Second opinion

A study of medical referrals in a seminar for general practitioners at the Tavistock Clinic, London

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SUMMARY. An experienced seminar made a special study of the psychological aspects of referrals for second opinions, investigations, or hospital admission. The cases were a random selection, incidentally forcing the seminar to examine some of the poor medical practice that is rarely published and to recognise the disturbing force of the doctor-illness relationship, as distinct from the doctor-patient relationship. General practitioners use referrals in many ways and select consultants for quite unexpected qualities, often to preserve the relationship with their patients, and contrary to many superficial impressions otherwise. Referrals are part of the continuous flux of patients in and out of a doctor's life and this movement is important to his sense of identity and to his defences against anxiety.

Introduction

I hope to convey something of how the psychoanalytic and group-analytic influences bear on the work of the seminar, as different case-presentations unfold; the cases that emerge each week may be linked, rather in the way that dreams occurring during one night may be seen as part of one story. One case may be quite incomprehensible until the next one has been heard.

Seminars for general practitioners at the Tavistock Clinic (' Balint groups ') are often mistakenly imagined to train general practitioners in psychotherapy and, indeed, to promote the risk of ' wild analysis ' by family doctors. It is hoped to provide a better sense of the way seminars may enrich the understanding and work of the general practitioner, without turning him into a psychotherapist-manqué.

A group of general practitioners who had been coming to seminars at the Tavistock Clinic for about six years decided to study the psychological aspects of a sample of their own referrals. This topic was chosen in the hope it might highlight the doctor's own behaviour and his perception of his options in each case.

This was a seminar of particularly able general practitioners, very diverse in style and habit, who had learnt to work well together in a fearless way. If the paper appears to dwell on faults, quirks, and peculiarities, this is a reflection of the honesty and seriousness with which they were prepared to examine themselves. It is possible that we cannot fully appreciate the best work that doctors do unless we can also take adequate account of their worst.

The random selection of cases forces us to examine some of the very poor medical work that is ubiquitous, too easily ascribed to hurry, and rarely published. This study also exposed some of the capricious ways in which general practitioners choose which consultant to use—and sometimes the quite deliberate choice of a consultant who is not regarded as highly as others who are available.

There were initial difficulties in deciding quite what was to be considered as a referral and we soon decided to include any instance in which any outside help or

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consultation or investigation was invoked or when the patient was sent anywhere else, whether for admission or investigation. We had only the rudiments of a random technique—merely a *modus operandi*. Each doctor took it in turn to provide the referral for the next week's seminar. He undertook to keep a numbered list of all his referrals in one week (including investigations and admissions) and bring it, with the case notes the following week. We would then choose a number at random to determine the referral we would examine.

There are many problems about the validity of findings that may really have been pre-ordained, in spite of the constant surprise and freshness with which these cases unfolded and the way different aspects forced themselves upon our attention. The more neatly and convincingly a theory seems to emerge from the data, the more sceptical we may become.

This dilemma is rooted in the psychoanalytic approach. This can engender a particularly open and receptive state of mind or, second-best, sustain a wide range of specific expectations. Suppose, for example, a doctor sends his patient to hospital for treatment. To name just a few obvious possibilities, this may be done because of the medical indications stemming from the disease, while the patient's individual characteristics, as a person, may be irrelevant; or it may have little to do with the physical condition, but may instead reflect the doctor's feelings about this patient, and in that sense reflect some disturbance in the doctor-patient relationship; or there could be a combination of these factors.

Example 1

The case was allegedly a two-minute one: a girl of 14, brought in with plantar warts and sent to hospital for treatment. For a moment, it looked as though there was nothing to discuss. Then, out of stony ground it emerged reluctantly that some doctors do not automatically send children to hospital for the treatment of plantar warts. The young woman doctor who agreed about this then gave the particular reasons clinching the referral with this child—namely that she had very extensive clusters of warts on both feet. The seminar were slow to move, but did eventually spot that this particular reason for referring this case of warts was, if anything, exactly the opposite—a reason against it. An isolated wart is most suitable for curettage, whereas extensive clusters of them, as in this case, are not best treated in that way. The general practitioners began to collect their wisdom and to recognise that the kinds of treatment that might be recommended, formalin soaks, elastoplasts and so on, are things that the general practitioner could well have done for herself. So the plot thickened.

The general practitioner now changed her ground and said that actually the trouble about these plantar warts was the pressure from schoolteachers and physical training instructors who insist that the parents take the children to the doctor and get them treated. They get excluded from gym and excluded from swimming which is quite ridiculous, but it forces the doctor's hand. However, it was uncomfortably admitted that in this case there had been no such pressure and the doctor admitted that she had gone out of her way to tell the mother that if she did not get the warts removed in hospital she was sure the child would be excluded from P.T. and swimming at school.

Clearly there was an aura of suspicion and anxiety about these warts. Somebody then voiced an impression that doctors don't like to touch these nasty things. Then someone else noticed that the doctor had elaborately referred to this throughout as (variously) a case of (phonetically) " verrusia " or " verruchuy " or " verrukay ", and she was not quite sure how to pronounce it or what the word really was. The fact was that even wrapped up elegantly in Latin she couldn't get her tongue around the beastly things. And she certainly didn't see a wart as a mere wart.

So the first point begins to appear: this doctor has the germ of a phobia for warts and her attitude to treating them is distinctly disturbed. Patients with warts coming to this doctor are liable to get slightly peculiar treatment, whatever their personalities, although there may have been special overtones in this case, where the doctor's own schoolgirl memories were possibly evoked by her schoolgirl patient. But it goes further, since the other doctors may not be quite innocent of this particular disturbance. The discussion of possible treatments did lead to quite startling underlying ideas around the seminar: of the foot suppurating and " a great horrible ulcer left;" of how they " would rather somebody else made a mess of it." So, we get a mixture of some nasty ideas about the condition itself (the warts have now turned into a suppurating ulcer) or there is a sense of a rather horrid treatment with responsibility projected on to the schoolteacher. The doctors discussed whether they would or would not support

any teacher who proposed excluding the children from swimming; it turned out that some firmly would and some firmly would not, pointing out that it would be perfectly satisfactory to put elastoplast strapping over the warts to prevent cross infection. But an even sharper flavour of the disturbance emerged when the discussion elicited one doctor's suggestion that " You could guarantee to cure these warts by x-ray therapy." Following the alarm and shock at this outrageous suggestion, to irradiate the foot of a growing child for warts, as yet untreated—again a hint of the desperateness of the condition like a sort of cancer—the *reductio ad absurdum* went on to the horrified joke that amputation of the foot would also cure the warts.

Doctors' anxiety about illness

It is an elementary fact, rarely mentioned, that doctors are disturbed by illness. Doctors are supposed to be at ease with illness and disease, a little shaky maybe with death, but it is (allegedly) only the doctor-patient relationship that floors them. This work with the referrals exposed the ever-present problem of the doctor-illness relationship as well as the doctor-patient relationship. It turned out that most of these doctors—and, presumably, doctors in general—have a particular and often quite conscious horror of certain specific illnesses, different for each doctor. It is instructive to compare notes about this among doctors, but behind the conscious tip of the iceberg—our sense of whatever particular illness we should most hate to get—behind this is a range of hatreds and favourites, phobias and pre-occupations regarding disease processes and what they mean to the doctor.

The case of warts is itself the tip of an iceberg and there are, at this point, a series of crucial theoretical and technical problems for the seminar leaders, and for others who are interested. If a little case of warts can disclose all this, what is going to happen if we look at a case of cancer or venereal disease; but worse, what personal difficulties and pathology in the doctors themselves lie beneath these small ' warts ' on the professional persona (the poor management of the case—this was not just a subtle psychological problem)? Are these doctors really no more medically competent than schoolteachers? And what is being said, covertly, about the schoolteacher-seminar-leader himself, who may fail to set a model of grasping awkward facts—or who is suspected of reacting in disturbed and exaggerated ways when presented with his colleagues' failings (like the imaginary schoolteachers quoted in the discussion).

Referrals as a method of keeping patients

It is often said that admission and referrals are liable to represent a breakdown in the doctor-patient relationship. It is not so simple. When doctors want to get rid of patients, they get rid of them. General practitioners like to insist that in general practice " the buck stops here "; hospital staff can always pass problem patients around and bundle them back to the general practitioner. This is another hoary old myth; the turnover of patients in general practice is enormous and every doctor has his own ways of getting rid of the patients who do not suit him. I have come to see admissions and referrals more and more as ways of *keeping* the patient through a period of difficulty.

Example 2

A doctor described the arrival of a new patient, a big merchant seaman, belligerent and startling, who wanted to be circumcised. The doctor examined him and could see no reason for him to be circumcised, making in fact some two-edged remark about there being " really nothing there to take off." However the matter dragged on and finally the doctor referred the man for consultation with a surgeon; and he chose a surgeon whom he knew to be generally against circumcision and who would not do it. The doctor was somehow challenged and intrigued by this patient whom he could easily have got rid of in a variety of ways; and he really stayed with his patient far more closely by doing what he did. As he put it, " I gave him a letter for a West London surgeon who just does not like circumcision; and so I will be expecting to see him back again in a day or two."

It misses the point to see these episodes as mere ' breakdowns ' in the doctor-patient relationship rather than understanding them as something related to the precise stamp

of the particular relationship going on. We have to keep our bad objects around us—projected and at a distance maybe, but we need them there. The way a doctor disposes his patients within and around his practice is something to do with the type of world he makes for himself.

Example 3

In another example the admission to hospital was in itself quite sound. This was another woman doctor and she began by stating that this case was a " Mr Henry Levy (a pseudonym here), a lawyer, a new patient ", and she noted that it was a Jewish name. She had first noticed him coming down the road, and moving with a peculiar gait. Later in the consulting room he turned out to be a well-spoken professional man, vaguely ill for a few weeks and he had been living abroad. She still wondered if he were an Anglo-Indian and, curiously, she continued to think this in spite of his name and even in spite of his mentioning that he had fought in the 1967 Six-Day War in Israel. She thought about malaria and was relieved when she examined him to find that he had ordinary chickenpox.

She offered to admit him to hospital " for social reasons " as he was living alone and was so unwell. He said he could manage and had a friend coming in, but then there was another call next day to say that it was very difficult; and so the doctor took a note round and left it at the door, for him to be admitted to hospital.

What emerged from this case was the importance of problems of identity and boundary, of what happens at the fringe of things. The seminar picked up the emphasis about " the isolation hospital " and then began to notice how unlike this very gregarious doctor it was, how scared she seemed when she left a note at the door instead of going in to see the man again herself.

Moreover, she is usually a rather harum-scarum personality, and this over-correct medical-school-presentation (" This patient is Mr so-and-so, aged so-and-so, a solicitor . . .") told us that she was no longer herself. It displayed to us an anxious need to get labels fixed quickly and concealing her persistent anxiety as to who this funny-looking Jewish foreigner with a nasty rash really was. She was not on top medically either. She had not thought about the possibility of chickenpox encephalitis, for example, as a reason for the peculiar gait—which would have been an additional good reason for admission.

New patients

This all led on to questions about how doctors do establish who new patients are, why and whence they come to us. The case led to quite an outburst from another doctor describing how he hates people coming to him ' out of the blue ', where somebody anonymous just passes the door and sees his name outside. It makes him feel he does not know who he is himself. He is very much happier if somebody else has sent the patient and he, the doctor, can find out what that somebody said about him, get some feedback about himself.

In other words, doctors seem sometimes to need this coming and going of patients—and referrals are part of it—as in some way constantly setting and verifying and testing the boundaries of who and what they are themselves, and where they are in their world.

Practice boundaries

I have noticed in looking through the notes from this period of the seminar's work how often the other cases discussed were cases on the fringe of the practice. They would often be presented as " this is a man of 40 (or a lady of 70, or whatever) *who lives outside my normal area* . . .". It sometimes seemed helpful to see these cases and the referral cases as being in the nature of free associations to each other.

Example 4

The doctor, who hated anonymous people dropping in, went on to describe a fringe patient of his living miles away, but accepted into the practice and really used by the doctor to help him explore himself. The patient was a professional man getting into difficulties with alcoholism and homosexual problems, a sort of alarming *alter ego*. This patient, like the previous one, was almost immediately described with a name and a job and the doctor was trying hard to maintain that he knew who this man was, where he came from and why—although the description proceeds with enormous complexity which

nobody can follow, through connections about the patient being the general practitioner's friend's cousin's mother-in-law's sister . . . or something of the sort.

This recurrent theme of patients outside the practice who are taken on, seems to be an exact counterpart of the referred patients who are temporarily sent out beyond the edge of the practice. The seminar seemed to be saying, " Look! Don't forget that we really keep patients in the practice even though they seem to be outside it ".

Doctors need to have their patients, and their practice in general, to represent and contain objects that are essential to them, but hard to maintain in their inner world.

Investigations for the doctor's anxiety

Example 5

It turned out that he ordered nearly twice as many investigations as anybody else in the seminar. It also came out that, whatever the medical pros and cons, this clearly had much more to do with preserving a picture of himself doing everything properly in a well-run practice. He spoke of how he had an elaborate and fool-proof cross reference system to ensure that the report of a chest x-ray is noticed and brought to the attention of the patient if there is anything wrong with it.

However, it emerged that the patients are sent off after the investigation has been done and are told that they need not get in touch unless they hear; they will be told only if there is anything abnormal. The others laughed aloud as they saw how all the fool-proofness is to ensure the doctor's peace of mind, that he enjoys all the making sure, all the certainty that everything is all clear, while the uncertainty, which is so unpleasant, is projected squarely on to the patient.

In effect this doctor was busily disposing significant quanta of anxiety all round his practice. He, in the middle, could thereby be the more assured and confident. There was good reason (see below) to think that, unconsciously, he believed he was putting his anxiety into his patients as a sort of excreta from himself—and indeed another of his reasons for doing so many investigations was, as he put it, that he did not want to have other people clearing up after him, he " did not want people picking up my droppings " if ever his patients went to anyone else. So he was always cleaning out the practice investigating everything and in that sense having the decks clear while he employed an extensive range of his patients—perhaps about a third of those that came to him—to contain and carry (in his unconscious fantasy) the dirty droppings of anxiety.

Example 5 (continued)

This aspect became clear in its concreteness, when he referred two women, mother and daughter, for chest x-rays after influenza. (The x-rays may be thought necessary or not; that is not important.) The seminar were somehow struck by the way mother and daughter were lumped together as if they were identical—a hint that, in his mind, they were more like " things " than individual people; and we were provoked by his reluctance to say anything further about the case. Then it came out. " All right, if you ask for it I can talk for an hour about them."

The long saga that followed disclosed a clear theme. Both women had in their time been involved with and somehow invaded by violent black men, bogy-men. The father, the older woman's husband had not been black, but he seemed like it and he had died of Huntington's Chorea, a weird latent hereditary horror that may be present while totally invisible. The doctor saw the household as being much happier and cleaner with the removal of this bogy-man, and recently a violent negro had also been eventually got rid of by the daughter. Or had he? There was an illegitimate baby described as " obviously half-caste " and this quickly gave way to bizarre ruminations about how " obviously " or not a doctor can tell quite what sort of colour a baby is when he is not sure whether it is black or white; or what it means anyway.

The x-rays were profoundly concerned with this doctor's anxieties about the concrete effects upon his patients of the violence and dirt (blackness) that, in unconscious fantasy, he projects into them. It is pictured that his unconscious thoughts might, if put coherently, be: " Has the black dirty violence been cleared out? Are things cleaned up? Are my destructive droppings still to be found in this woman or that man? I am worried about this because I believe that I have been putting my droppings into them. I am putting anxiety and imputing disease into them. I see this disease as hideous

black men inside these women and I therefore know there is very good reason for worrying about whether they are clean of my droppings. Perhaps they'll show up on the x-ray ".

Example 6

The very next referral case the next week (from another general practitioner) came like a further association, with more of a story about wonderful card-indexing systems. This was a schizophrenic man who had work in Scotland Yard, checking data, cross-indexing and classifying records of criminals and crimes into such categories as murder, rape, knifing, robbery . . . etc. His present symptom at this point was not surprising—he found he could not take in what he was reading and it was impossible to go on with the work. The doctor had determined to send him to a neurologist as a case of dyslexia or dysphasia, and actually made arrangements to do so, but the patient—more sane than the doctor—persuaded him to send him to a psychiatrist after all.

The message is now writ large: underlying the picture of the careful doctor with his card index system, there is the picture of a lunatic in a criminal world trying to manipulate terrible images, but unable to cope.

Consultant/general practitioner relationship

Some aspects of all this become more intelligible if more is noticed and understood about the relationship between the general practitioner and the consultant. And, as with the patients, there are so many ways in which the practitioner uses them, sees them. Naturally they sometimes want ordinary help with their patients, but matters are complicated by all the ancient hopes, pleasures disappointments, and envy. Of course we all want to get our teachers off our backs but, simultaneously, perhaps we do not ever really want to be parted from them. Sometimes there is almost the odd feeling that doctors have patients primarily in order to maintain and sustain their inner relationship with their own teachers, idols, and the alma mater. Whatever we do with our patient can in some way represent some sort of gesture, approving or otherwise, to the people who taught us. This goes on inside ourselves, but very much in flux with external practice.

Example 7

Sometimes referrals are quite consciously determined by primary thoughts about the consultant, about the hospital and especially about the teaching hospital. I was once doing a locum in general practice in the country and the remaining general-practitioner partner sent me on a routine fortnightly visit to an elderly woman who was an obvious advanced case of neglected myxoedema. It was a demonstration teaching case and I sent her up to London for admission to my old teaching hospital under the professor—a fairly rare, advanced, untreated myxoedema. Really, of course, the referral was something almost entirely between me and the professor of medicine. I was, in effect, saying, " Look what a good pupil I have been . . . Look what awful things happen in general practice when doctors don't stay near you. . . ."

Strangely enough, when I reported to the general practitioner wondering how to put the matter tactfully, he anticipated me. He said, " I suppose you think she's got myxoedema. I've often wondered but somehow never got round to doing anything about it . . .". She was in fact moribund and died about a week later, of a perfectly treatable reversible illness. Her doctor evidently knew about it but, in this instance, something had inhibited him from acting.

A study of cases that fail to be referred awaits a future seminar.

Idealising the old medical school of one's youth and remaining tied to it does not necessarily occur in pure culture. One afternoon we seemed to have a transparent version in which the general practitioner was playing little-girl and appeared to have moods in which she referred nearly everything to her medical school. This prompted the doctor with the elaborate cross reference index system for patients to deliver a brief lecture to the seminar on methods of using consultants: and he described how well-organised he is, carefully earmarking good consultants and bad consultants all over London, reserved for different purposes and representing various qualities. The bad ones were just as important as the good ones and could be inflicted on suitable patients when the occasion arose.

We appeared to have two sorts of silliness. Firstly, the woman doctor being the over-dependent silly little girl who idealises daddy and secondly, the silliness of the male doctor who appeared to see himself as a sort of master-mind, controlling a much more wicked world from the centre.

Example 8

But once again, reference to the other case that came up that afternoon gives an explanatory hint of the unconscious pressures that push doctors, like other mortals, to fall into the use of stereotyped defensive positions. This case was a tangle of rows and hot situations about a complicated family saga. Two points arose: firstly, that rival consultants were being brought in on all sides, enraging the general practitioner: yet, secondly, there was a dreary dead centre to it all with a story of mother's previous baby girl who had died, and a living sister described as " looking curiously dead "—all this showing through as soon as one moved away from the atmosphere of fighting and excitement and homosexuality. The doctor had actually confessed to an astonishing wave of anxieties about what sexual fantasies might overtake him when he called upon the household and would find the young man in bed alone.

This sequence of material displays how excitements around homosexuality and fighting may serve to defend against sombre images involving women—a mother with a dead baby girl, or a sister who appears to be inhabited by a corpse ("looking curiously dead "). Certain compulsive stereotyped behaviour that may prevail between some general practitioners and consultants does often reek of unconscious homosexual excitement and fantasy: but it is sometimes possible to get a more precise idea of varying configurations that meet the differing requirements of particular doctors, with various specific types of case.

Sometimes, for example, we require a tough consultant, sometimes a gentle one—and these may be ' realistic ' conscious considerations, having regard to the style of patient; but it goes further and unconscious factors may determine the search for an idealised consultant, a denigrated one for, for that matter, a consultant who is an unknown enigma.

There is a contrast between the pattern of events in which the consultant is carefully selected, appraised and chosen, in constrast to the state of affairs where the consultant used is unknown and kept unknown. This may be akin to the ' they-never-tell-you-anything ' type of collusion betwen patients and hospitals, where the patient never asks. Sometimes, both general practitioner and patient gain from an aura attached to the unknown big-wig and this can be the best management, either because the doctor wants to slide into a passive dependent little-boy role or it can also be from some sense of needing to be propped up, stiffened, built up by something shared between himself and the big enigmatic consultant.

The doctor's fantasies

Example 9

One case was a boy of eight who kept getting attacks of severe abdominal pain and after hearing about it we formed some conviction that the episodes were psychosomatic and connected with family problems. The boy was effectively without a father since the parents had divorced a few years previously. His father had been a compulsive gambler and sometimes violent to the mother. A sense of violence in the case and in the abdominal attacks came to the surface as well as some recognition that the mother had an ability to get people around her to be doing things, feeling things, and acting out for her.

The point of immediate interest is that the general practitioner referred the boy to a new male consultant whom he did not know, quite impulsively and without any awareness of why, in preference to the excellent woman paediatrician whose work he knew and who was the local alternative. It might possibly be left simply that this reflected the doctor's pre-conscious awareness that this boy needed to make contact with his lost father who would be embodied in the new father-figure consultant, thereby reappearing as a mystery-man.

The discussion touched on various angles, e.g. the sense of needing a big man who would be tough and institute violent and unpleasant investigations, somehow matching the violence of the symptoms. Or, alternatively, there was the idea of meeting a large gentle man who would be able to control the violence in a way that a woman might not be pictured as being able to do. After the discussion of violence and our speculation as to whether it had been unconsciously on the doctor's mind, influencing his choice of a male consultant, the doctor did then admit, rather diffidently, that as a matter of fact it had been overshadowed in his thoughts by the fact that his own son had been sent home from school with a broken ankle that day, and had to be taken to hospital. He had felt sure it had a bearing on the case but he had not been able to work it out. We inevitably wonder, at this point, about what sort of violence was going on, in fantasy in this boy's abdomen, giving rise to his symptoms. We may suspect—wild analysis perhaps—something along the classic theoretical lines* of the internalised lost object, the violent lost father existing in fantasy in the boy's tummy. (Children have tummies, not abdomens). The theme is developed in the next case.

Example 10

The next case in the seminar that day, was another doctor who wanted to report " a really weird episode." He had been treating a middle-aged man for bronchitis, but sensed that he was under some strain and had in mind to have a chat with him when an opportunity arose. However, he was forestalled by a call to see this patient who had been found with a note saying, " I am trying to have a sleep. Please don't wake me". The patient lived only a few doors away from the doctor—perhaps in more senses than one—so he walked round and found him stone cold. A clear suicide, it might be concluded: but, even more strange, the doctor suddenly formed a deep conviction that, in spite of the note, this man had not taken his own life, but had really been overcome by an intense fatigue linked with some premonition. The doctor firmly told the man's wife, on the spot, that he was sure this was not a suicide, but a heart attack; and this was supported firmly by the later autopsy results.

Under pressure from the seminar the only explanation that the doctor could give for his intuition was a feeling that it involved his own recent preoccupation concerning cardiac transplants. He felt a hideous repugnance for the whole business and had made his family promise that if anything happened to him they would on no account subject him to any such procedure. He had himself been suffering from heart trouble lately. His conviction that the dead man had died naturally sprang from a sense of recognition, empathy, with a wish to die peacefully when the time comes.

In the discussion, the violence and macabre fantasies associated with having bits of other people and of dead people inside you, were quite explicit. The doctor whose son had broken his ankle and who had sent the little boy to the male paediatrician had been reading a report of transplant follow-ups in the United States. He had read that many of these patients had afterwards met violent deaths, including being murdered, as if there were something provocative about the thought of them walking around with somebody else's heart, somebody else's kidney inside them. The other doctor, whose patient had died suddenly, was really sensing that when parting and ending have to occur, somehow you had better manage to deal with it in some way other than by internalising the lost object or rather the fantasy of some botched-up version of it. There is no reason to think that he or any of the others had ever read Freud's *Mourning and Melancholia* where the process was outlined 60 years ago.

It may be helpful to retrace the sequence. Firstly, there is the little boy with attacks of acute abdominal pain. His father was a violent gambler now divorced and disappeared. The doctor, whose own son has broken an ankle, decides, without knowing why, to send the young patient to an unknown male consultant.

The seminar then went on to discuss, in connection with another case, the concreteness of our violent fantasies about internalising bits of other people and how we develop these fantasies (as well as trying to act them out) under the stress of partings and endings

*According to psychoanalytical theory, mourning involves a prolonged ambivalent intra-psychic process, involving fantasies of an internalised version of the lost object.

and death. Obliquely, we build up a theory about the boy's abdominal pain as being linked with his fantasies about something violent to do with his lost father, or bits of his lost father now going on inside him: and these may in fact be his own fantasies or they may be the fantasies about the case in the mind of the doctor and of the seminar—when confronted with this little boy and his symptoms. We do not know a great deal about the little boy, but there seems to be some good evidence that this was indeed the doctor's picture of the situation; and I think that this determined the way in which he dealt with the case and the kind of referral he made.

Seminar work

Perhaps the most telling evidence about the doctor's unconscious picture of the situation was that indicated by the very next case (the cardiac death) presented in the seminar—stirred in another doctor as a kind of free association and able to emerge in the ambience of a group of colleagues sensitively attuned to one another's fantasies and anxieties. This is the essence of a seminar working well, where the members' understanding of their patients and of one another is steadily enriched by each member's insight into himself.

REFERENCE

Freud, S. (1917). *Mourning and Melancholia. Collected papers.* London: Hogarth Press.