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BULLETIN

Svenska Föreningen för Medicinsk Psykologi

Inbjudan skrivarpristävlan 2008

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Kongressintryck från fyra deltagare

Ingresser till Riksstämmosymposierna

Läkares känslor i klinisk arbetsmiljö

Läkare och skrivande

Skrivarpriset – två prisbelönta texter

Historien om Johan och Greta

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Kalendarium

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Ordförande har ordet

I alla år har föreningens medlemmar fått sin Bulletin i brevlådan. Sedan ett par år finns Bulletinen därjämte tillgänglig på föreningens hemsida. Detta är det första numret av föreningens Bulletin som nättidning. Dessa 67 sidor är också den mest omfattande Bulletin som publicerats. Pga av galopperande kostnader för tryck och distribution kan vi inte längre tillhandahålla Bulletinen och Paraplyt i pappersformat till samtliga medlemmar med bibehållande av medlemsavgiften. Pappersditributionen kräver också rätt mycket ideellt föreningsarbete – tid som styrelsen hellre ägnar åt medicinsk psykologi.
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Det gångna året har innehållit fyra höjdpunkter, som återspeglas i detta nummer:

- Balintkongressen i Lissabon där vår förening presenterade 5 av 17 plenara papers!, och undertecknad installerades som ordförande i The International Balint Federation – en hedrande men framför allt stimulerande och angelägen uppgift.
- Riksstämman. Föreningen stod för ett Rikssymposium (Läkares känslor i klinisk vardag), var medarrangör och initiativtagare till ett andra (Kvinnlig könsstympning, se fg nummer), stod för ett sektionssymposium (Läkare och skrivande), samt var initiativtagare till Läkaresällskapets gästföreläsning av Balintveteranen John Salinsky, som blickade tillbaka över 35 års allmänläkarpraktik
- Balintstudiedagen i Stockholm den 1 dec, som beskrivs i kommande verksamhetsberättelse.
- Prisutdelningen i Skrivartävlan och och publiceringen av bidragen.

Vi har fortsatt utveckla Föreningens hemsida, **www.sfmp.se** som utvidgats och uppdaterats i dagarna. Besök gärna hemsidan! Och kom gärna med kritik, kommentarer och ändringsförslag. Vi uppdaterar den 2-3 ggr per år.
På Balint-fronten har när du läser detta ett council meeting med vidhängande tvådagars balintkonferens avhållits i vid Döda Havet med ett tjugotal deltagare i anslutning till israeliska balintsällskapets nationella möte som samlat ett 60-tal deltagare noteras Balintmöte i Dubrovnik i juni, Balintledarutbildning i Danmark, september 2008, council meeting i Leiden, Holland i oktober, nästa världskongress i Brasov i de rumänska bergen i aug 2009. Se kalendariet längst bak, vår hemsida och för utförligare info . **www.balintinternational.com**

Jag vill tacka alla styrelsemedlemmar för gott samarbete och alldeles särskilt Lena Svidén och Anita Häggmark vilka nu avgår. Anita har suttit som v ordf i styrelsen ett 15-tal år och fortsätter sitt engagemang inom Balintledarutbildningen och med Balinttliknande grupper för studenter. Vi glädjer oss åt att Lena kommer att fortsätta engagera sig i skrivartävlan – hon kombinerar brinnande såväl det litterära som kliniska intresset,
Henry Jablonski

Kassören meddelar

Avgiften är 200: - för 2008 och insätts på föreningens postgirokonto 651 450-9.
Särskilt faktura sänds ut.
Ange yrke samt gärna ev. specialintresse, t ex Balintgrupper, undervisning i medicinsk psykologi, psykosomatik, konsultation etc**. Glöm inte att meddela ev. adressändring och e-mail-adress** på talongen eller direkt till
www.sfmp.se/kontakt
Med en **aktuell e-mail-adress** kan vi också fortsättningsvis nå er snabbt med utskick om föreningsaktiviteter, sektionsprogram, aktuella frågor från läkarsällskapet och information om konferenser och möten här och på andra håll i Europa (utöver den informationen som kommer i Bulletinen).

Med vänlig hälsning
Göran Roth
kassör

Inbjudan till Skrivartävlan 2008
Svenska Föreningens för Medicinskt Psykologi Skrivarpris utlyses

Svenska Föreningen för Medicinsk Psykologi inbjuder till 2008 års skrivartävling.

Texten ska beröra det medicinskt-psykologiska området. Vi välkomnar alla slags bidrag – perosnliga rapporter, litterära texter, filosofiska, human- eller samhällsvetenskapliga rapporter eller undersökningar. Det väsentliga är att texten på ett angeläget sätt belyser vårdrelationer, praktiskt kliniska situationer, etiska och kulturella frågeställningar inom vård och behandling i en tid, som ställer krav på såväl omprövning och förändring som på att bevara det goda och konstruktiva i befintliga former.

Bidragen får ej tidigare vara publicerade i litterärt eller vetenskapligt sammanhang. Författaren ges stor frihet i ämnesval och utformning av sitt bidrag, som dock ej får överstiga 8 sidor, (1,5 radavstånd).

Priset för det vinnande bidraget är 6 000 kr. Ytterligare 1-3 bidrag kan få hedersomnämnande och pris om 1500 kr. De vinnande texterna publiceras i bl a Bulletinen för Medicinsk Psykologi .
Bidragen i word-format ska vara bedömarkomittéen tillhanda senast den 15 dec 2008. Svenska Föreningen för Medicinskt Psykologi, Henry Jablonski, drhj@jablonski.se som också lämnar ytterligare upplysningar.

Skrivartävlan 2008 för med stud/med kand och AT-läkare
Svenska Föreningen för Medicinskt Psykologi

Svenska Föreningen för Medicinsk Psykologi inbjuder till 2008 års skrivartävling för medicine studerande/kandidater och AT-läkare.
Läkarutbildningen kan innehåller möten och kliniska situationer som blir betydelsefulla för den blivande läkarens syn på sig själv och sitt yrkesval.

Vi inbjuder till en skrivarttävling på detta tema. Bidragen ska utgöras av

- en redogörelse för en egen upplevelse/klinisk erfarenhet under kliniska studier, klinisk tjänstgöring/praktik eller arbete inom vården, eller den dubbla erfarenheten av att vara/ha varit patient och medicinare
- en reflektion över betydelsen av denna erfarenhet såsom du själv har tänkt och känt kring eller bearbetat den på annat sätt: i grupp eller i enskilda samtal.
- vad denna.erfarenhet betytt för synen på läkaryrket och ev. för den egna personliga utvecklingen, existentiell syn etc.

Bidragen får ej tidigare vara publicerade i litterärt eller vetenskapligt sammanhang. Författaren ges stor frihet i ämnesval och utformning av sitt bidrag, som dock ej får överstiga 10 sidor, (1,5 radavstånd).
Priset för det vinnande bidraget är 5 000 kr. Ytterligare 1-3 bidrag kan få hedersomnämnande och pris om 1000 kr. De vinnande texterna publiceras i bl a Bulletinen för Medicinsk Psykologi. Bidragen i word-format ska vara bedömarkomittéen tillhanda senast den 15 dec 2008 till Svenska Föreningen för Medicinskt Psykologi, Henry Jablonski, drhj@jablonski.se, också lämnar ytterligare upplysningar.

Balint groups with young doctors in their foundation years at a County Hospital in Sweden.

In 1996 I got the opportunity to gather somatic specialists in different groups in the County Hospital of Halmstad on the west coast of Sweden. The participants in these groups were on the same hierarchical level, but from different departments.
Everything has a beginning – I got that task because I had just moved to the city, was privately unknown to everybody, and was at that time chair of the Swedish organisation for psychotherapy supervisors. Another factor that had a great impact on our work was that I had never been employed by the County Council, and therefore had no ideas about who was who in the organisation.

Senior consultants, senior registrars and specialist registrars from departments of intensive care, infectious diseases, ear, nose and throat, orthopaedics, internal medicine, neurology, gynaecology, surgery and paediatrics joined the groups, and in two of them there was a GP invited. The groups were put together so that there was a wide spread from different departments in every group. The doctors had the permission to leave their ordinary job in order to come to the groups. They had no previous experience in neither psychotherapy, nor supervision or Balint groups and they were invited to join a group every fortnight during 2½ years in order to get a forum to reflect upon their professional meetings.
The background was that the doctors had complained over the fact that there was never any time for them to stop and think about their professional life.
The goal was formulated as “Together with persons at the same level in the hospital’s hierarchy be able to focus on each person’s professional personality in the meeting with the patient.”

The groups were offered as an arena to talk freely on misunderstandings and mistakes in clinical practice as well as about problems in relation to other persons in the staff of the department. Time was offered to reflect upon ethical professional standpoints, feelings and thoughts about death, to meet severely ill persons and their relatives. In order to feel confident to open up around these special issues, much effort was put into defining the boundaries of the groups.

All in all I met about 100 medical specialists in this very hospital in different groups during the years until I started with the doctors in their foundation years, which I will call "The AT-doctors" as we call them in Sweden. Within the very first years' programme where most participants were senior consultants I also had one AT-group. We met between 1997 and 2000.

These first mentioned groups, where senior consultants had had their own experience of a Balint group, made it easier for the AT-doctors to be allowed to leave their job and go to the groups at a time when they usually had other responsibilities.

The AT doctors have finished their medical school, and sometimes worked as locums before they start their 21 months work here. This period consists of 6 months of surgery, orthopaedics and intensive care, 6 months consisting of internal medicine and paediatrics, 3 months of psychiatry and 6 months of General Practice.

There is no political context of the groups. At all other hospitals in Sweden the formation doctors work without having Balint groups, but here the director of studies has decided that participation is a compulsory activity.

Another background to our groups is that there had been some complaints on the AT period in this very hospital – the young doctor's trade union make sort of a consumers' list every year telling where it is good or bad to go for your foundation years.
These groups together with efforts on better clinical supervision have made this hospital advance on that list. For every yearly announcement for foundation doctors there are usually 50-60 applicants.
The AT-doctors come to the hospital through this competitive selection and they come in intervals 4 times a year with 4 persons each time. At the same intervals 4 persons leave the group. Ever since the year of 2002 there are two groups now within this new programme and since then they have been running in a way which technically would be described as **slow open – open ended groups**.

The AT- doctors are allowed to leave their ordinary job one whole afternoon every month in order to see me, and while I meet one group the others meet their director of studies talking about different theoretical issues or they get information from different departments, and then we switch. Unfortunately we have not been allowed to meet every fortnight which was my recommendation initially and how the first years of the AT groups met.

All departments have promised not to insist on keeping the AT-doctors when it is time for the groups to meet and the ATs must not have their bleepers or mobile phones switched on during sessions.

Participation in the Balint groups has been seen as an offer which means that you are allowed to leave your ordinary job at the emergency or some other ward on paid time one afternoon in order to meet each other – and me.

So far the compulsory part of it has not been questioned during these 7 years. I don't register their attendance anywhere more than for my own memory. The matter of passing or failure of the AT period is not within our groups.

This arrangement has had the effect that very seldom someone is absent from the groups – and sometimes they come even if it is their day off.
We meet in a library which is a resort for the educational staff at the hospital and there is a teddy bear on one of our sofas. The bear is always in somebody's lap and sometimes they pass it over to each other.

Balint groups in Sweden have traditionally been exclusively for GPs. Working with foundation doctors has never been done in any other part of Sweden – the previous kind of groups I had with the senior consultants from different departments were also unique.

We work within an ordinary group psychotherapy framework as the boundaries are important to make room for a creative process. Like Winnicott's playground and intermediate area you need to have safe surroundings in order to play.

There is a very special confidentiality in this group and we agree that the professional secrecy should be such that each one would assure the others not to tell outsiders what we have talked about. After one incident some years ago I also add that even if you in "good faith" want to help a colleague by talking to someone outside the group, you have to refrain from that.
Putting so much weight on how to behave and respect each other has an implication on how to handle delicate material from a patient as well.

Further the newcomers have to promise to give priority to presence and to be active in the meetings. Every time newcomers join we talk about the rules once more, and the elders serve as models for how to use the group.
Balint group is not psychotherapy. The participants are not my patients, which has certain implications. We always start out from something that has happened in their job – and if anyone reflects on that with material from their personal life it is all right with me – but *I* never bring the topic up.
A Balint group represents for me the focus on the professional meeting and the equality among the participants and their professional independence towards the group leader.

Since I am not a medical doctor they can only use me from my professional background. On the other hand I have lived very close to medical doctors through all stages in a career during most part of my grown up life, so I have a **cultural knowledge** about their profession.

The general aim with a Balint group is to make the doctor more conscious and skilful; to notice the processes and problems in the communication between oneself and the other, which threatens both parties' conscious striving to reach a good cooperation. It is a kind of mutual consultation in the group and they meet in order to better understand their own work, to understand what happens with themselves and the patient in the professional meeting. There is also a good learning possibility to understand something of your own work even when somebody else is presenting a case.
When the ATs start working they are thrown into the deep end on the emergency ward, although they have an older colleague to ask for advice. They also have the possibility to phone a senior consultant. However, these senior members of staff are less accessible at weekends and nights. Formally there is always a second line on-call responsible for their

work, but when junior doctors are alone and there is no time to find someone else they have to work very much independently.

I usually start by asking if anyone has met a patient –
The group and the leader are silent during presentation.
There is always a clinical focus and there is always something to talk about.
My job as the leader is to create a safe and free atmosphere in the group and to
make the participants focus on the doctor – patient relationship instead of seeking solutions.
It is also my job to create an atmosphere for learning rather than to be a didactic teacher.

The purpose of the group is to make the AT doctors realize how the unconscious manifests itself in the patient as well as in the doctor in each consultation. We try to recognise the transference as well as the counter transference for the doctor, even if I very seldom use the technical terms. We also try to identify the projective identification when it occurs.

The foundation doctors as a group

The doctors come from different medical schools. Some of them have completed a "problem based education" where they start very early with clinical training and sometimes they have met Balint groups during this time. The majority comes from ordinary Swedish medical schools with early exposure to clinical experience and a few come from more traditional medical trainings such as those offered in Hungary – where students don't have Balint groups, and they don't meet any patients until their third year of studies.

Frequent topics

I want to talk here about issues that arise in the Swedish groups. I will also say something about the differences I have noted when I compare the issues brought up by AT doctors and the GP groups I also lead in another town.

The AT groups find topics where the focus is more on themselves and their own feelings than those of the patients' feelings, when compared to the GP groups.

A reason for this could be that they are so new in their positions and they need to struggle with themselves before they can get a closer interest into the emotional life of the patients. It is very special to meet the AT- doctors as they are eager to find out what the profession will become for them, they are still in the phase where they are seeking a professional identity.

Most topics in the groups emerge from situations where the AT doctor feels **subordinate or insecure** or when there has been some kind of misunderstanding, either in the contact with a patient, the relatives or some personnel at the hospital. Junior doctors are expected to be able to change environment constantly, meeting personnel who don't even bother to learn their names. In an environment like this it is highly likely that parallel processes will occur, where the AT doctor does not see the patient as an individual.

Here is a situation where the AT **has felt inferior** in relation to the patient.

- A starts directly telling us about a patient he met today. She was a woman of 45 who came with a relative to the emergency room complaining about an intense pain in her shoulder. Before he went into the room a senior colleague said that she had fibromyalgia.

"I think that gave me reluctant expectations." He further tells that when he was performing the neurological examinations she was very irritated, making faces with her relative towards him and said:"Are you going to do a gynaecological examination as well?"

Her shoulder aches and she says that she wants a cortisone injection.

A says that he feels that the patient doubts his knowledge and perhaps his age, and he is bothered by that. He notices that the relative also has devalued his capacity. He further tells us that he went out to his more experienced orthopaedic colleague who very dismissively said:" She is mad! – These patients are hopeless!"

We do a round reflecting on the patient as if each of them had met her; they share thoughts about her pain and how to trust and understand the connection between soma and soul. The group members also explore what happens when you distrust what someone says.

B says that she is very determined that she wants to avoid these kind of patients as she feels that they are cheating her and she says she has nothing to offer. Her idea of treating them is to pretend to agree in order to get rid of the patient, but this approach will be unsatisfactory.

C says that she has been sitting in with a GP who likes to work exactly with this type of patient and it seemed so interesting that this is perhaps the kind of patient that she will try to specialise in after the AT period.

The group continues reflecting on "what happens to me when I meet someone that I can't cure? And how was it for this patient to come to the emergency room? Did she notice A's reluctance in the beginning?" They talk about what they think the patient is feeling, about her worry of not being listened to and on what degree of pain she needs to present in order to make the doctor become interested. If the patient exaggerates her pain she may arouse disrespect. However, she risks being ignored if she says too little.

Michael Balint said that a sick person is someone who is appealing for attention and love. Most patients know how to get it. Like children, they know what the parents praise or punish, the patient has the ability to read the doctor and give him or her the kind of patient the doctor wants to have – This is so, at least with the neurotic patient.

This seemingly strong and arrogant woman was perhaps taking care of her vulnerability by being offensive. Why did this grown up woman need a relative in the room? The group

members are talking about the fragility of the patients while they themselves are preoccupied with their own vulnerability.
They also reflect on another aspect of their role – how much to examine, when to stop, considering that this is enough, as the reason for her pain is still unknown to the doctor, and very likely also for the patient. A says that he doesn't know why she didn't go to see her ordinary GP who usually gives the injections – had he refused and in that case – why?
An important aspect of this is that the AT doctor while working in the emergency room of the hospital has a job where he probably will not meet this very patient again.
They continue to talk about their upcoming 6 months as GPs and having to work on their own and being the only doctor in the room. In the hospital there is always somebody else to ask for advice after a while.

E told us he had met a man who was slowly suffocated by sarcoma and had told E "please do something". E stayed with him until he died and it had been decided in the ward earlier that the patient was not to be resuscitated. But when E was sitting there, a nurse came and said: "Couldn't you do more?" in front of the patient. We talk about the feeling of not being sufficient. Everybody is very attentive and sharing. We also talk about timing and of being able to tolerate uncertainty without plunging directly into action. Somebody says that "We never learnt in medical school what to do and how to behave when a person can't be cured."

They talk about **difficult encounters**, like giving a patient a cancer diagnosis; sometimes without much time to prepare beforehand.
"I want us to talk about the difficult conversation", says K, a young, very feminine looking woman. She tells us about a patient to whom she was ordered to bring an unfavourable

diagnosis: a fairly young man with advanced terminal kidney cancer. There was nobody else other than her for the next three days to tell the young man about the test results and he was asking for them now. K tells about her reluctance to get into the situation, her idea that somebody else would have done it better, as she was bothered by not knowing enough about the disease. She found it difficult to mention the word "cancer" but is sure he understood the seriousness in his situation. The day after their talk he had referred to her as "he". When the senior consultant came three days later and referred to K's information the patient insisted on calling her "he". The consultant replied, "You met Ms. K the other day", and the patient agreed by saying "Yes I met him".

She speaks about the reaction from the patient of referring to her as if she was a man and she understood it as if he so strongly did not want to hear what she said that he needed to wipe her out as a person. The group went into the feelings of the patient and that this neglecting of who she was did not mean that he will have no need for her later on, even if she is not the best when it comes to medical knowledge.

It is normal for the patient – and anyone - to behave abnormally in a stressful situation. When the doctor has conveyed to the patient what is almost unbearable to hear, it is important to be present again and again to reply to new questions.

K tells us that she has changed her mind by what has been said in the group and will follow him further even after he has been moved to the other ward."

The topic *death* is always present in the AT-group.

F said one day that she had been in a situation when a 9 months old girl died and she was in charge in the emergency ward and was the one to tell the parents. She talked about how sad she was and how it felt that her senior colleague had left. She asked the group if it was possible to be "too sad" and wondered how the others handle similar scenarios. The group

spoke about whether you are allowed to cry, if you are professional in certain situations, about being able to cry without loading the burden to the patient. But F also speaks about being alone with one's thoughts at home. Everybody is active and F gets a lot of sympathy.

G tells us about a patient who is around 45 years and has advanced Parkinson's disease who said this morning that he wanted to die. Every morning this patient lies on the floor with intense cramps and he can't walk. The group works on what he wanted to convey by saying this to G – did he mean it, or was it a way to make G help in any special way? They all say something about how it would have felt if it was their patient, and they talk about feelings of hopelessness, to be true to oneself, not to say something glib and how terrible it is to realise that one can identify with the patient's reason for wanting to die. The group talked about being young and feeling that one's own death is so distant, about giving comfort, having the time just to sit down and hold the patient's hand and to listen without being able to give hope of survival. M says there are things you do for the patient even if it is not obvious what it is. Our session ends by G saying that the group has helped him become more interested in having further talks to this patient, that his own curiosity around this patient has been awakened.

H tells us about her on-call evening that was like a nightmare. She only had four hours work and usually it is rather quiet, but this time there were three acute premature children coming in plus an acute caesarean where the baby was ill. She phoned her senior consultant when the third came and he had just left when the fourth patient arrived. After this she dreamt about a little rabbit standing close to a dangerous motorway. Everybody in the group was very empathic about her story and we all had a good talk about being so vulnerable, not having enough time and being forced to make priorities.

Treating friends and family

D wants to talk about a consultation with someone who has a medical education and comes to the emergency room craving to get morphine medication and how to handle that. This leads the group to talk about being ill oneself as well as treating friends and family. Many feel it is a difficult situation when your friends start using you as their private physician. The group often comes back to issues around this theme. They also talk about how difficult it is to be considered as the one supposed to know when the patient is a much more experienced older colleague.

Empathy

There was an investigation in Sweden some years ago which was called “supervision in empathy” which showed that especially male medical students after a couple of years’ study reduced their empathic capacity. This was considered to be because:

The one-sided emphasis on an intellectual way of learning meant that more multi-dimensional methods, that include understanding of emotions, were put aside.

The students’ picture of themselves became more destructive as a consequence of an impersonal approach taught by their teachers and other hospital staff.

If you feel that you are of no value it results in the same feeling towards other persons. Self hatred results in contempt towards others.

Strong emotional reactions are awakened by confrontation with suffering, death and tabooed situations and events. This in turn activates the students’ psychological defence mechanisms in order to eliminate or reduce the intensity of their own feelings. All this has a negative impact on the empathic capability. Holm/Strand/Söderberg/Bárány, Läkartidningen 15/1997.

When studying at medical schools students learn how to distance themselves from feelings in order to be able to work in areas that are considered taboo. By using the group it becomes easier to accept one's emotional vulnerability as something healthy and ubiquitous.
I believe that the foundation doctors in the Balint groups have increased their ability to handle difficult situations and developed their empathic capacity.

M tells us that he is afraid he might become a worse doctor than he wishes to be. He is talking about old people being sent in the evenings to the emergency ward because some relative or a nurse from the city feels the old person needs nutrition, or rehydration. The patient usually has dementia, only stays overnight and is then sent back to where he came from. The feeling of being part of a game where you as a doctor do what nobody else wants to do, and at the same time agree that an old person is brought to a strange and confusing place where he does not get any substantial help. The group talks about the sense of powerlessness, about having no contact with the patient. They share the feeling that the medical system has an aim to get rid of the patients.

The GPs compared to ATs.

The GP groups often discuss the subject of time or rather the lack of it. It is much more difficult for them to get away from their surgeries and come to our group sessions, while the ATs have arrangements where they are always allowed to come. GPs have a very tight schedule all day which is often interrupted by something unexpected. They talk about it in terms of shame and guilt, and the intense feeling that a patient is hindering them in having a smoothly running day. This is a frequent theme in the GP Balint groups. Apart from giving a patient help they always have to look at the wrist watch. On the other hand, they work with a hidden time table in relation to the patient, who is unaware of how much time the doctor is

willing to offer when they meet. We try in the groups to explore the implications this has for the patient.

This point of view has so far not been taken up in the same way by the ATs.

Another theme by the GPs are that they have patients who demand to be on the sick list and they speak a lot of how to handle and understand those who don't want to go to their work and start bargaining with their GP.

GPs are more prone to activity than the ATs. If I say I want to hear about their feelings, the AT doctors attempt to do this, while some of the older GPs are eager to give good advice to the person presenting the case. The GPs have been working for a long time and perhaps they feel it is more important to show each other that they are experienced clinicians, whereas the ATs are more comfortable expressing feelings of impotence and inadequacy as they are still learning.

On reports to the National Swedish Board of Health and Welfare

During the period we have met there have been a number of doctors who were reported for mistakes to the National Swedish Board of Health and Welfare. The majority of the reports are within the area of misunderstandings in the consultation, for example issues that the patient felt that the doctor ignored or avoided talking about. A mistake within the field of medical skill is a minor issue. In the Balint group it is possible to process what has happened in the aftermath of the crisis. But above all, it is a way of being able to reflect on what really happened without feeling rejected. The group has an arena to talk about the shame and how you are understood in the eyes of the colleague: On not feeling clever. We talked about not

underestimating the incident but also not to become an insecure doctor whose decisions are unduly influenced by anxiety rather than relying to his/her clinical skill.
The GPs use the Balint group intensively to process the reports. AT doctors are also reported, but in their case there is always somebody else who is ultimately responsible, unless they have avoided asking for help.

Gathering medical doctors in Balint groups is a fairly uncommon concept in Swedish health care. It is a way for the doctors to make their jobs more meaningful, but it also has implications for the patients' situation. At least in my country patients have become more actively interested in how they are being treated. They are no longer willing to be passive health care consumers. Whether you are a doctor or a patient, when you have the feeling that you can't decide on matters that are important to you, the quality of life is decreasing.

Michael Balint in his preface to his book *The doctor, the patient and the illness* wrote: ”The most important aspect covered by the present book is a changed appreciation of the general practitioner's role during treatment: listening, understanding and using the understanding so that it should have a therapeutic effect.”
This statement could be understood as a therapeutic effect on both the doctor and the patient! It is valid concerning GPs as well as ATs.

As a young doctor it is possible to make yourself behave in a way that resembles what you think the patient's stereotype of a doctor is. Some of the ATs have talked about becoming afraid of the patient, not daring to say what they mean. Before you are experienced it is difficult to be a real person to your patients. On the other hand the doctor has to develop sensitivity for the emotional meaning behind the patient's physical symptoms.

The foundation doctors don't have to work totally on their own, but they have to learn how to formulate what they think in front of the patient and gain approval for it with their supervisor second on call line.

They need help to understand their own strength and weakness in the occupation, which leads to a safer ground when choosing what to specialize in later.

I would also say that attending the Balint groups for AT doctors is a vital part of creating their professional identity.

An important aspect of being in this kind of group is that very early when doctors **are still prone to adapt to new ways of working – start using their colleagues in a reflective way. It means that it later – whether they belong to a Balint group or not – they have had the experience that it is possible to confide into someone else when things are about to go wrong. Balint groups help doctors to get a strong message early in their career that it helps to be open and honest both in front of patients and colleagues.**

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Emotions and emotional conflicts in hospital doctors
- a report and some reflections on Balint group work in hospitals

by Henry Jablonski, MD, M Sc, Sweden

(detta är en förkortad version av Lissabonföredraget)

The aim of this presentation is to initiate a discussion. I will try to address a couple of questions:

- How can we enhance Balint work among hospital doctors?
- Do we have to modify or reconsider the Balint setting to adapt to the hospital culture and to the needs of the hospital doctors?

Before I start my discussion I want to say that the description of patients and doctors in the examples of this paper have been changed and modified to hide their identity and safeguard their privacy.

Doing Balint work in Swedish hospitals is a rare thing. A number of attempts have been made failing within less than a semester. But there are two interesting exceptions:
Elisabeth Olander, psychiatrist and psychoanalyst of Uppsala, was running several groups at the University Hospital there for many years. To my knowledge she has not presented her excellent work in writing. But her experience has been transmitted in supervising and teaching to prospect Balint group leaders. If I were to speculate from what she has told about these groups, her work was successful because

- she enjoyed the confidence of the head of the departments,
- she was deeply committed to help the younger doctors to understand the human predicament of being a doctor
- she is original, humorous and lovingly provocative out of concern for the patients and clinical reality and has a true passion for life, and
- she has an unbroken rebellious vein. As a medical student and young doctor in the 50´ies and 60´ies she had the guts to challenge prominent authorities of psychiatry and internal medicine at this very hospital.

Longstanding Balint work at a hospital in Sweden has been and is still done by the psychologist and psychotherapist Juanita Forssell at the regional hospital of Halmstad in the south-west of the country. Her interesting paper given last year at the University College of London is highly recommended for reading (J Forssell 2006). It gives an account – though far from complete - of her contribution. And she will give an abridged report here at the congress too. The results of her Balint work on all medical hierarchical levels have made Balint training and reflecting an integrated part of the professional development and the clinical culture of this hospital.

This presentation is based on

- my own quite recent experience as a Balint group leader in hospitals starting in the end of 2002, and
- the evaluations given by the participants each semester (Jablonski 2005).

<u>What is different in hospitals compared to out-patient clinics?</u>

Why is it so difficult to run Balint groups in the hospital environment? Not that it is easy to establish working conditions for a Balint group in out-patient clinics but the hospital environment seems to present particular obstacles. To suggest some

1. Structural complications
   - The hierarchy of the clinic/department

- The irregular working hours
- The fragmentation/splitting of working tasks

2. Psychological obstacles
    - Challenging the institutional ways of coping with anxiety (Menzies Lyth 1988), group dynamics, collective defences, defences and attitudes/values held by key persons at the department
    - Developing the doctor-patient relationship may be perceived as a disturbance in other parts of “the chain of treatment” at the hospital clinic.
    - Institutional dysfunction might be revealed in whole or in part by the Balint group work which might offer possibilities for cosntructive change but also for opposition against it
    - The culture of many clinics does not allow their doctors much individuality and autonomy. In one way it is a hierarchical medical standardised factory BUT at the same time it can be governed by irrational concerns from the floor, i.e. anxious members of staff demanding consultation or intervention “that cannot wait” though it actually can wait (=lack of holding function)
    - Individual psychological defences tend to be stronger as severe disease and immanent death is very present constantly in the daily working life in which the doctor is taking decisions that imply crucial and dramatic changes in the lives of his patients.

<u>Adaptation of Balint group work to hospital conditions</u>
The leader has partially to tune into the mode of the hospital environment and, at the same time, work hard at maintaining the vitality of the group work. This may be an unnecessary and self-evident statement but I have heard of too many examples of leaders failing because they insist on a psychotherapeutically/psychoanalytically flavoured adherence to rules and framework – or do we Balintians have our own orthodoxy? Those leaders find an excuse for the failure by blaming the hospital doctors or the institution for lack of motivation and structure. Whereas this may be true it is not necessarily the whole truth. The picture given by the hospital doctors can be quite different. They may have felt the leader was overly rigid and authoritarian, too passive and that the conditions for group work were not stated clearly enough from the onset. In fact it could be argued that such leaders should be more aware of the real situation including themselves. Given their own needs for a particular structure and the prevailing working conditions of the hospital doctors, maybe they should not have started the group at all.

What I would rather like to discuss is the hazards of doing Balint group work with hospital doctors. How can we address them and how can the minimum requirements for emotional learning and for the emergence of a working group process be outlined?
My general attitude is that I try to see what can and what cannot be changed in the routines of work at the hospital department. From there I go into a dialogue with the initiators with the aim to judge if there is sufficient room left for Balint work.

I use several hours to inform the leaders of the departments and its sections on the aim and method of Balint work and to discuss the specific conditions, continuity, schedules, group composition etc. I send written material on Balint work in advance. These consultations should be a mutual inquiry into exploring motivation and conditions for Balint work. Basically it does not differ from starting up any Balint work but the situation is more complex and demands, I think, more afterthoughts beforehand. The results of preliminary discussions between the staff and me often result in at least one internal round of discussions within the

department. Then they take up the dialogue with me again. I usually question why the initiators think that Balint work should be a part of their internal training programme. Do they see other options that better fit their demands, their working schedules and other conditions? *Example: After three months of discussions with the management group of a hospital department we assessed that the structure and climate on all levels did not allow for a regular Balint group. We agreed that a Balint-inspired, time-limited, semi-structured group should be offered to specialist registrars and young specialists. It will be lead by a senior psychosomatically orientated specialist at the clinic and me (partly jointly and partly individually) This would seem as a more adequate answer to the needs of the doctors and the present possibilities to make space for education at the clinic. Ten doctors applied. The outcome was positive and has led to continuous Balint work.*

Once the administrative contract for Balint work has been agreed on providing the means and the time, the clinic invites all interested doctors to one or two information meetings and written information about Balint provided by me is distributed to everyone. Alternately I have been invited to present Balint work at a regular doctors´ meeting held at the clinic. No doctor is allowed into the group without having had this personal information from me/co-leader. Conditions for participation are stated very clearly ("the group work contract") and the doctors are invited to register. The composition of the group is established in co-operation with the senior doctor who is administratively in charge of the training programme. If the applicants outnumber the places available, people are put on a waiting list since it is reasonable that openings will appear within the first semester, dropouts occurring mainly because of unforeseeable changes in working conditions.

When it comes to frequency of attendance, coming late to sessions, leaving before sessions end, leaving in the middle of a session to take a call, keeping the personal seeker turned on etc I take a very flexible attitude. It seems to me what really matters in the group work is how and why these "discontinuities" take place. And that seems to decide whether these happenings are really disturbing or can be handled as back ground noise that could be overlooked and should not be allowed to divert the focus from the work being done in the group. It becomes more of a problem and work for the affected individual doctor to catch up. And these discontinuities can also to a minor extent serve as food for reflection.
The only issue I am really careful and stern about is insisting having absences reported. If members do not report that they are not coming , to me it signifies they do recognise neither themselves nor the group members and the group leader as significant. I am always careful to "count in" each and every member at the beginning of each session. And it takes some didactic efforts to make them report beforehand, or if they become occupied at the last minute to leave a message through a colleague. It is both comic and fascinating when hospital doctors as well educated and generally well brought up persons realise indeed that it is impolite to keep people in uncertainty and suspension – which is obvious to them outside of their hospital environment. They usually recognise that the hospital culture promotes such regressive behaviour – as if "something funny happening on the way to Forum" always could be justified to be more important and urgent than a scheduled commitment. If they want to take Balint work seriously (and hospital work too for that matter), they have to work against such tendencies.
The group leader has to be aware of

- on the one hand personal "sloppiness" and "sloppy" conforming to " bad hospital drifting along manners and jargon" on the one hand,
- and the unavoidable uncertainties about emergencies built into hospital work on the other.

When a hospital Balint group works well, a session will start by the leader informing from the previous session that dr A is working night this week, Dr B is on vacation, Dr C emailed the day before she forgot to tell she has another meeting, and Dr D informed by email this morning that she fell ill. Then one group member will say that Dr E is stuck with an emergency caesarean section and probably will join in 15-20 minutes. Another doctor will say that he is second in line at the emergency room and will have to keep his seeker open (but it is agreed that the senior doctor will do his work if needed during the Balint session so that he in fact is the third in line). Not until then there is the time to ask the seven doctors present: "Who has got a case?"

To my mind and my experience the important thing is that every member does his/her utmost to preserve the working process. Then it matters little if a disturbance occurs. The doctor from the operating room will sneak in and tune into the group and feel welcome. The third-in-line-doctor may have to leave one out of 4-5 sessions – bad luck, but no essential harm done to the group work.

Why am I not disturbed, me - a psychoanalyst whose second nature it is to maintain the frame of the sessions? Why do I accept that members only come 2 out of 3 sessions or even only every second? That they may sneak in and out from a session? Because I experience an intensity and an urgency overall in the discussions in these hospital groups that may well match well functioning GP groups. And I see an intensity in the group process – the rapid emergence of a caring and sensitive "spiritual sibling group" which is similar to groups were members come 8 times out of 9.
Example:---------

If I find signs that the administrative contract is failing (i.e. participants are assigned scheduled tasks that coincide with the time for the Balint meeting) I report immediately to the head of the dept and I also ask the participants to address the problem at their staff meetings.

Particular characteristics of cases and emotional problems presented in hospital group
There are still strong undercurrents in the hospital culture that the doctor should be technically very competent and agile and have *full control* of every aspect of the treatment down to last decimal of the laboratory results. When other professionals of the clinic fail or are panicking for whatever reason, they come running to the doctor and ask for help or take-over - although this is not self-evident from the aspect of a well functioning medical team.
A common type of dysfunctional ward has a particular family pattern as its template. Head nurse, nurses and aid nurses are like mother and elder daughters who take care of the patients (small helpless children, sibblings). They are enmeshed with themselves and in caring for the patiients. Daddy, the doctor, is an infrequent visitor but eagerly awaited to take care of everything that is too disturbing and anxiety-provoking, and also to set things straight if some child is not behaving. In addition (comment by J Forssell) the Daddy-Doctor feels quite uncomfortable being faced with this confusing mix of important and trifle demands at the ward. He/she is eager to get away as soon as possible to operate , carry on with his research or meet with his mates.
The hospital doctor is expected to be able to handle every situation adequately and objectively, often implying an *emotional aloofness*. And this seems to me a crucial cultural and intellectual fallacy: there is no such thing as a neutral distance and full control. Doctors are human beings too who suffer pain, discomfort, irritation and sadness, experience joys and temptations and act on the basis of such currents whether conscious of them or not. There are no reasons why emotions evoked in clinical work and mature reflection on them should not be

integrated with high tech medical skills. All Balint trained doctors agree this is the only road to a truly rational medical treatment. In fact a lot of hospital doctors do not live a professional life of aloofness. This was beautifully illustrated in the Michael Balint Memorial Lecture of 2005 given by Paul Sackin (Sackin 2005). Reading it I had flashbacks of memories of important senior doctors in my own hospital training who combined a personal and passionate attitude towards their patients with medical mastery and interest for the latest technology. So the statement above is certainly not the whole truth. Because if it were, the obstacles for Balint work at hospitals would not be possible to overcome.

Even if it means simplifying the following differences between hospital and outpatient practice doctors seem significant:

1. Hospital doctors deal largely with matters of life and death

Hospital doctors deal largely with matters of life and death and conditions that affect daily life critically, whereas GP´s ideally stay with people who live their lives with various kinds of ailments. On the whole the GP follows the gradual changes and keeps his "clinical Argus eye" open to possible new conditions that might appear in his/her patients. Again, the hospital doctor has to take decisions on using treatment programmes so powerful that they may in themselves severely affect the quality of life of his patient, even shortening it. Relations to the dying/severely ill patient and his relatives can be very complicated and exacting. The sensitive doctor may also find him/herself caught *in conflict between programmatic and individualised treatment*. How can the doctor assess the individual situation and help the patient to make existential choices and cope with the uncertainty about ”the remains of the day”? Even a sensitive doctor may not be fully aware of this conflict until it is raised in a Balint group.
Conscious guilt feelings and unconscious guilt and the defences against it are common in hospital doctors and much time is spent discussing these doctor-patient meetings in the Balint groups. An emerging awareness of such conflicts can be a very painful, sad and also provocative awakening for group members. Most doctors gain an emotional and intellectual freedom by working on such meetings in the Balint group. But a few find it too threatening. In my experience inability to cope with guilt is the main reason for dropping out of groups.
Example: -------

It goes without saying that some patients can touch the doctor very deeply - feelings of fascination, sympathy, repulsion and deeply felt concern may surge. The closeness involved in intensive care of a severely ill patient also can give relations an intense obscure and wordless character. Indeed a caring/symbiotically flavoured attachment in intense hospital care could well be seen as an important part of good enough management of the patients.
Defining what is good medical treatment can never be expressed in medical terms only.

Example: ------

2. "The screaming body syndrome".

I use this homemade diagnostic expression to describe a small group of patients who consume a lot of medical resources and doctors. I refer to patients who diagnostically are combining

a. one or several somatic diagnoses (auto-immune, gastro-intestinal, neurological, gynaecological) that are more or less clear (at closer scrutiny less clear, though no doubt something *is* wrong physiologically)

b. iatrogenic damages secondary to the treatment of a. Those may be heavy use of strong pain-killers and sedatives and body impairment due to operations and invasive diagnostic procedures.
c. a severe psychiatric disorder which has not been recognised from the onset. In retrospect part of the clinical picture could be understood as a severe personality and psychosomatic disorder/severe somatoform syndrome/conversion syndrome/malignant hysteria/pre-psychotic or latent psychotic states with bodily delusions etc (this unwanted child has many names).

I do not claim that the GP never meets with these patients. He/she does, but the GP surgery is often too insignificant a stage for the drama of these patients. The hospital and hospital doctors in contradistinction are more suitable for their needs of medical involvement in their own self-destruction. But this bottom line statement is not clear to the doctor. He/she is facing a very demanding and critical patient who presents symptoms for years and years, and who has been referred to him by respected colleagues for further investigation and treatment. It is discomforting for a doctor to take actions, which he hardly can justify. Still these patients insist on investigations and cures that are dangerous to health, and they refuse often categorically an active "wait and see"- strategy. This also raises the questions of collegiality, whether the patient has been referred in earnestness, or if it is a "referral away", a pretext of the referring doctor to get rid of the patient temporarily or for good. The questions of collegiality can also be raised in a wider context: When you look back at some of the treatments some of these patients had, it seems some doctors colluded with the destructiveness of their patients far beyond *lege artis* practice/the state of art of medical practice. Part of the iatrogenic damage consists in the psychological vicious circle of medical attention beyond reason that these patients have received, and go on expecting, as illustrated in this quite average case:
Example: ------

3. Hospital subculture and collective defences against anxiety in hospital staff

The oscillations between various tasks may promote schizoid/emotional-distance-type/"intellectualisation" psychological defensive reactions in hospital doctors to the prevailing schizoid/extremely split clinical reality. Certainly the day of a GP contains a great variety of encounters and problems, human tragedy, joy and trivia. And these shifts from one quarter of an hour to the next make both for the joy and the burden of our profession. Still, in the hospital environment the amplitude of the oscillations of reality is higher.
Example: The specialist registrar may within a working day, which only allowed for a bar of chocolate and a cup of coffee at 3 p.m ("I have to rely on my liver glycogen", one colleague said), find him-/herself in and out of:
Performing a number of routine planned early abortions; delivering a healthy baby by an emergency caesarean section; talking to a woman with a still-born baby, and also having to cut out out a piece of the little baby´s bone for DNA-analysis; talking to a 40-year old woman in her first pregnancy who comes for abortion information and counselling and claims that the pregnancy is badly timed, "in half-a-year my life situation will be better", she says.

It is important both for the doctor-patient relationship and the general efficiency of work to roughly distinguish between
- the reaction of the patient to the actual hospital meetings/procedures, and
- a crisis within the patient triggered by severe illness) which is fairly independent of the hospital "here-and-now", and
- habitual patterns, personality traits and disorders in patients and communication disturbances which are secondary to them.

The discontinuities of the doctor-patient-relationship may cause of confusion in communication. If you are just one cog of the cogwheel it is reasonably more difficult to understand what is going on in the transference/counter-transference between you and your patients. The GP stands a much better chance to establish a proper relation with his. Though it happens to GP´s too, in the hospital it is more common that the reaction of a patient towards a certain doctor may be affected by what happened in relation to other doctors, nurses etc in the previous chain of events - a displaced transference reaction. It seems even likely that a certain doctor should become the target of strong emotional reactions just because he/she is sensitive and emotionally accessible. Then again, patients who generally have little trust or are very anxious or behave strangely – either as an expression of their character (disorder?) or as an expression of severe crisis - may provoke many members of the staff. Adverse reactions in the staff can be extreme because the doctor has his prejudices or own neurotic counter-reactions reinforced by others who have had only a superficial contact with the patient but enough to reinforce the simplified picture of a particular patient in the "affected" doctor. A mobbing process towards a patient may crystallise. Making the patient the laughing stock or target of hidden contempt or reservation can be expressions of the collective barriers of the staff against dealing with the anxieties of the patient, who instead of being calmly talked to is ostracised.

Example:------

<u>A few remarks on the results of the written evaluations</u>
The results given on a five-graded scale of the evaluations at the end of each semester (see supplement; Jablonski H 2005) are generally good judging from the answers in about 100 questionnaires.
The *focus on the doctor-patient-meeting* is perceived by everyone (4,5- 5,0). The respondents feel that *they professionally have learnt from the cases they presented themselves* (4-5) and from the *cases presented by other* members of the group (4).
As opposed to GP groups, hospital doctors feel *they benefit just as much or even more personally as professionally* from the group discussions. The score is also in this respect well above 4. With the GP groups the evaluation of the professional aspect of Balint work get the same scores, 4-4,5, but the personal ranks lower 3-4. I think this difference reflects non-addressed burdens of responsibility and guilt that I discussed before. But I can also speculate that it also says something about the lack of human emotional nourishment.
It seems that the group members appreciate the *trusting atmosphere of the group* (4 or 5, only one in ten would put a 3) . I would have expected that in groups, where the attendance is low and uneven and the group constellations differ from session to session, that the individual spread within the group would be wider. But it is the same as in GP groups. It could reflect the general good collegial atmosphere of the department that is brought into the group work in combination with the Balint group process itself.
Negative criticism over these years refers unanimously to lack of continuity and not being on time for the sessions – either themselves or the others.

<u>Concluding comments</u>
Thinking about the intensity in the hospital Balint groups I cannot but repeat what has been said many times before at Balint congresses. It seems these groups try to make up for a severe deficit in the training of medical students. Not that every student is capable of joining such a group. Maturity and readiness to scrutinise ones professional ways of relating might come

later. But it seems to me that the intense urgency in these doctors to work in the group reflects the many years during which these issues have accumulated in them unspoken.
Rereading the report by Schoenberg&Suckling (2005) about how medical students can benefit from Balint groups, I recognise so many themes and sentiments. There can be no doubt that those medical students, who are capable and offered the possibility of relating to and working through these issues, are far better equipped to deal with clinical reality than those who have to wait another 6-25! years for their first training. They will be more adequate to patients, to colleagues and they will have lesser propensity to suffer from feelings of guilt, helplessness and repressed irritation. *Not offering Balint work to interested doctors and medical students is a significant waste of human resources in the health care system*. Doctors will be able to make use of such feelings instead of being the victims of them and/or victimising their patients. Being professionally more at ease they will be more able to benefit from the pleasures of doctoring (Matalon 2003). This is an experience-based conviction Balintians have held for a long time. This has also recently been confirmed by the research of D Kjeldmand (2006) in her Ph D thesis on Balint work..

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Supplement:
Questionnaire for evaluation and assessment of Balint group work (revised 2006)

“A little but significant change in the doctor`s personality” – an aim to long for or to fear?

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About ten years ago there were several alarming reports in Sweden - like in other countries - about how medical students loose their ability for empathy during their education. A Swedish psychologist Ulla Holm – wellknown in Sweden for having investigated the conception of empathy - presented a summary of those reports together with a study of Swedish doctors. She has been referred to, sometimes with loss of the nuances, and the Swedish medical education has been much criticised and especially non – medicals have been very much alarmed about the loss of empathy among doctors.
We think there is something that is true about it, but we don´t think the empathy has disappeared, rather is it hidden, not necessarily for ever.
What is the relationship between Balint´s “little but significant change” and the hidden empathy ? We are going to reflect upon the influences of activated defence mechanisms and especially focus on omnipotence. In the papers mentioned above the loss of empathy is said to be partly due to activated “narcissistic and omnipotent traits” in the doctor. Of course there are some doctors, who are more disposed to an omnipotent defence, but we think it is a rather common defence especially among young doctors in emotionally stressed situations and a defence that is quite possible to work through.
We´ll start with some vignettes:

Vignette 1

In the late seventies I was asked to supervise a group of pediatric residents during their six months work at a Children´s Psychiatric Clinic. They were not going to be psychotherapists, so the work was a bit Balint- like with the focus on the encounter with whatever patients they met. Part of the time we were also paying attention to the new doctor´s role, so different from being in the well structured and hierarchical organisation, they were used to at the Pediatric Clinic. In the seventies the difference between doctors, psychologists, nurses and so on was almost denied at the Children´s Psychiatric Clinics.
The prospective participants were enthusiastic, but one of the doctors refused joining the group with the explanation: “I have found a way to be with my patients and their families. I think it is a pretty good way, and I don´t want to loose it!” Of course I couldn´t promise him he wasn´t going to loose anything, and neither could I give him a guarantee for what to gain instead. So, alas, he did not participate. What did he fear ?

Vignette 2

Before next vignette I will make a short presentation of “The Doctors´School”.
This is a course that has existed in Stockholm since 1996. It runs during the medical students´ first four terms and is a way of introducing early contact with clinical work and consultation technique. During three days each term the students – in groups of four – visit either a health centre or a hospital to meet patients and make video interviews together with a specially trained tutor. There are also included seminars on ethical problems.

Example from Doctors´School:

The student is in his second term of his medical education, a 23 years old man. He is making a video-taped interview with a woman of 75 with complaints of pains in her back and knees.

He is sitting with one leg upon the other, with one foot on the other knee – his usual way of sitting. In spite of this position he manages to lean forward and look the patient straight into her eyes. He declares, that he is in his first year of medical studies and doesn´t know very much about diseases yet, but he is very interested in listening to her story.
The patient tells her story willingly. The student allows her to talk, puts in some questions when he doesn´t understand, or for defining the course of events and the like, but he puts very few leading questions – because his medical knowledge is still limited. At the end he makes a short summary to be sure that he has understood things correctly.
I need to make a few complementary questions, but I have got a good conception of the patient and her problems. Together we can decide about investigations and treatment. The patient is very satisfied with the consultation.
The student thinks he looks awful at the video and gets very occupied with his way of sitting. I have to assure him that he has made a very good interview and that his good contact with the patient is much more important than the way he holds his legs.
Will the longing for being the perfect doctor prevent him from being the “good enough” doctor?

Vignette 3
Dr A, has been a GP for almost two years. She joins a Balint group since one year and she is frequently presenting cases in that group. Her presentations are always about her guilt feelings, and she gives very detailed descriptions of what she has said and done and what she should have said and done instead. The guidelines of Evidence based Medicine are her bible. She is always afraid of doing the wrong things and is occupied by accusing herself for having made severe mistakes. She gives her patients plenty of time , asking, examining – she must not miss anything! Sometimes she calls her patients between the appointments to control they are still alive.
Time and again she gets comfort from the group. They try in different ways to convince her that her guilt feelings are irrational. That can give her relief for a short while, but soon the same pattern is repeated. The group is becoming more and more tired and resigned…
What is she longing for? What does she fear?

Concerning **vignette 1** : The pediatric resident seems to have found a solid way of working , but his fear to join the group gives us the suspicion that it is built on a fragile ground and could reflect an omnipotent defence. Even a small change is dangerous , as if the whole image of himself as a doctor could fall down like a house of cards. He seems to have been very lonely in his struggle to find a professional method. It is not easy for a young doctor to be confronted with children, who are chronically ill, dying , abused ! To leave the safety of the firm, hierarchical structure and enter the freer but less distinct one at the Children`s Psychiatric Clinic could also be threatening to his professional role. This might have contributed to his clinging to his familiar way of acting.
In one way it might seem respectful to accept his “no thank you” and leave him in peace. But wasn´t that to give him up too easily?
Working in the Balint-like group could have been a chance for him to reflect upon his encounters with his patients and little by little feel more safe in his professional role.
But could persuading him be a good way or are there other ways for a doctor like him? Perhaps would a personal tutor be more easily accepted by him? Or might participating in a structured clinical seminar group, discussing psychiatric topics, be an appropriate first step for him?

Concerning **vignette 2 :**
The student is a young and promising man. He seems to still have some of the normal and healthy omnipotence of the adolescence as many young students have. Disillusion is inevitable but has to be gradual. To enhance this development there is the need of good supervision.
This student gets embarrassed when he looks upon himself at the video. There seems to be a short step betweens his feelings of enthusiasm and fearlessness during the interview and those of failure when he gets occupied with his way of sitting. That does not correspond to his ideal image of the perfect doctor. To give up that image and be satisfied with being a "good enough" doctor is a process of mourning , a process usually leading to an increased safety. We think that the Doctors´School and Junior Balint groups are good ways to support the students in this development.

Concerning **vignette 3**

At first a few words about dr A:s "bible" : During the last years in Sweden – as well as in other countries - it has been more and more emphasized that all treatments and methods should be Evidence Based. Of course this is a good thing, but is there a risk that other important ingredients of a consultation are forgotten or ignored?
Probably we can learn something from the discussions on psychotherapy and evidence. Much of the research on the effects of psychotherapy has shown that the working alliance is more important than what kind of therapy is chosen. Of course the therapist/doctor must have good knowledge of the treatment he/she offers , but it is very important that the therapy is chosen for just this patient and in agreement with him.
So just to use an evidence - based technique is no guarantee for a successful outcome. Those who are familiar with Balint work know that of course this is relevant also in somatic care.
A bible can be used in a "word for word" way, that hinders instead of enhances reflecting upon its substance and how to use it in different situations.
Dr A. gives the patients a lot of time and examinations, but that is not necessarily the same as being empathic. It seems to me that she spends this time more for her own needs than for the patients.
But she does not seem omnipotent at all – does she?
Yes, we think she does, but in a disguised way. There is a paper from 1982 by the French psychoanalyst Janice de Saussure called "Guilt as a Narcissistic gratification". Her thoughts have been useful for Anita many times during the years as a psychoanalyst as well as a Balint group leader. The paper deals with guilt feelings, almost resistant to therapy. These feelings are often very painful and so they are in this case. Dr A is longing for relief, but she does not allow the group to help her.
My hypothesis is that she is fearing to loose something if there is a change. She claims to her irrational guilt feelings. An omnipotent fantasy is included in these feelings : " If I had done in another way – the right way – everything would have been different. The patients would recover and none of my patients would ever die!"
Perhaps it might sound paradoxical, but she has to mourn her guilt feelings.
I think this might be a hypothesis, valuable for a Balint group leader.
It is often possible to see a parallel process – perhaps the cases Dr A. presented in her Balint group were about patients with corresponding omnipotent fantasies ." If the doctor could find out my diagnosis exactly and give me the right pills, everything would be different – not good enough but perfect!" There would be no signs of ageing and no death.

The doctor and the patient could unconsciously share those omnipotent fantasies. When they do so, the patient gets disappointed again and again and the doctor correspondingly gets feelings of shame and guilt for not being able to fulfil their irrational expectations.
To recognise and help the Balint group to look at the parallel process is often a good way not to hurt the doctor´s feeling, but invite her to reflect, and give some new thoughts back to the patient and share the mourning of the illusions with him/her.

Concluding discussion

John Salinsky and Paul Sackin have in their well-known book "What are you feeling, Doctor?" studied a Balintgroup ,running for five years, and especially focusing on how the defence mechanisms of the doctors affect their encounters with the patients. They say: "Many defences were necessary to preserve the doctor´s ability to work, but we also found that many defences were excessive and inappropriate, denying doctor and patient to share feelings in a therapeutic way".
We totally agree with them and think, it corresponds very well with our reflections on the omnipotent defence. Sometimes "the omnipotent doctor" is described almost like a caricature from a distance, a bit disdainfully to secure :"I´m not like that".
On the contrary we think this is a common defence but sometimes disguised as in our examples with the pediatric resident´s "No thank you" and doctor A:s chronic guilt feelings.
Sometimes it is difficult to recognise such hidden omnipotence , you just have the feeling that the empathic process is disturbed.
We think that one might look upon Balint´s words "a little but significant change in the doctors personality" as an expression of the ability to know and to deal with one´s defences, like omnipotence, to be their master and not their slave. Then it would be possible to <u>regain</u> the "lost" empathy.
The road is a road of mourning and the Balint group is a place for containing and enhancing this process. That might sound as a heavy and sad work,but there is always room for joy – even laughter – at the same time. Through the parallel processes the patients will be helped in their mourning of not reaching the Impossible. There is Swedish phrase about the importance of not letting the Best be the enemy of the Good.
This phrase can be helpful also in the Medical education. It is important to support the students during the inevitable disillusion, letting it come gradually, thus enhancing the professional as well as the personal development.
Of course there are individual differences between the students from the beginning, but we think there is a possibility for everyone to develop.
If such a process has started in a favourable way , joining a Balint group could be the natural next step without much fear of "the change". If , on the other hand, the first process has been defective, the Balint group still can be a good chance but might be looked upon as a threat.
It is important to identify those doctors and not abandon them , even if joining a Balint group might not be the appropriate thing for them at the moment.

Finally: Is it an aim to eradicate every trace of omnipotence in order to be a mature doctor and human being? No, of course not . A healthy omnipotence is necessary for being creative and brave.
One of our colleagues said : "Without a certain amount of omnipotence you wouldn´t dare to drive your car to your work in the morning". And we will add: "Without a certain amount of omnipotence you wouldn´t dare to be a doctor!"

References:

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2. De Saussure, Janice *"Guilt as a Narcissistic Gratification"* Scandinavian Psychoanalytical Review 2/1982
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When Balint groups work less well.

Dorte Kjeldmand, MD, GP, PhD, Sweden
Karen Glaser, PhD, USA

One theme of this congress is the future of Balint work. If we want to address the future we must scrutinize the past and the present and search for answers to the following questions: Why are there so few Balint groups? Why do some groups work badly? Why do people drop out of Balint groups and are they hurt? Why are some Balint groups so difficult? What, if anything, is special about obligatory Balint groups?

We set out to search for answers to these questions, Dorte as a researcher, Karen as an experienced Balint group leader. Dorte interviewed Balint group leaders, analyzed and applied theories; Karen dived deep into her ocean of experience and searched for the ugly fishes.

In this performance we will try to present what we found, a mixture of experience, empirical data and theory, and we will do our best NOT to avoid the nasty stuff. We hope to engage you in a discussion of what we can learn from 'failure.' This might lead to new understanding for all of us in a true Balint-like parallel process.

We may have to acknowledge that Balint groups may be subject to similar dynamics as other groups. Hence we begin with presenting some theoretical aspects on small groups viewed from the angle of complex systems theory. A complex system is a system that is not simple and linear and yet not totally chaotic.

A group is constituted of *local dynamics*, of members using tools to do tasks, individuals with individual motives, competences and characteristics. The members give rise to and are constrained by *global dynamics*, processes in the group. The group and its members depend on and affect the surroundings, the *contextual dynamics*. These dynamics are all influenced by, on the one hand conscious and rational motives and wishes; and on the other hand hidden agendas and unconscious motives.

The formation of a new group can take place in four fundamentally different ways. The formation forces can be *external* or *internal*; the process can be *emergent* or *planned*, as is illustrated in Fig 1.

External forces can be the initiating force in a planned action as in working teams and other organizational groups, and this is called *concocted* groups. Here the motive to form the group derives from the initiating organization and not primarily from the members. They may therefore focus the work in the group on satisfying external demands from the organization. Groups that are planned and started on the initiative of the future members are called *founded* groups and here the members will coordinate and integrate their own goals, intensions and expectations.

These initiating forces are important factors in the start and further development in the group, but the dynamics in the group will also be strongly dependent on how the members act. No group is formed if members do not make contact and behave as group members.

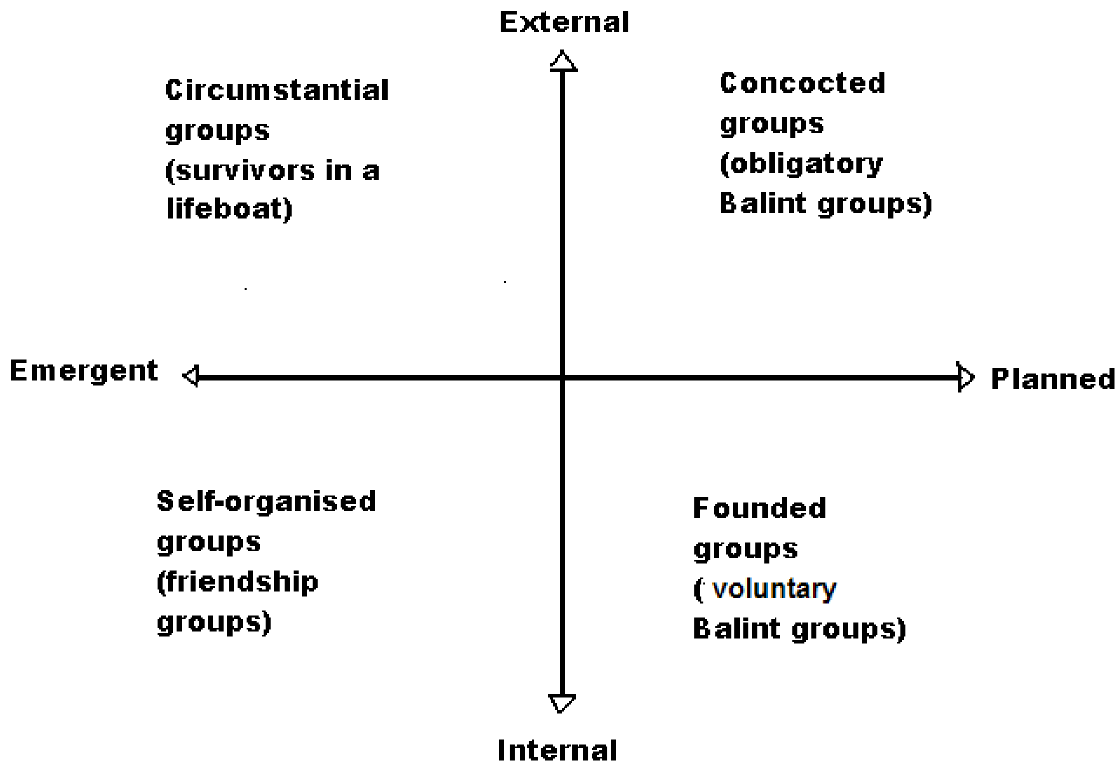

Figure 1. The four group-initiating forces and examples of groups emanating from them .

We often recognize how important ‘frame’ is to any individual group. There are rules and parameters to ensure the safe continuity of groups and group work. In the USA, where most Balint groups are situated in residency training programs, the structure and context of the training program can either serve to protect the Balint group and its process or to create other problems for the group leaders and the ultimate function and well-being of the group itself.

The general impression from the interviews with eight Balint group leaders from five countries was, that the leaders were empathetic to the working conditions of the general practitioners, they were dedicated to the task of creating a safe milieu in the groups, and that the goals and methods of their leadership were alike independent of nationality.

When putting the question to the interview-texts of what creates difficulties and why do members drop out, three main themes emerged from the analysis: (1) *the individual member*, (2) *the group including the leader*, and (3) *the surroundings of the group*. A multitude of sub themes connected to the main themes were found. In order to visualize the findings, the themes and sub themes are arranged around a triangle with the three main themes at the corners and the sub themes on the axes between them below in figure 2.

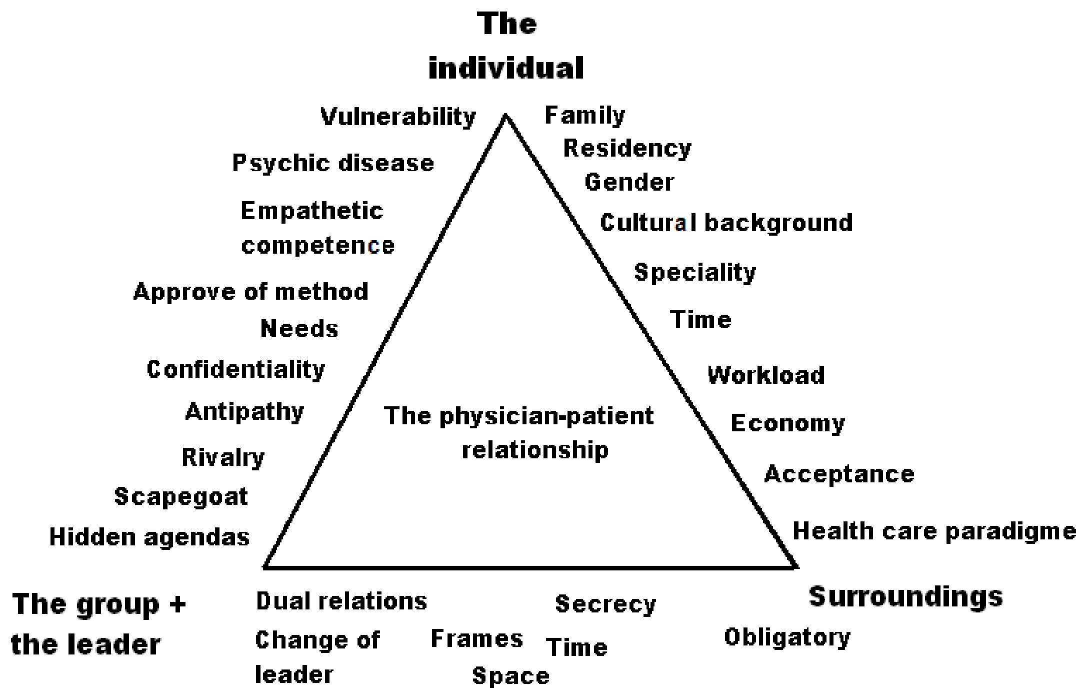

Figure 2. The findings from the analysis of the interviews with eight Balint group leaders on their experiences of difficulties and dropouts in Balint groups. The three main themes are arranged in relation to the sub themes.

The *participant* is part of a complex psychosocial system that in a multitude of ways interferes with Balint group participation. These range from practicalities such as abode and work hours of the spouse to more or less severe personal problems or disabilities. In times of the participants' own illness or other traumas the personal vulnerability to issues arising in the group was increased. It was also clear that people dropped out because they simply did not like the method, they were looking for other ways of learning.

The *leader*s' central role was emphasized as the keeper of the frames and rules, of which confidentiality was one of the most important. Some leaders who had obligatory Balint group for residents experienced difficulties with the processes in the groups, particularly when there were conflicts in the relationship between the resident and the faculty. The Balint *group* was demonstrated as susceptible to the same mechanism as other groups, and stories of rivalry, hidden agendas and scapegoats were told.

There is a mutual exchange of influences between the group and the *surroundings*, but the findings indicated that the Balint group was the weaker part. The society's total economic, cultural and political state together with the health care paradigm constituted important parts of the context of the Balint group.

The world of health care is subjected to the same economic limitations as the rest of the society and the biomedical paradigm is firmly established. Although the psychosocial aspects of illness and health and communication in the consultation are getting more attention in the literature it is hard to see radical changes toward a more human and patient-centred view of the physician-patient relationship in real life. Hence it is not surprising that there are so few Balint groups, but that there are Balint groups at all.

<u>The Failed Group Story</u> (as one example)

A mandatory resident training Balint group was in place for several years in a Department of Family Medicine. The group met weekly for one hour of time. For the past several years, residents' time for teaching and training in the behavioural sciences was severely decreased. At the same time demands on residents in training to quickly become efficient in the day-to-day office practice increased. The financial pressures were such that one of the Co-Leaders, the MD Family Practitioner, could not make time to co-lead the group. There were among the new group membership, one or two somewhat hostile and insecure trainees who were somewhat averse to group work in principle. The remaining Leader of the group was a psychologist who was not introduced to the group by the faculty in charge of the residents' training and educational experience.
We can list the many systems 'errors' here in the mechanism for setting up a good 'frame' and context for a safe and successful group.

Questions for your consideration:

Questions raised are not necessarily Can This group be Saved or Re-vived? But: what are the lessons for other groups – what is a fatal wound, what contextual issues might be overcome, why did this group fail?
Will Balint groups go the way of psychoanalysis or can we do something to protect them in context?
How important IS the full context and frame when we are on the run in a busy practice?
How do we preserve the Balint frame and is there a place in medical training for other groups (support groups, process groups). –do we need a label or language for these?
What are the roles of leaders and members?
What is our understanding of the context?

The Sacrifice a Member for the Peace of the Group Story (as another example)

One member of a group had a slightly different view of the power-structure in the physician-patient relationship, for instance did he use sick-leave certificates very restrictively. He was one of the initiators of the group and for a long time very enthusiastic and worked hard. He was the only male member and the leader was female too. Slowly he became uncomfortable in the group, which acted against him with suspicion, and as he did not want to change his opinions he dropped out. The remaining members in agreement with the leader decided that he was more instrumentalist and "hard" than they and did not fit in the Balint way of being a physician. Just as well that he left. Now the group could continue agreeing on their "right" way of thinking instead of facing the possibility of other ways. That would have been challenging though more difficult and might have displayed other disagreements or rivalries in the group of females. The leader joined the group in the process and did not follow up on the matter.

Questions for your consideration:

How do we avoid falling into the convenient trap of neglect, happily letting the group work, ignoring other ways of thinking in our Balint groups?
Is there a culture of how to be and how not to be in Balint groups and is it beneficial or just convenient?
Do we allow dissidents and listen to their stories?

When we mix young physicians with older and more experienced ones do we then inform the older ones that they are now role-models, doing our job for us, and they are no longer allowed to be safe, weak and faulty?
Why do we not conduct "mutual selection interviews" in order to sort out people who for different reasons will not benefit from joining our Balint group?
How do we protect members in the group from our own blind spots?
Follow-up on dropouts? If yes, who is responsible and how to do it?

References:

The Tale of a PhD on Balint groups, 5th and final part.

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Department of Public Health and Caring Sciences, Section of Health Services Research, University of Uppsala, Sweden.

The thesis called "The Doctor, the Task and the Group – Balint Groups as a Means of Developing New Understanding in the Physician-Patient Relationship" has been completed and the dissertation was successfully conducted September 19th 2006 at Uppsala University, Sweden.

Balint groups were studied using both quantitative and qualitative methods, asking both participating general practitioners and Balint group leaders for their experiences. My theoretical foundation was based on theories of general practice , patient centredness , competence development , group dynamics, psychodynamics and complex systems theory .

The studies in summary:

Study I: Twenty Balint group participating general practitioners were compared to 21 general practitioners without access to Balint group by means of a questionnaire. Compared to the reference physicians, the Balint group participators were more satisfied and reported higher feeling of control in their working situation. They considered themselves competent in dealing with patients with psychosomatic problems to a higher degree that did the reference group. There seemed to be a time-effect of Balint group participation as the difference increased with time in Balint group .

Study II: An instrument is developed and tried on the physicians participating in study I. The presented instrument named "How patient-centred am I?" could separate a group of patient-centred physicians from a group of non-patient-centred and can thus be useful in evaluation of training programs. It is not validated enough to test the individual physicians, but can be used by them in private or as a tool in joined reflections on the physician-patient relationship, in the tutoring process of young physicians or to detect early signs of burnout .

Study III: Nine general practitioners with long Balint group experience were interviewed and the text was analyzed qualitatively using a method based on a phenomenological approach. The interviewed general practitioners described their Balint group participation as beneficial and essential to their working life in several ways. Their experience of their Balint group participation's influence on their working life was constituted of the following interrelating themes: *competence*, *professional identity* and *sense of security* increasing through *parallel process*, leading to *endurance and satisfaction,* thus enabling them to rediscover the joy of being a doctor.

Study IV: Fifty-one Balint group leaders filled in a questionnaire and eight Balint group leaders were interviewed regarding their experiences of difficulties and dropouts in

Balint groups. Roughly 10% of the members dropped out of the Balint groups. According to the findings in both questionnaire and interviews, the reasons for this were either practical or connected to processes in the groups, and there was a tendency to place the responsibility on the member leaving. Some left because they were discontent with the method as such, wanting more straightforward teaching, others as a result of events in the group that were sometimes destructive. Whether these persons were hurt is not known because the follow-up of these cases was insufficient. Obligatory groups seemed to differ profoundly from classic voluntary Balint groups for specialists.

The results of this thesis point at the Balint groups as a means for general practitioners to develop competence in the physician-patient relationship. The Balint group can provide a safe place for inter-collegial reflections over the task of general practice leading to a strengthened professional identity. The group discussions on emotional aspects of obscure or frustrating patient encounters can lead to new understanding of the relations. At the same time the group is a place to find support and means to gain control over the working situation. This may reduce the risk of burnout .

Not all physicians benefit from the Balint group method and there are also risks of bad group dynamics, which may be hurtful. Balint group leaders need to be highly aware of these processes and actively investigate into why members drop out of the groups and whether they are hurt. They should consider the possibility of "mutual selection interviews" more often, as participation of a member demands a stable psychological condition and an open mind. Physicians without these characteristics would probably benefit more from other methods, e g mentorship. This makes obligatory Balint groups an issue for discussion.

The thesis concludes that professionally conducted Balint groups are generally beneficial for general practitioners as a means to make the physicians endure, even thrive in their job. The method seems to be a gentle, efficient way to facilitate development of new understanding of the physician-patient relationship with possible positive effects for the patients as well.

Acknowledgements: I want to thank those of you who in any way participated in the studies and also all members of the International Balint Federation for the interest and support I have received during the eight years I have worked on the thesis.

Tutors: Inger Holmström and Urban Rosenqvist,

The thesis can be read on this page:
urn_nbn_se_uu_diva-6937-1__fulltext.pdf (application/pdf)

References (a small sample, please find the full list in the thesis):

Intryck från the 15th International Balint Congress i Lissabon 1-5 sept 2007

Pepa Jönsson, psykiater och psykoterapeut, Stockholm:

Jag deltog i en Balintkongress för första gången. Det var dessutom första gången, som jag var i Lissabon. Redan från början slogs jag av en varm och välkomnande atmosfär både från

värdlandets representanter och från övriga deltagare. Inte minst bidrog det att kongresslokalen var inrymd i en av Lissabons två traditionfyllda och anrika medicinska högskolor. Man kan också säga att kongressen gick i musikens tecken. Vid öppningscermonin fick vi lyssna en timme på känslomättad portugisisk modern klassisk musik framförd av skickliga professionella musiker på specifika portugisiska instrument. Under någon fikapaus stod man och nynnade på italiensk opera tillsammans med några andra deltagare. Under avslutningsmiddagen upplevde vi Fado-sång framförd av både en professionell artist och av en av deltagarna från värdlandet. Dessutom fick vi ju själva bidra med musik från våra hemländer. Den svenska gruppen framförde ”Rosa på bal” av Evert Taube. Anders Häggmark gjorde en lysande Fritjof Andersson medan den samlade kvinnokraften kråmade sig i rollen av en kollektiv Rosa. Så när Sven Bertil lägger av på Gröna Lund är ersättaren given.

Och nu något om innehållet i kongressen. Titeln för kongressen var ”Medicine, Evidence and Emotions 50 Years on…” och var indelad i tre huvudteman: ”Past and future, Research and New contexts. På eftermiddagarna fick vi sitta uppdelade i Balintgrupper där vi fick ta upp egna fall. Grupperna var blandade så att medlemmarna kom från olika länder och hade olika bakgrund och åtminstone i min grupp upplevde jag diskussionerna såsom mycket givande. Föreläsningarna hade både ett vitt spann och ett djup, vilket gav livliga frågestunder efteråt. Det verkar som att vi i Sverige står oss väl i jämförelse med andra länder vad gäller kunskapnivå och forskning inom området men tyvärr verkar utbredningen av Balintgrupper vara koncentrerat till några få orter i landet. Onekligen borde Balintgrupper införas i grundutbildningen för läkare på samtliga medicinprogram i landet. Nu finns det på gång endast på Karolinska.

Jag har bara skrivit positivt om kongressen eftersom det var en så positiv upplevelse och jag ser fram emot att få delta i nästa kogress i Rumänien om två år.

Dorte Kjeldmand, allmänläkare och med dr, Eksjö:

Efter denna missmods sommar var det en gåva att få komma till Lissabons 35 gradiga klimat, även om programmet var så fullspäckat att jag endast hann nyttja hotellets pool på takterrassen én ända gång. Det var min femte internationella Balintkongress, men jag hoppas inte min sista. Stämningen var som alltid generös med många känslor, goda skratt och lugna pratstunder. Programmet var välgjort och klaffade, från de trevliga servitörerna som välvilligt tryckte på knapparna på de flitigt besökte espressomaskinerna i pauserna till den storslagna buffén på slutfesten. Luncherna serverades som matsäck (med fotomontage av Michael Balint påtryckt) så vi kunde sitta ute i en liten park och äta i trädens skugga i sällskap med gäss, änder och höns med kycklingar (vilket gjorde det nödvändigt att titta noga efter innan man satte sig i gräset).
Som vanligt varvades träffar i Balintgrupp med vetenskapligt program i form av presentationer i plenum. Mitt intryck är att nivån på de vetenskapliga arbetena har höjts successivt sedan min första kongress 1998. Men fortfarande saknar jag att dessa spännande arbeten publiceras i ”gängse” vetenskapliga tidskrifter. De skulle därmed spridas som gemensam kunskap, bli refererbara och kunna påverka båda akademiska och organisatoriska makthavare världen över.
Det var just det som var det genomgående temat för hela kongressen: Hur kan vi sprida Balintverksamheten ut över de smala målgrupperna som nu har tillgång till den? Och är det

acceptabelt att tvinga sig på medicinstuderande och läkare under utbildning som inte kan välja bort metoden? Dessa frågor lär vi komma att fortsätta diskutera många år framöver.

Anders , allmänläkare och Anita Häggmark, psykiater och psykoanalytiker, Stockholm:

Kongressglimtar
Inspirerande inledning : Virtuos musik av unga musiker på synt och gitarr.
Fyndig farmakologi: Läkemedelskommitténs ordförandes undersökte ”drogen doktorn” enligt FASS.
Patienten Proust: Balint-nestorn *Michael Courtney* gav oss Marcel Prousts upplevelse av en flash och betydelsen av att vara ”fantastically ill”.
Besvikna Balintgrupper: Dorte Kjeldmand och *Karen Glaser* inbjöd till självrannsakan för balintgruppledare när gruppen inte fungerar.
Studenters situation: Heather Suckling delade med sig av sitt arbete med Student-Balintgrupper, som ger möjlighet till reflektion över studentens roll bland patienter och sjukvårdspersonal.
Mumsiga matpåsar: I speciella Balint-påsar av tyg serverades den portabla lunchen, som kunde intagas i parken bland höns, ankor , gäss , fredsduvor och påfåglar .
Fantastisk fotbollsfest: Avslutningsfest på fotbollsstadions restaurant med brak-buffet och sanslös sångtävlan.
Bästa betyg till en välorganiserad, givande och rolig kongress i ett backigt, charmigt och sommarvarmt Lissabon!

Läkare och skrivande - varför och för vem?

Sektionssymposium på Läkarstämman 2007 – en sammanfattning

Bakgrunden och inspirationen till symposiet är att det vid Svenska Föreningen för Medicinsk Psykologis senaste skrivartävling inkom inte mindre än 29 bidrag, varav många var av mycket hög klass och samtliga vittnande om ett stort engagemang för den goda sjukvården.

Symposiet avsikt var INTE att stimulera till skönlitterärt författarskap, utan att lyfta fram det personliga skrivandet, som en möjlighet att formulera känslor och få distans till starka upplevelser i vardagen.

Medverkande vid symposiet var:
Thomas Eklundh, psykiater i Stockholm
Tina Nyström Rönnås, distriktsläkare i Tumba
Elisabeth Hultcrantz, ÖNH- professor i Linköping
Inge Carlsson, familjeläkare i Eslöv
Lena Svidén, distriktsläkare i Rinkeby - moderator

Undertecknad, som alltså var moderator, inledde med en historisk överblick över läkare, som samtidigt varit (och är) författare till skönlitteratur. Och de är många! Alltifrån Hippokrates och evangelisten Lukas till artontonhundratalets Berzelius. Så har vi förra seklets med stora svenska namn som Axel Munthe och lappdoktorn Einar Wallqvist, Erik Ask-Uppmark, Gunnar Björk, Arvid Brenner och Jerzy Einhorn. Och Svenska Akademins Lars Gyllensten. Ser vi ut över världen har vi förstås kända ryssar som Tjechov, Bulgakov och Tjernikovski, ryktbara engelsmän som Conan Doyle och Somerseth Maugham, amerikanen Oliver Sachs, och fransmannen Lois-Ferdinand Celine.
Och i nutid har vi som Georg Klein och P.C. Jersild, som ofta syns i samhällsdebatten. Vi har deckarförfattarna Karin Wahlberg, Åsa Nilsonne och Jonas Moström, skojaren Rickard Fuchs, poeterna Eva ström, Kajsa Siverbo-Widell, Pia Dellson och Claes Andersson. Vi har Lars Andersson, Carl-Magnus Stolt, Anders Drejare, Ulf Lockowandt,…… och många, många fler….
På Karolinska Universitetssjukhuset i Solna (Camera Obscura) finns en boksamling som 2005 skänktes av Lars Erik Böttiger, pensionerad överläkare i invertesmedicin. Den innehåller inte mindre än 600 volymer av icke-fackligt slag, författade av 165 läkare från 17 länder!
I läkarnas grundutbildning i Göteborg, Stockholm och Lund har skrivandet också börjat ta plats. Och i Uppsala har Merete Mazzarella – som är professor i nordisk litteratur i Helsingfors - haft skrivarkurser för läkarstuderande.
I samband med Läkartidningens 100-årsjubileum 2004 utlystes en novelltävling. Trettio av de hundra inskickade bidragen gavs ut i bokform ”Att vara doktor” på Brombergs förlag. Så nog skrivs det hemma i stugorna/läkarvillorna!

Efter denna inledning var det så de övriga symposiedeltagarnas tur att berätta om sitt skrivande och delge auditoriet något av vad de skrivit.

Thomas Eklundh inledde med en text kallad ”Det finaste man kunde bli”. Inför en andäktig publik reflekterade han där kring sin mammas liv, hennes syn på läkaryrket och hennes sista tid i livet. Som medicine kandidat blev han nu anhörig.

Tina Nyström Rönnås läste upp sin text ”Att vara doktor – en vardagsberättelse”, där hon i lågmäld ton beskrev en dag i en allmänläkares liv. En dag, fylld av känslor av de mest oväntade och skilda slag men samtidigt en alldeles vanlig dag. Många i publiken log….

Inge Carlsson delgav oss några dikter han skrivit.
Med självdistans, en absolut pricksäker ironi och mycket kärlek beskrev han några patienter.

Och nu var det dags för auditoriet att skratta….

Elisabeth Hultcrantzs första text hade titeln ”Professorns mottagning”. Det var en allvarlig beskrivning av chefsrollen i en ny tid. Att vara först, att vara duktig och att vara kvinna. Och så kompliceras bilden av att man plötsligt inte mår bra ….. Mycket tänkvärt.
Sist fick vi också med ett patientperspektiv på sjukvården, när Elisabeth delgav oss ”I en sal på lasarettet…..” - ett barns reflektioner från en sanatorievistelse vid mitten av förra seklet.

Nu hade de två timmarna gått, och vårt intryck var att åhörarna var mer än nöjda. Förhoppningsvis hade vi stimulerat ytterligare några kollegor att ibland skriva litet mer än journaler och epikriser, och kanske kan det personliga skrivandet uppmärksammas också vid kommande läkarstämmor.

Lena Svidén

Läkares känslor – tillgång och belastning i den kliniska arbetsmiljön

Rikssymposium på Läkarstämman

Svenska Föreningen för Medicinsk Psykologi stod bakom detta Rikssymposium.

Lotti Helström var moderator

Juanita Forssell, psykolog och psykoterapeut med mångårig erfarenhet av Balintgrupparbete på sjukhus och i öppen vård talade om yngre läkares situation
Jan Björk, överläkare, gastroenterolog, Karolinska Solna, talade om hur Balintarbete hjälper honom att handskas med för honom känslomässigt komplicerade patienter (vilka skulle vara komplicerade för de flesta av oss)
Henry Jablonski, psykiater och psykoanalytiker, talade utifrån egna erfarenheter som Balintgruppledare.
Juanita Forssells fullständiga text finns (på engelska) i Bulletinen för Svenska Föreningen för Medicinsk Psykologi 2008:1 som finns på föreningens hemsida www.sfmp.se
Här följer en förkortad presentation av Henry Jablonskis presentation.

”Utan tvivel är man inte riktigt klok”
av Henry Jablonski
Över en 20-årsperiod har jag sammarbetat med sammanlagt c:a 150 kollegor med var och en i 1-6 år som Balintgruppledare. Jag kan inte påminna mig om att ha träffat *någon* som *inte* tyckte om att vara läkare. Så fast vi här tar upp problematiska, mörka och alltför ofta mörkade sidor, så är glädjen med yrket underförstådd i allt det jag har att säga. Att komma till tals med det problematiska är för seriösa läkare det bästa sättet att behålla arbetslusten, yrkesstoltheten och utveckla sig i yrket.

Vi läkare är precis som andra människor. Vi behöver uppskattning och bekräftelse. Vi är ängsliga för att bli kritiserade och aggressivt bemötta. Vi är rädda för att göra fel och skäms vid tanken att kollegor och patienter skulle ringakta oss eller tycka att vi är udda. Många av oss har en lättaktiverad skuldmedvetenhet, som förstärks av att vårt handlande gäller människors väl och ve. I en del specialiteter är frågan om liv och död dagligen närvarande. Ett visst mått av ensamhet är oundviklig för alla som tar eget ansvar och har en relativt självständig ställning Men jag vill hävda att det finns en tendens bland läkare att göra sig alltför mycket ensamma med de känslomässiga aspekterna i det kliniska mötet med patienterna.

Goethe säger: ”Det man inte kan uppnå flygande får man halta sig fram till” (Was man nicht erfliegen kann, muss man erhinken). Men det är också mycket mänskligt att som läkare tro att man flyger fast man haltar - om man har en *alltför* präktig självbild. Tage D säger: ”Utan

tvivel är man inte riktigt klok”. Så vad händer när en sån läkare upptäcker den haltande verkligheten? Eller är det bara hans patienter som haltar och kraschar?
Så finns också kollegor som underskattar sig själva och tror att de *ständigt* haltar sig fram fastän de gör ett gediget jobb. Med alltför mycket tvivel riskerar man också att förminska sin roll som doktor – att inte förstå sin betydelse för sina patienter.
Det är också viktigt att ägna en tanke åt vad patienterna betyder för läkaren.
Mötet med våra patienter har många bottnar. Det är oftast en *ojämnlik men ömsesidig relation* som kan vara adekvat men också kan innehålla:

- brist på normal lyhördhet
- irritation, osäkerhet, förvirring, hjälplöshet
- ångestdrivet eller skuldmedvetet agerande i st f lugn klinisk närvaro
- förtjusning och förälskelse
- medveten manipulation inkl. förförelse
- skuld och genans
- diffus olust

Detta kan vara tydligt för läkaren. Han/hon känner helt enkelt inte riktigt igen sitt normala professionella jag. Men det är också lätt att glida förbi dessa känslomässiga aspekter av mötet med patienten. Då ombildas de lätt till mer eller mindre förtäckta motreaktioner . …..
Om defensiva förhållningssätt tar *för stor* plats ser jag det som en tydlig varningssignal på skevhet i vårdkulturen, att känslor inte hanteras adekvat i den kliniska arbetsmiljön. Att känslor av sorg, besvikelse, kränkthet, ilska och att bli starkt berörd inte riktigt får finnas, inte tas på allvar, - och inte heller kan bli till nytta i det kliniska mötet. En sådan återhållsamhet riskerar att leda till psykisk deformering, (t ex en yrkesrelaterad karaktärsneuros.)

Det är bra att ventilera sina problem! Dorte Kjeldmands doktorsavhandling 2006, visar bl a i en kontrollerad studie att allmänläkare i Balintgrupp mår bättre och har större arbetstillfredsställelse. Kjeldmand har inte kunnat visa vilken effekt detta har på patienterna men det är rimligt att anta att detta också gör att patienterna får ett bättre omhändertagande.

Balintgrupparbetet är *fokuserat* på läkar-patient-relationen och det övergripande målet är att minska oklarheten om vad som pågår i behandlingsrummet så att läkaren ska kunna arbeta vidare på ett bra sätt med sina patienter. De flesta av oss har väl märkt, att kan man bara formulera problemen och ställa de rätta frågorna till en lyssnande omgivning, så ger sig

svaren ofta nog av sig själva. En respektfull och kollegial diskussion kan göra att läkarens professionella manöverutrymme vidgas.
Grupparbetet leder oftast till både en ökad enskild integritet och ökad samhörighet. Allt detta tar man med sig tillbaka till sin mottagning.
Läkaryrkets många glädjeämnen kan också delas i en Balintgrupp. Och glädjen i sig att samarbeta med kloka, erfarna och engagerade kolleger.

Två texter ur 2006 års Skrivartävlan

Som vi meddelade i förra numret kom det in inte mindre än 29 bidrag från 27 författare. Första priset **"Skopi med förhinder"** i av **Elisabeth Hultcrantz** och /andra priset**"Under text"** insänt av **Inge Carlsson**. Publicerades i Paraplyt resp. Bulletinen och finns att också att läsa **www.sfmp.se/verksamhet/skrivartävlan**
Vi presenterar här två av de sex bidrag som fick hedersomnämnande:

Kerstin Wallins **"Historien om Greta och Johan"**. "I berättelsen möts ålderdom och ungdom, friskt och sjukt, styrka och svaghet, och
Anna Lindblads **"Betraktelser från tvåmanstält"**. "- en sparsmakad måltid för hjärtat. Tre insikter och en avslutningning, som ger livskraft."

Samtliga åtta pristagares texter finns på vår hemsida www.sfmp.se

Kerstin Wallin **"Historien om Greta och Johan"**. "I berättelsen möts ålderdom och ungdom, friskt och sjukt, styrka och svaghet

Historien om Greta och Johan

av Kesrtin Wallin

Greta finns, men har inget personnummer.

Johan finns, men han har inget anställningsnummer.

I mitt uppdrag som familjeläkare ingår att vara sjukhemsläkare och med åren har den erfarenheten formats till berättelsen om Greta.
Jag har sett både kroppsligt och själsligt förfall, men det jag minns bäst är de gamla med integritet och livsvilja, trots närheten till döden.
Jag har också i mitt hjärta gömt de nya, unga vårdbiträdena, ännu inte skumögda av bitterhet eller trötthet. De finns i verkligheten i Sverige just nu tillsammans med de äldre och kloka.
Jag känner en stark önskan att visa på det som utspelar sig i det tysta, i den dolda världen, långt ifrån TV-såpor och lyxkrogar.
Djupast önskar jag en väckelse för det mänskliga, för ömhet och respekt i vården.
Johan och Greta finns.
Greta och Johan skall samarbeta till livets slut.
Deras gemensamma nämnare är livet, men också döden, den enda möjliga utgången.

Greta sitter i en sliten karmstol på sjukhemmet. Utanför fönstret faller skymning, inne i rummet lägger sig ett grått täcke av tristess.
Det spritter till i kroppen, hon har nickat till. Hon borde tända en lampa, men kommer inte upp ur stolen. Blöjan har hamnat snett. Det känns fuktigt och kränkande.

Suset från dörren drar förbi som ett luftdrag och den nye pojken, Johan, kommer in i rummet.
Han är ung, har finnar i ansiktet och klet i håret, så där att det ser vått ut.
När han har bråttom är han hård i nyporna, men han har snälla ögon och han pratar med henne som om hon är klok i huvudet.
”Jag skall hälsa från Karin, hon ringer igen. Du sov när hon ringde.”
Besvikelsen är oproportionerligt stor. Hon ringer ju igen.
Karin, enda dottern, enda barnet.

Greta sitter i karmstolen med plast på sitsen och kan inte resa sig.
Hon tar tag i Johan och tar stöd av bordet. Den mörka fläcken baktill är stor.
Hon hör hans suck, som han tror inte hörs, och han leder henne mot duschen.
”Vi får ta en kvällsdusch i stället för morgondusch,” säger han, utan att vara ovänlig. Han verkar medveten om att hennes yttre förfall inte motsvaras av ett inre.
Hon lever i en obalans. Det är bara klänningen som är i balans, hopplöst mönster, blekt. Ägg och sås fram, kissfläck bak.
Hon känner att förtvivlan är på väg och tittar på Johan och säger tack, hon vet inte för vad, fast jo, hans medkänsla.

I duschen känns det inte så oävet, fast hon har tappat känslan för att hålla sig ren. Någonstans längs vägen blev det för besvärligt, behövdes för mycket hjälp.
Gretas tunna, toviga vita hår kan aldrig mer bli vackert.
Hon undviker att tvåla in sina bröst, särskilt det högra, där knölen sitter. Hon vet att det är cancer, vad skulle det annars vara?
Doktorn var här, ung och hastig, ville att hon skulle till sjukhuset, undersökas och opereras.
Greta svarade att hon kommer att dö av annat, innan cancern får grepp om henne.
Döden skrämmer henne inte längre. Hon ser och känner hur kroppen sviker henne, bryts ned.
Greta känner däremot inte av själsligt förfall. Nyheterna intresserar henne fortfarande och Sverker, dottersonen, har skaffat henne CD-spelare och talskivor.
Sedan motståndet inför tekniken lagt sig, har hon börjat njuta av att höra en okänd människoröst läsa högt för sig.
Hon blir glad när hon tänker på Sverker. Omtänksam är han, ringer henne ofta och småpratar om riktiga saker.

Greta kallar honom ”den nye”, fast han arbetat där i nästan ett år.
”Jag heter Johan,” rättade han henne den första tiden. Johan tänker att Greta retas med honom.

Hon tänker mycket, har han förstått. När han var alldeles ny blev han förvånad när de talades vid. Då och då citerar hon psalmer eller långa stycken ur Bibeln, fast hon inte ens är religiös.

”Vårt liv varar sjuttio år eller åttio år om det bliver långt; Och när det är som bäst, är det möda och fåfänglighet, ty det går snart förbi, likasom flöge vi bort.”

Johan känner sig sorgsen när han hör hennes röst genom duschförhänget. Orden gör honom arg också. Han avstår att tala om vad han känner och blir gladare när han bestämmer att stjäla sig tid tillsammans med henne. Han förstår hur trist hon har det.
”Jag har ett rikt inre liv,” säger hon bakom duschdraperiet, som om hon läser hans tankar. ”Jag är klar nu”, fortsätter hon och han hjälper henne upp från pallen som står i duschen. Hon är mager och skranglig, ryggen är sned och krum.
Johan sveper en ren badhandduk om Greta och leder henne försiktigt mot sängen, där han lagt fram rena underkläder tillsammans med finklänningen.
”Firar vi något, Johan?”
Han blir generad över den nästan högtidliga stämningen.
”Jag har litet extra tid innan jag går av. Susanne arbetstränar, så vi är en mer än vanligt. Tänkte vi skulle fika och fördärva aptiten till kvällsmaten.”
Greta känner något som liknar glädje och hon ser länge på den unge mannen med håret som ett rufs, ring i örat, inget skägg.

Sänglampan och bordslampan är tända. De sitter tysta, var och en i sina tankar. Sockerkakan smakar gott. Hon spiller inte. Greta tuggar med egna tänder och tycker om att sitta i stillheten med en människa nära, den nye, Johan.
”Jag tror jag vill vila litet före kvällsmaten,” säger hon och känner av yrseln igen.
Johan lägger yllepläden över henne och stoppar om. ”Tack, säger hon, tack, att du tar så väl hand om mig.” Han vänder sig om i dörren, sänglampan lyser svagt. Greta har redan somnat, men Johan ler mot henne.

Han försöker väcka henne till kvällsmaten, men hon vaknar inte.

Karins familj kommer och rummet fylls av många ljud; snyftningar och gråt, beskäftiga kommentarer, mummel, allt blandas tillsammans med de praktiska bestyren.
Sedan blir det alldeles stilla.
Syster Magda har tänt ett ljus och lagt blommor, skarpt lila astrar, i Gretas händer, så tunna, så

kalla.
På nattduksbordet ligger ett papper med grön text, karbon emellan, dödsbevis står det.

Den unga kvinnliga doktorn har kommit, lyssnar på hjärtat, länge, lyser i ögonen med en ficklampa, känner, granskar.
”Jag gör det noga, så att jag alltid kan sova gott. Jag vet att ingen av mina patienter vaknar upp på bårhuset och hittas död med blodiga nävar, efter att ha bankat på bårhusets portar.”
Hon ler ända upp till ögonen. Hon kan också läsa tankar. ”Hur känns det?” frågar hon. ”Bra”, ljuger Johan.
Han stirrar på Greta, ser efter om bröstkorgen rör sig och tycker att han ser en sockerkakssmula i höger mungipa. När ögonen tåras måste han blinka. Han minns alldeles tydligt hur det lät när hon andades för någon timme sedan.

Det är bedövande tyst i rummet. Bara väggklockan hörs. Pelargonen i fönstret rör sig i vinden, som tar sig in genom fönsterspringan. Syster Magda har släppt ut Gretas själ.

Johan tänker att änglarna är här för att hämta Greta:
”*ty det går snart förbi, likasom flöge vi bort.”*

Betraktelser från tvåmanstält
av Anna Lindblad

Skeppsbruten

Jag är en av de där kvinnorna i vitt som skyndar förbi i sjukhuskorridoren. En av dem som alltid ler och sällan ger upp. En sån som blir kallad ”lilla vän” av de manliga överläkarna och vars rock alltid är minst fyra nummer för stor.
Men jag är inte bara läkare, utan också patient. Jag drev mig så långt att min kropp till slut gav upp. Jag, som alltid har orkat en liten bit till, hade plötsligt inga krafter kvar.

Det är sällan rea på insikter. Det gick många svarta dagar innan jag kunde möta patienter igen. Ännu längre dröjde det att känna lust inför arbetet. Lätt kantstött, men med ett annat lugn, rör jag mig nu genom kulvertar och korridorer. Och när jag ler kommer leendet från hjärtat.

De här texterna kan läsas som korta betraktelser eller vykort från resan in i sjukskrivningen och vägen tillbaka.

Var sitter det onda

Smärtan i dina muskler, kommer den från din hemstad? Eller är det språket som pinar dig, oförmågan att kunna uttrycka precis just det som du egentligen vill ha sagt? Yrseln, kommer den av alltför många krångliga papper, komplicerade regler, nya system? Du har ont i magen. Tål du inte mjölken, avskildheten, tristessen, väntan på något, ett jobb? Eller är du faktiskt sjuk, kan jag hjälpa dig?

Historia

De flesta skriver inga memoarer. Deras berättelser kan bara anas i journalernas sparsamma prosa. Vår tids människoöden dokumenteras helst kortfattat i sjukhusens datasystem. Men inom varje läkare döljer sig ett bibliotek av ansikten och hemligheter, omsorgsfullt skyddade för insyn.

Att handla mot sin övertygelse

Han har druckit i 40 år och minns inte om han har kissat idag. Armen är blå och hänger i ett förband, men trots frakturen känner han ingenting. Han säger att han inte vet hur armen gick

av. Jag är psykjour och träffar honom för att han har druckit i 40 åt. Ortopeden tycker inte att de har något mer ansvar för honom; han har ju fått sitt förband och om hemsituation är ohållbar är det i alla fall inte deras sak. I remissen till psykkliniken står det att de vill att han rehabiliteras. Men från vad? Från benbrottet som förde honom till sjukhuset eller från 40 års alkoholmissbruk? Inget av dessa två är akutpsykiatriska tillstånd. Jag kan inget göra. Avdelningen måste spara sina platser till de verkligt suicidala, psykotiska, maniska patienterna som också kan komma under denna jour.
Jag säger till patienten att han har rätt till god somatisk vård även om han är alkoholist, men han ser inte särskilt hoppfull ut. Han får återgå till akuten för beslut där. I efterhand får jag höra att patienten skickades hem, trots att ingen trodde att han skulle klara sig själv.

Det skär fortfarande i hjärtat när jag tänker på honom. Jag utlovade god vård, men han fick ingen. Kunde jag ha gjort annorlunda? I ett system där var och en tvingas sköta enbart sin egen begränsade uppgift är det de utsatta och mest hjälpbehövande patienterna som faller mellan stolarna.

Tvåmanstält

Landstinget förser sina anställda med uniform. Byxor och bussaronger i neutralt unisexsnitt finns för varje kroppsform. Bara läkarrocken skvallrar om status och kön. Sydd efter manliga mått i storlek 44-56 signalerar den tydligt vad som är norm. Varje kvinnlig doktor som har försökt att hitta en rock som passar vet att det är lönlöst. Vi kommer ut ur linneförrådet iklädda tvåmanstält, med fickorna hängande i knähöjd.

Lilla Anna och långa farbrorn

Överläkaren frågar personalen om de har sett den lilla flickan. Han menar mig. Jag är medicinjour på ett länssjukhus och året är 2003.

En tid senare vikarierar jag som distriktsläkare i Stockholm. Jag ber en sköterska om assistans, och inför patienten undrar hon vad ”lilla doktorn” vill ha hjälp med.

Sverige är ett av världens mest jämställda länder, men kvinnliga läkare är fortfarande långt ifrån självklara.

Arbetsglädje

Det gäller att klara måndagens första timmar fram till lunch, för då vet man att resten av veckan kommer att gå bra. Så brukar det ju vara. Måndag efter lunch väntar man på kafferasten, och därefter på att få gå hem. Tisdag och onsdag tragglas igenom med vissheten att torsdagens schema är luftigare. Dessutom närmar sig arbetsveckans höjdpunkt: fredag. Fredagsfika och tidig hemgång. Bara orka skyffla undan sista arbetet före helgen. Lördag och söndag är så korta! På lördag kväll kommer tankarna på jobbet och på söndag är väskan redan packad, redo för en ny måndag då man måste orka fram till lunch. Så drar man sig fram, alltid bara en liten bit till.

Naturlig selektion

Läkare går långa jourpass på akuten och berättar gärna efteråt om hur man har ”skottat i gruvan”. Vi är mammas duktiga barn och vill gärna ha beröm.
Ibland beklagar sig kollegor över arbetstiderna, men det är sällan utan en illa dold stolthet. Så snart det talas om att avskaffa joursystemet hörs ljudliga protester. Kårens machohjältar kämpar till sista blodsdroppen för rätten att jobba ihjäl sig.
De som inte orkar med tempot sållas ut i sann darwinistisk anda. Hur många läkare ska behöva sjukskrivas, ta livet av sig eller byta yrke innan vi accepterar att doktorer är helt vanliga människor?

220 poäng senare

I skolan lärde vi oss inte hur man hjälper människor som har ont i kroppen, men vars lidande sitter i själva livet.
I skolan lärde vi oss inte hur man hjälper människor som ifrågasätter oss från allra första stund.

I skolan lärde vi oss inte att hjälpa varandra när arbetet blir alltför tungt.

Om vi åtminstone hade lärt oss att vi duger.

Tårar på toa

Utan marginaler behövs det inte mycket för att börja gråta. Hur många trötta doktorer gömmer sig inte på toaletter och i omklädningsrum medan tårarna rinner. Några minuter i ensamhet, kallt vatten i ansiktet, ett djupt andetag och det går att arbeta en dag till. Men säg inget till någon annan. Kring ämnet sårbarhet råder sträng sekretess.

Läkare hjälp dig själv

Det finns en gräns för hur många gånger en människa kan rycka upp sig och ta sig i kragen. När jag till slut söker vård föreslår sköterskan i telefonen att jag ska skriva ett recept till mig själv i väntan på en läkartid.

Jag får träffa en doktor på vårdcentralen. Han är en upptagen person, men ger mig medicin, en sjukskrivning och en telefontid. Efteråt känner jag mig värdelös, som om jag borde ha klarat det här på egen hand.

Insikt

När man ligger stilla kan man inte ta livet av sig. Det är en stor tröst när allt annat känns hopplöst.

Insikt 2

Jag finns även när jag inte presterar.

Insikt 3

Det är ögonblicken som gör livet uthärdligt.

Långt senare

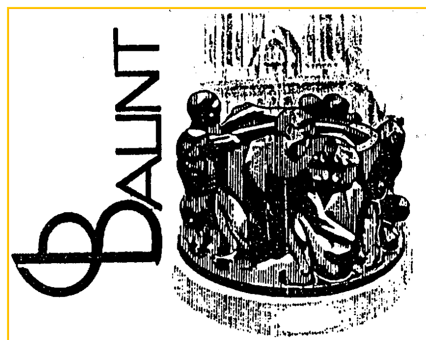
En dag blir jag sugen på en viss sorts mat.
En dag skrattar jag för att något känns roligt.
En dag ser jag att påskliljorna är väldigt gula.
En dag blir jag nyfiken och vill inte längre dö.

Vitaminer

Rehabiliterad och åter i arbete träffar jag en patient som frågar:
Hur kan jag vara psykotisk när jag ser så frisk ut?
Tanken slår mig att vissa samtal är som poesi. Näringsrika.

KALENDARIUM

1. **Balint School, Dubrovnik 2-7 juni 2008**
2. **Danska Balintsällskapet Selskab for samtale og supervision i almen praxis 11-13 sept 2008**
3. **IBF council meeting Leiden 18 oktober 2008**
4. **IBF World congress aug 2009, Brasov, Rumänien**



Balint group: sensibility to the unconscious

("Muradif Kulenović" School of Balint Method)

June 2-7, 2008

Course Description

Participants in Balint groups follow the ideas, and benefit from the experiences of Michael Balint. The main goal of this course is to study the doctor-patient relationship rather than the interaction between the participants in the seminar. Not all those who follow Balint's ideas will be involved in teaching the theory of Balint groups, but all aim to help doctors to become more flexible and better observers of both themselves and their patients, so that their treatment of patients is more efficient and reliable.

Balint group members explore and emphasise the psychological and emotional aspects of their work with patients and recognise their importance, especially of that part which is still often denied, namely the unconscious.

Course Directors

Sanja Blažeković- Milaković (University of Zagreb)
Heather Suckling (University of London)
Kornelia Bobay (University of Budapest)
Stanka Stojanović-Špehar (University of Zagreb)
Marie-Anne Puel (University of Paris)

Resource Persons and Participants

Because of the essential nature of the course it will be apparent that all those attending are in a real sense the resource persons. This invitation to participate is addressed to all individuals who are or would like to be actively involved in Balint group education. There will be time each morning for 1 or 2 "short papers" (presentations lasting for not more than 10-15 minutes followed by discussion.) Audiovisual equipment will be available. Please contact the organisers if you wish to present a short paper.

General Information

The course is designed as postgraduate level, it runs over one week with scheduled morning and afternoon sessions.
Venue: the **Inter University Centre, Don Frana Bulica 4, 20000 Dubrovnik** tel: 385 (0)20 41 36 26
Language: the working language is **English**.

The educational activities begin promptly at 09.00 on Monday 2nd June.

Each day will start with the presentation of a short paper by one of the participants after which there will be small group work (Balint groups.)There will be free time to explore Dubrovnik. There are many activities to enjoy in Dubrovnik in the evenings with some excellent concerts. Those interested in taking the course are requested to complete an application form that can be obtained from - MSc Stanka Stojanovic-Spehar,MD, Secretary of Croatian Balint Association.

The IUC will issue a Certificate of Attendance.

Course fee:

Upon arrival to Dubrovnik the participants will be asked to pay the Course fee in Croatian Kunas equivalent to 100 Euros

Accommodation:

The following hotels are recommended, please book directly with the hotel.

	Single room
Hotel Lero*,**	91 euros
Hotel Bellevue****	238 euros
Hotel Rixos Libertas *****	338-2003 euros

Hotel Lero*,** Iva Vojnovića 14
Tel.:+385(0)20 341-333
Fax:+385(0)20 332-123
E-mail:
booking@hotel-lero.hr
sales@hotel-lero.hr
groups@hotel-lero-hr
www.hotel-lero.hr

HOTEL BELLEVUE****
Pera Cingrije 7, 20 000 Dubrovnik
Tel: +385 20 330 000
Fax: +385 20 330 100E-mail:
welcome@hotel-bellevue.hr

Hotel Libertas Rixos*****
Tel: +385 / 20 / 33 37 20
Fax: +385 / 20 / 33 37 23
E-mail: libertas@rixos.com

Hilton Imperial Dubrovnik*****
Marijana Blazica 2, Dubrovnik, Croatia 20000
Tel: 385-20-320320 Fax: 385-20-320220
www.dubrovnik.hilton.com
E-mail: sales.dubrovnik@hilton.com

If you prefer, you may book through … GULLIVER TRAVEL, d.o.o.
O.S. Radića 32, Dubrovnik, Croatia,
E-mail:**ivona.sokol@gulliver.hr,**
who arrange bookings for the Inter University Centre.

For further information please write to:

The School Course Director is Prof.dr.sc. Sanja Blažeković-Milaković, “Andrija Štampar” School of Public Health, Medical School University of Zagreb, 10000 Zagreb, Rockefellerova 4, Croatia,
phone +385 1 4590 100.
E-mail: sanja10@net.hr

OR

MSc Stanka Stojanovic-Spehar,MD, Secretary of Croatian Balint Association.
Dragutina Golika 34a, 10 000 Zagreb, Croatia
e-mail: stanislava.stojanovic-spehar@zg.htnet.hr

Om supervision og samtalebehandling

Klitgaarden

Formål og indhold: På kurset diskuteres, demonstreres og superviseres samtalebehandling ud fra en psykoanalytisk forståelsesramme.
En del af kurset vil indeholde supervision af supervision som en nødvendig og integreret del af samtalebehandlingen.

Kurset er baseret på deltagernes medbragte bånd- eller videooptagelser af samtaler og vil foregå i en større og to mindre grupper.

Det er en fordel at have læst Torben Bendix´s bøger "Din Nervøse patient" og "Giv mig en tanke…" inden kurset. Søren Kaltoft & Lars Thorgaard: " Lægen som lægemiddel" vil danne grundlag for temadiskussion.
Et lille hæfte om supervision, Torben Bendix: "Tanker, tips og tommelfingre" vil blive udleveret på kurset.

Målgruppe: Kurset henvender sig til nybegyndere og erfarne, yngre læger, praktiserende læger og andre interesserede, der arbejder med samtale og supervision.

Form: Internatkursus. Højst 16 deltagere.

Undervisere: Overlæge Tove Mathiesen, Randers og overlæge Erik Pedersen, Herning.

Tid: Kl.13, torsdag den 11.september til kl.14, lørdag den 13.september 2008.

Sted: Klitgaarden, Skagen

Kursusafgift: For medlemmer kr. 7000,- for ikke-medlemmer kr. 8000,-, Yngre læger kr.3.500,- ***der skal indbetales senest 1.juni 2008*** på selskabets bankkonto 1199 60012733 eller per check vedlagt tilmeldingen.
Der ansøges om tilskud fra efteruddannelsesfonden.

Tilmelding og yderligere oplysninger: Tove Mathiesen, Lokalpsykiatri Djursland, Hovedgaden 61, 8400 Rønde E-mail: tove.mathiesen@dadlnet.dk , tlf. 7789 6800

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IBF Council Meeting och mini-Balintkonferens Leiden 18 okt 2008
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16th International Balint Federation World Congress, Brasov, Rumänien, aug/sept 2009,
, se www.balintinternational.com

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