year.

It is precisely because the FPA model developed by Main is one which by the fact of its success and vigour, commends itself to emulation, that it is important to examine not only the similarities with the work of Balint's general-practitioner groups, but also the differences. The range of psychotherapeutic problems and situations is far narrower

in the FPA context than in the context of general practice. I noted in the two FPA seminars which I visited, and again in discussion with seminar leaders, that there was not only an understandable concentration of focus on the vaginal examination and the sexual act, but that the doctor-patient relationship was largely discussed in terms of a mother-daughter relationship. Main himself pointed out that this relative narrowness of range made it hazardous to draw too close a parallel.

Nonetheless this scheme is still gathering momentum and must be the envy of those engaged in planning the future vocational training of general practitioners.

When to train

My first approach to the problem of integrating seminars into vocational training for general practice was to consider the two-year period of further professional training recommended by the Royal Commission. This period, the fourth and fifth postgraduate years for most doctors, would mean that the average age of the seminar members would be the late twenties.

Hildebrand[15] found that the mode (the most frequently found figure) of doctors attending the Tavistock Clinic seminars was six years after qualification. Dividing the doctors by decades since date of qualification he found that slightly more than two thirds of those doctors who were in the first decade since qualification were able to use the seminars productively, half were able to do so in the second decade since qualification, and thereafter rates of success gradually decreased with length of time since qualification. Further, after the Tavistock Clinic had introduced a selection procedure, to screen out those doctors who were considered for one reason or another unsuitable for seminar training, the number of doctors joining the course who had qualified at least 21 years before entry was almost halved. All of these figures suggest that doctors during the period of "further professional training" would be at an optimum age for seminar training.

There seemed to be many attractive facets to a scheme of seminars for assistant principals, not the least being the chance of introducing doctors at an early stage in their careers, to the attitudes and skills of holistic medicine. It was disappointing, therefore, after discussion with some of the most experienced group leaders, to discover that there were some fundamental technical objections to any such plan.

First, not only will the two-year period of further vocational training take place in practices where the assistant principal will have no permanent base or future, but the time will probably be split between two or more different practices. The trainee's commitment to his patients will therefore be fragmentary, and as such it will form poor material for seminar discussion. The second objection is even more fundamental. I mentioned earlier that the life span of a seminar passed through certain well-defined phases. The period around the end of the second year is a particularly critical one. Dr Robert Gosling, who has been in charge of seminar training at the Tavistock Clinic for the past few years, pointed out that at this time doctors tend to become bewildered, frightened and depressed by the amount of unhappy communication that they receive from their patients. At this time they are not yet able to judge when it is possible to intervene effectively and when it is not possible, nor have they achieved a reliable expertise in therapy. What makes this depressive phase bearable for doctors in a Balint seminar and allows them to pass through this phase to a more productive era of work is the long term commitment of the doctor to his patient and of the group leader to his seminar.

The young doctor would have to face this phase without the help of either of these factors and would experience the end of the seminar at a time when he was exposed to maximum distress.

'T' Groups

There was an alternative solution. If Balint seminars were unsuitable for trainees

then perhaps there was a different type of seminar in which they could learn something of psychotherapeutic technique? Gosling suggested that these might be run along the lines of what American psychiatrists call 'T' groups. The essential difference between the 'T' (sometimes called 'sensitization') group and the Balint seminar is that the former is much more closely allied to a therapy group and that it relies heavily on interpretation of group behaviour and on examination of the doctor's feelings and responses in the group situation. Leaders of Balint seminars, because they are anxious to concentrate the work of the group on an examination of the doctor-patient relationship as it occurs in the doctor's practice, assiduously avoid this kind of interpretation. The only exception to this rule is that the behaviour of the reporting doctor is sometimes interpreted as a mirror either of his own behaviour or his patient's behaviour in the doctor-patient relationship.

It is possible that 'T' groups have a place in the future curriculum of general practitioners during the early years of training. The leaders of such groups, however, would have to be found from the ranks of psychiatrists with a special knowledge of group techniques (a fairly uncommon expertise) and a great deal of research would be required before the value of such groups can be assessed.

How then, can the trainee be helped to gain the kind of insight into patient-centred medicine that comes from successful seminar training? Talking about this problem in relation to training undergraduates, Gosling[16] says, "Unless a student can see someone practising whole medicine and carrying within him the tensions that that entails, he will not be prepared to allow himself to use his own intuitions, sensitivity and knowledge . . . and this I think is best done at the student stage, through apprenticeship and identification with a master". It seems that what is true for the student is also true for the trainee practitioner. He will learn best by apprenticeship. The problem now is to train the teachers.

A new model for seminar training

It is the new generation of trainers, required to implement the recommendations of the Todd Report, who will be the first educational target of the new model of seminar training which I here suggest. The scheme is a three-tiered one, modelled loosely on the FPA system:

1. **Teachers' seminars**
   At the first level there will be groups, based on postgraduate centres, whose memberships will be largely drawn from general-practitioner teachers in the area of the centre: These groups will be led by general practitioner leaders—that is by doctors who have already undertaken several years of seminar training and are selected for this work by a panel of experts.
2. **Workshop seminars**
   At the next level these new leaders (called general-practice leaders) will themselves attend workshop seminars led by senior (psychoanalyst-psychiatrist) leaders. Here the work of the general-practice leaders will be supervised, and an added gain will come from the exploration of the problems and difficulties of the triad situation of teacher, trainee and patient.
3. **Advanced seminars**
   These will be run by senior (psychoanalyst-psychiatrist) leaders, to which members of the first level (teachers') seminars may eventually graduate, and will have as one of its aims the production of future general-practitioner leaders.

Recruitment

The figures[15] suggest that even after the introduction of screening assessment interviews only some 60 per cent of seminar doctors were subsequently considered to have benefitted materially from the training. Before the introduction of these interviews, the figures were even more unpromising. I believe, however, that there may be a bias in these figures which makes them appear unnecessarily gloomy. The global sum from which these figures are calculated is the total number of doctors *applying* to the Tavistock Clinic for training. This highly self-selected group may well contain a higher

proportion of neurotic doctors (seeking covert therapy through their application for seminar training) than is to be found in the community of general practitioners as a whole. Nonetheless, there will be a substantial proportion of general practitioners who have a positive need *not* to be exposed to seminar training with its breaking down of the rigid defences which alone make the practice of medicine bearable for them. Although it may be prudent to accept that 40 per cent of doctors will fail to make use of the seminar, even after pre-selection interviews, much may depend on the criteria applied in selecting future teachers, and some thought might be given to the inclusion of experienced seminar leaders in teacher selection committees in order to ensure that a fair proportion of suitable doctors is recruited. It seems likely that among potential teachers there will be many doctors who will fall into what Balint describes as subclasses C_2 and C_3. These are doctors well established, experienced and successful practitioners with excellent reputations among both patients and colleagues, who are too strongly defended to allow the "limited though considerable change of personality" which is a pre-requisite of the training scheme. It must be stated that many of the doctors who might be so classified would make excellent teachers in almost all the other fields of general practice, and would prove valuable recruits to the training programme. Since, however, the intention in the Todd Report is that assistant principals will rotate between different teachers and so be exposed to different apostolic functions during their two-year training, it may only be necessary to achieve successful seminar training in quite a modest percentage of teachers in order to expose the majority of assistant principals to teachers who have acquired these new skills.

Choice of group leaders

Workshop seminars would clearly be led by the most senior and experienced psychoanalyst–psychiatrist seminar leaders now working in the field, and it is to be hoped that a number of younger psychoanalyst–psychiatrists would wish to be associated with them as part of a training for future leadership.

Advanced seminars would continue to be run by the present body of seminar leaders, though in time it is possible that some practitioner leaders may achieve a level of expertise which would permit them to run these seminars also. The experience of the FPA system suggests that there will be many volunteers from the ranks of eclectic psychiatrists who may wish to take on group leadership. Unfortunately the knowledge, skills and attitudes which qualify doctors to become consultant psychiatrists, and indeed tutors in psychiatry appointed to postgraduate centres, are by no means *necessarily* those required to make seminar leaders. To quote from the Todd Report, "This technique (psychotherapy), which most clearly differentiates psychiatric treatment from that given in other branches of medicine, has been comparatively neglected in most British medical schools". It must be clear that to exclude from seminar leadership excellent consultant psychiatrists who have perhaps already made a considerable contribution to the postgraduate education of general practitioners in psychiatry, on the grounds of their unsuitability, will require a machinery for making such appointments which is both highpowered and vigorously independent. This problem underlines again my conviction that the subject of seminar training should be divorced from the question of postgraduate training in psychiatry.

Teachers' seminars will be led by general-practitioner leaders. In discussing the skills involved in making a good group leader, Main pointed out that these were not necessarily the same as those involved in making a good psychotherapist. There were, he said, several good leaders who were probably not so good in the setting of individual therapy, and several excellent therapists who did not have much skill in handling groups. A parallel argument was made by Gosling. He pointed out that psychoanalytical training, although it conferred enormous skill and knowledge in the handling of therapeutic

relationships, did not necessarily impart a skill in handling groups. This skill, he thought, might as easily be found among the ranks of general practitioners who were seminar trained as among the ranks of psychoanalysts.

I was pleasantly surprised to find among senior seminar leaders a general acceptance of the notion of general-practitioner leaders. But there were also warnings of possible pitfalls. Main reiterated the need for ruthless and impartial selection of such leaders by an independent body. Balint felt that the only criterion for qualification was an adequate familiarity of the candidate for group leadership with the workings of the human unconscious, and that this could be assessed only by watching a candidate conducting a seminar.

Gosling pointed out that although the FPA 'old guard' who had become seminar leaders were not psychoanalysts and were in the first place clinic doctors with a particular interest in the psychological problems of their patients, most of those who are now active in the field have virtually become full-time psychotherapists. A snare which must be avoided is that general-practitioner seminar leaders become so involved in seminar leadership that they cease to be active general practitioners. Desmond Pond, professor of psychiatry at the London Hospital, suggested another psychological difficulty which imposes logistic problems. He pointed out that a certain psychological distance or tension should exist between a seminar and its leader: accordingly he felt that there might be difficulties for a general practitioner leader in holding a seminar for doctors in his immediate neighbourhood, and thought that it would be prudent for him to hold his seminars in postgraduate centres outside his own area of practice.

Characteristics of the new seminars

The teachers' seminars, as envisaged in this paper, will have two new characteristics which may be beneficial to seminar training, and will certainly require study. First, they will be time-limited. The life cycle of a Balint seminar is described in much of the literature in qualitative terms, but not much is said in quantitative terms; while different phases in the life cycle of the seminar are described, there is no clear statement concerning time limits.

Most often, seminars end spontaneously after four years, and the termination is brought about by the *ad hoc* decision of its members to withdraw. They may do so because they feel they have achieved what they set out to achieve in undertaking seminar training, or as a final flight from a situation which has become intolerable (though flight from the seminar usually occurs in the first year of training[15]). There are, however, some doctors who continue to attend groups for a period of many years. A few belong to Balint's 'old guard' and constitute research seminars. But there are others who continue for 10 or 15 years or more to attend maintenance seminars. Having discussed the life span of seminars with one of the leaders of a long-standing group, I asked his permission to bring up the subject with the seminar members during my visit. The group responded with considerable anxiety to the idea of termination, and there was a completely unrealistic wish that the group would go on for ever. It is this latter situation that gives some substance to the often heard jibe levelled by non-seminar doctors at their seminar colleagues that they are attending seminars for covert treatment.

Just as the junior FPA seminars are limited to a two-year stay for its members, so these teacher seminars should be limited, though a term of four years would seem more appropriate. The work of these groups would then occur under a certain pressure of time though it remains to be seen whether this will enhance the work or impede it. With any imposed timetable the danger exists that the spontaneous development of the group members may be inadvertently inhibited; an experimental approach will eventually provide us with the answers.

The second major difference will be that seminars will have as their model a fellow

general practitioner rather than a psychoanalyst. It is possible, therefore, that doctors will earlier accept the possibilities and limitations in their own field of work, will less distort the pattern of their practices in order to accommodate repeated long interviews, and will earlier achieve a realistic appreciation of the aims of seminar training.

Criteria of success

A *sine qua non* of educational objectives is that there should be criteria of success. If seminar training is to be accepted as a respectable tool of medical education, which is a more modest claim than I have made for it in this report, then a great deal of thought will need to be given to validation of the technique. A weakness of the criteria for success in *A study of doctors*[15] is that assessment is based on the opinions of the psychoanalyst-psychiatrist group leaders concerning the performance of seminar members in the setting of the seminar itself. Bacal[17] and others at the Tavistock Clinic have considered this problem, and a research programme to assess the effectiveness of seminar training is now being mounted. It may well be true that extrapolation of this judgment to the wider field of the practitioner at work in his consulting room is quite valid but it has to be shown to be valid. The work of Lucy and Ralph Zabarenko at the Staunton Clinic, University of Pittsburg, may provide us with a model on which future validation exercises can be carried out. This work involved an independent assessment, by trained observers, of the quality of the work of general practitioners in their own professional environment. However threatening this kind of exercise may be for us, an educational programme without a means of validating its efficacy rests its claim to value on nothing more substantial than the enthusiasm of its advocates. Extension of seminar training will involve us not only in a deeper and more comprehensive study of the doctor-patient relationship, not only in a study of the teaching model of teacher, trainee and patient, but also a study and perhaps a monitoring of the quality of care in general practice.

It would then be possible to create what modern educationalists would certainly demand of an ideal model of vocational training, a major feedback mechanism from the experience of the practising graduate to the teaching centres where knowledge, attitudes, skills and methods of thought are modified and updated as part of a continuous evolution of the curriculum.

The future

This report is based on an assumption about the value of seminar training. Not all who read it will share this assumption. But most will agree that general practice as a discipline addresses itself to the medical care of the whole man. So much of our scientific medical education is founded on the Cartesian notion of the ghost in a machine, and so dazzling have been the prizes won by this approach to medicine, that we find it hard to redistribute our educational priorities even in the postgraduate field. Rene Dubos[18] says:

> But physicians and their patients know intuitively that medicine—human medicine at least—transcends the natural sciences on which it is based. The science of medicine must be supplemented by the art of medicine . . . What this mysterious art consists of and how it differs from objective scientific knowledge is not easy to discover.

'The mysterious art' is that part of medicine which general practice claims to be peculiarly its own. But because we have come to think of medical education as being primarily the acquisition of scientific expertise, the acquisition of expertise in 'the art' has been relegated to the uncertain and unpredictable schools of experience and personal maturation. There is an assumption that 'the art' while it can be learnt, cannot be taught, that, since it has to do with such imponderables as the doctor's personality, his ability to make and use relationships, his feelings of sympathy and liking for his fellow man, it is outside the remit of a vocational training programme. Yet if we accept that this 'art' is the essence of our professional expertise, we cannot ignore the challenge of defining

it and teaching it. It is here that the Balint seminar makes its unique contribution, and as such, it is not an eccentric or exotic extravaganza in the curriculum, but an essential part of the core of general-practitioner training.

The growth of a programme such as I have outlined will be slow in the early years. It will require, as a pre-requisite, a great deal of support, including financial support, and a central place in the planning of further vocational training for general practice.

At a time when the College, in the light of the development of university departments of general practice, is re-examining its own rôle in medical education, the sponsorship of a scheme such as this offers an opportunity which I believe only the College can take to modify and enrich the training of future general practitioners.

Acknowledgements

I wish to thank the Council of the Royal College of General Practitioners for the award of an Upjohn Travelling Fellowship, and to thank the many doctors who allowed me to join their groups. Drs T. Main, R. Gosling, and J. Horder were most generous with their time and encouragement, and I am grateful for the continuing guidance of my mentor Dr Michael Balint. Finally, I should like to thank my secretary Mrs H. Benstead for her unfailing help in the preparation of this report.

REFERENCES

1. Magraw, R. (1966). *Ferment in medicine.* Philadelphia and London. W. B. Saunders Co.
2. Jefferys, M. (1969). *Human relations in general practice.* London. Office of Health Economics.
3. Lees, D. S., and Cooper, M. H. (1963). *Journal of the College of General Practitioners.* **6,** 233.
4. Lees, D. S., and Cooper, M. H. (1963). *Journal of the College of General Practitioners.* **6,** 408.
5. Zabarenko, L., Pittenger, R., and Zabarenko, R. (1967). *Journal of the Royal College of General Practitioners.* **14,** 140.
6. Montague, A. (1963). *Journal of the American Medical Association.* **183,** 577.
7. Balint, M. (1957). *The doctor, the patient and the illness.* London. Pitman Medical Publishing Co.
8. Playfair, H. R. (1962). *Journal of the College of General Practitioners.* **5,** 419.
9. Greco, R. S., and Pittenger, R. (1966). *One man's practice.* London. Pitman Medical Publishing Co.
10. Clyne, M. B. (1961). *Night calls.* London. Tavistock Publications.
11. Menninger, K. (1948). *Annals of internal medicine.* **29,** 318.
12. Balint, M. (1969). *Journal of the Royal College of General Practitioners.* **17,** 201.
13. Royal Commission on Medical Education (1965/68). Report. London.
14. Balint, M. (1964). *Lancet,* 1293.
15. Balint, M., Balint, E., Gosling, R., and Hildebrand, P. (1966). *A Study of Doctors.* London. Tavistock Publications.
16. Royal College of General Practitioners. *Education in psychology and psychiatry.* Reports from General Practice VII. (1967). London.
17. Bacal, H. A. Personal Communication.
18. Dubos, R. (1968). *Man, medicine and environment.* London. Pall Mall Press.