Beyond Balint: a group analytic support model for traumatised doctors

Introduction

The UK Primary Care Reforms over the last two decades are a symptom of global economic and political change. The identity crisis of the professions is linked to the decline of the primary and secondary sector in the economy, and the need of the overall system to squeeze growth and efficiency out of the remaining tertiary service sector. For the last 20 years professionals in western countries have been subjected to a process of 'proletarianisation'; their vocation is, in part, turned into a surplus producing market operation. These changes in the *environmental mother* (Winnicott, 1965) of society, on whose support professionals rely, are a result of the altered ideological climate of the post cold war age with its emphasis on de-regulation, free market determinism and the concrete thinking of an audit culture.

Self-Care before patient care

The process of treating what professional work as suspect until it has been proven to be of value through a process of validation, re-accreditation and evidence collection, has been experienced by many

doctors as a narcissistic injury. General Practitioners (GPs) I worked with in supervision felt ashamed. “Lesser people than themselves” had destroyed their grandiose professional ‘self-object’ and exposed their fear of being flawed and at risk of disgrace. Whilst the process of being “measured and weighed” in scales devised by politicians and managers exposed unconscious exhibitionist wishes in the GPs, the main effect was that they were driven to defend against being shamed by projecting feelings of denigration on to the *feared other*. The objects of projective identification became National Health Service (NHS) managers and their paymasters, the politicians. These two groups, on whom doctor and patient depend for resources, became the ‘despised and feared’ enemy.

Although the occurrence of shame was perhaps a symptom of these GPs making their peace with the system that persecuted and needed them, working with the doctors in a group felt like being in the presence of *trauma.* After the first primary care reform in 1990 GPs resorted to *us and them splitting* due to their need to retain a fragile sense of professional identity. They needed enemies in order to achieve a minimal sense of professional group cohesion; they tended to feel persecuted by new ideas and encapsulated their painful memories of loss and change. They found it unbearable to remember the trauma of losing their ‘unthinking dependence on the health system’.

The UK Health Reforms implied a re-definition of what is sacred and profane in the doctor - patient relationship. GPs can sometimes work through the traumatising effect of the recent health reforms and recover the capacity to care for themselves and their patients in a supervision group that addresses their vulnerable state. Group analysts have a group conducting model that can help move doctors and supervisors beyond the established Balint model. GPs have been subjected to repeated and ever faster re-structuring processes which leave them traumatised and speechless. They are therefore in need of a space in which re-enactments are permissible whilst the continued need for the classic Balint case reflection can still be met. An exclusive focus on the study of the transference and counter-transference between doctor and patient no longer meets the primary needs of struggling doctors. The GPs self care is now the best and fastest route to better patient care in a context of permanent transitions. Experiential learning groups for doctors need to focus on the patient – doctor relationship, the doctor – staff dynamic, the doctor – doctor partnership arrangement and the doctor – system link. The group analytic group, without a focus on both the doctor-patient relationship and the reform agenda but with a guarantee of a genuinely open and protected thinking space is in future the appropriate way to help doctors to work maturely with the system and to achieve a healthier life –

work balance. When these areas of a GPs life can find a place in supervision, the needs of patients, who no relate no longer to a single GP but a group of general practitioners, can be met more effectively.

Beyond Balint

The Balint model is based on an idealised doctor-patient relationship. Support consists of an exploration of the transference relationship between patient and *family doctor*. It is assumed that the doctor and the patient can develop a long-term relationship which functions like a holding environment and thereby reduces the anxiety in the patient, allowing the doctor to become a kind of transitional object for the patient. The Balint group tried to improve the doctor's ability to make sense of transference phenomena. GPs use this knowledge to make themselves available as an internalisable good object, a kind of *intra-psychic-medicine*, during the *six minute consultation*. (Balint et.al.1993) General practice has changed so fundamentally that the focus of supervision can no longer be the transference and counter-transference between doctor and patient. The Balint model of maximising what the doctor can do and be for the patient needs to be turned on its head. It is the doctor, traumatised by too much change over too short a period, who is in need of good enough care in order to go on looking after patients. In the absence of good enough organisational parenting, an open and protected

thinking space in a supervision group can become a transitional, parental object.

Doctor and patient no longer meet in a dyadic setting, both are located in a group matrix; patients in any practice see a number of doctors over time and develop an attachment to the partner group and their most and least favoured GP, the *idealised and denigrated object*. The *sacred space* between patient and doctor in the consulting room is no longer protected from public view; the interaction between doctor and patient is subject to audit, quality control and evidence based practice. This change is traumatic and has given many GPs the feeling that they are the *unwanted and denigrated children* of their *NHS mother*. In response to the loss of the nurturing environmental mother, many GPs have developed an intra-psychic defence which is reminiscent of *survivors* of trauma who feel guilty and ashamed of their existence and project their distress into external objects.

In a kind of perverse role reversal GPs in the role of the victim of modernisation often develop a grandiose defence which runs thus: 'I must be very important because my persecutors in politics and management need me so much that their own survival depends on my self-sacrificing victim role.' The stance of being the carer of the failing *environmental*

mother of the NHS is indicative of deep seated guilt and shame. Many doctors feel that they have taken the system for granted and abused it. For a long time they have split off the fear of retribution and the wish for reparation. Within this *disturbed organisational context*, doctors, in situations where they are called upon to be mature partners, no longer feel contained and do not function as the container. Inside they experience a sense of abandonment and an urge to vent their *impotent* rage. The loss of a *nurturing* environmental Health System and the need to cling to a *persecutory* organisational parent, are experienced as an attack, threatening the integration of the professional self-ideal.

The primary care sector mirrors larger events in the foundation matrix of the current world. Anthony Giddens (1999) has described globalisation as a process of dis-embedding in which we are separated from our *taken for granted assumptions* about social order and social identity. As health reforms are linked to the global and neo-liberal agenda, we can no longer rely for security on what we learnt during our professional socialisation. Being a doctor has become a *reflexive project.* The fear of re-traumatisation is ongoing: Doctors have to re-invent themselves in social situations that they cannot control and which force them to negotiate with other social actors who they regard as less important than themselves. Any change of this magnitude produces the need in individuals, teams

and whole organisations to adjust their way of working and their sense of being in social time and space.

The way Anthropologists conceptualise culture can help us make sense of what the relative ordinariness of the currently extra-ordinary rate of role adaptation among professionals might involve. Writers like Cohen (1995) say that culture with a capital C does not exist: an object, out there, facing the individual like the mass faces the Ego in Freud's account of mass psychology and ego development. In Cohen’s view, we are the culture, the culture is us and we live in a series of matrices of meaning that we weave, and we are woven by, through daily interactions. The form of a professional organisation and its culture is therefore an act of re-creation, an ongoing group process.

Paradoxically, change processes simply confront us with what is normal, that an organisation depends on our ability to re-make it in the image we have projected onto it through our inter-action in group settings. Each social encounter amounts to a mastery of our fear that we will not be contained and will be sucked into chaos, trauma and madness. If the organisation itself, if our status, rank and identity within it are a reflexive process then it makes sense to conceptualise supervision along the lines of a free floating dialogue in a group analytic setting and not adhere

firmly to the case presentation model. The search is for a tolerable connection between a social self (professional identity) in need of repeated adaptations and a core self (personal identity) looking for continuity and re-assurance and acceptance.

Mid-Life Crisis of Primary Care

Organisations are subject to a life-cycle. Primary Care is currently in a mid-life crisis and each person working within it has to do the psychological work appropriate for this transition. (Wilke, 2001) The NHS mother organisation and its professional members have to process the traumatic loss of an idealised past and self-image. The task of mourning involves separating from a self - regulatory system and attaching to an economically audited and controlled service. GPs have descended from a god-like status to become a mere cost factor. Being subject to re-accreditation has had a traumatising effect on the profession because it institutionalised this degradation. Rather than re-awaken professional curiosity in GPs, professional development and regular re-accreditation produced symptoms of *encapsulation* which can only be accessed through regression and a free associative process in a group. Earl Hopper (1997) has shown in his writings on the Social Unconscious that there is a link between encapsulation and failed dependency. Traumatogenic reactions to overly intrusive change and loss are

associated with a fear of annihilation and fragmentation. What has been experienced as too traumatising is too painful to remember. Instead of the ability to remember and mourn, a propensity to enact and to embody traumatising losses of professional pride came to dominate the London GP supervision groups I have run.

In these experiential groups GPs were not objectively threatened with extinction but they felt that their professional identity had been irreparably damaged, that their medical identity was leaking away. They felt abandoned by a health system that needed them and that they deeply loved. The double bind made them speechless when it came to voicing their own needs and desire for help and mutual support. Instead of owning their own *paranoid-schizoid* state, generated by their perceived lack of status and respect, they enacted their need for acceptance and recognition by attacking the group as mother and the conductor as father. Through their *hate in the counter-transference* (Winnicott, 1975) they were looking to restore a sense of normality. Unconsciously they worked on creating or splitting a parental couple in the hope of returning to some structure that was dependable and offered sufficient security to face up to the hardest part of the work of mourning and reparation: their own collusion in bringing the traumatising events about.

The persistent message from the NHS to doctors to *grow up* and to become less medical and more social in their orientation has for some years been experienced as an attack on their core professional identity. Audit and re-accreditation are generally seen as an intrusion into the previously sacred and private space of professional discretion and judgement. GPs often start a conversation with self- deprecating phrases and reveal that they have split their ego and over-identify with the half that is bad and undeserving of recognition. The valence for this true and false self scenario is set up by the foundation matrix of the medical career structure. Acceptance within the medical profession is based on a self-destructive split into idealised hospital doctors and denigrated general practitioners – some doctors live the full promise of medicine and others carry the trauma of failure and the helplessness of working in the face of chronic decline in many patients.

NHS reformers collude with this divisive career system when they develop a modernisation language that splits people repeatedly into us and them groups. Under the Tories (Conservative Party) fund-holders were with us and non-fundholders were not; under New Labour (Labour Party) GPs are willing to modernise or are closet conservatives who function to stop the primary care paradise from being ushered in. The *drivers* of change at the top of the NHS have a propensity to cast doctors

in the role of naughty children. A traumatising dynamic between a helpless child and an over-demanding NHS mother develops. The managers become the evangelists and *single-handed* GPs (family doctor without GP partners) embody the pre-modern age and are in *refusnik* mode when it comes to forcing doctors into group practices. The primitive pair of modernising hero and pre-modern anti-hero represents an unconscious attempt to create a *perverse* parental couple in the hope that it can re-vitalise a lost sense of connectedness and social cohesion which makes it safe again to differentiate into roles and hierarchical levels within the primary care group.

The NHS, has for two decades, been subjected to a Cultural Revolution. The modernisation cadres hang onto control, the quality religion and an overly zealous complaints and evaluation procedure. The ideologically driven modernisers are themselves subject to unrealistic expectations and cope with their own sense of being unable to meet the high 'stretch targets' set by the government by enacting a split self. The true self is reachable in a coaching session when the fear of being unable to meet the demands of the organisational parents can be owned in private. The false self is enacted in public, when faced with their own managers and with the resisters of change management schemes. The split in the self is defended against by a flight into busy, busy, busy mode. If, like me, you

have experienced managers in both settings, you end up feeling that they are in the grip of manic-depressive symptoms. Why should this be so? The manic pursuit of unrealistic targets by the managers, in order to cover their own backs, produces a very high level of anxiety and a deep failure in the containing function of the organisation. The moral panic associated with this pattern of interaction comes to the fore with the NHS when a mistake has been made and the ensuing public promise is made that "this will never happen again". A promise that the NHS spokesperson can make, the procedure manual can prescribe but the doctor and the patient can not keep in real life. So, it will happen again and the taboo of acknowledging the essential uncontrollability of *dis-ease* puts general practitioners and their managers in a distressing double bind between ideal and reality. The depressive position can only be owned by those in charge in the secluded and strictly confidential environment of a coaching session, re-enforcing the very split into a true private and compliant and false public self, the coaching is designed to overcome.

Working in an organisation that has to change as rapidly as the Primary Care sector means that clinicians need to think organisationally and managers need to observe, think and lead with *clinical* and political sensitivity. Doctor and Manager are paradoxically the potential self-object for each other. Every doctor has to integrate the roles of potent

leader, grown up follower and responsible politician. Without reflexive learning and support, these adaptations in professional identity and ways of working are hard to accomplish. In this context, supervision best takes the form of an open group analytic group, without the restraint of focusing exclusively on the doctor – patient relationship.

Many GPs, who have been stretched beyond their boundaries of competence by modernisation, have become what Turquet called psychological *singletons* (Turquet, 1975), only capable of defending their own psychological skin, feeling abandoned by a potentially good enough *father state* and fused with a persecuting stepmother NHS. Some GPs therefore feel helpless, impotent and abused and talk as if they inhabit a totalitarian system from which one can only withdraw into a form of *internal emigration*. In the process the intention of the policy makers to bind isolated GPs in a group practice gets lost and a system which was meant to evolve a more holistic, interconnected and *joined up way of working* becomes an organisational landscape characterised by pockets of isolated singletons and disconnected sub-groups - all traumatised and engaged in survival, mutual denigration, protectionism and primitive forms of projective identification in order to *self-contain* the powerful feelings of helplessness. Their *own* NHS has, for many GPs, turned from an all providing and nurturing *environmental mother* into a *failing and*

persecuting parent; an organisational parent that puts its own needs before those of its charges. The injunctions to grow up, to face the demands of financial controlling, user involvement and managerial accountability leads in reality to new forms of dependency and social defences against lasting change. The attempt to *drive this change through* generates resistance and in this interaction the health mangers and doctors repeatedly cast each other in the role of the victim and perpetrator. Each is the naughty child, the unrealistic dreamer, the embodiment of ignorance to the other; between them they have lost the ideal of care *from the cradle to the grave* which is the foundation myth of the NHS.

Support for traumatised General Practitioners

The support task in Primary Care is now to create *protected reflection spaces* in which organisational members can re-learn to exercise their judgement and re-capture their ability to co-operate and trust. The clinically based approach to thinking about change is well equipped to deal with the chaotic and complex organisational arrangements in primary care. The group analyst who provides support in this way can help re-build lost structures for holding, containment and ambivalence. To succeed, the group analyst needs to use two opportunities offered by Foulkes's conception of the group process. This is done firstly, by embracing the group analytic view of the group which holds the

individual, the pair, the sub-group and the whole group in mind and secondly, by facilitating an unrestricted flow of communication which opens the artificial boundary of the case presentation. The Balints commanded us to focus on the doctor-patient relationship and to resist working on material from the doctor's private life within the supervision space. Traumatised individuals, be they patients or professionals, need the freedom to re-enact what they cannot yet put into words. Their group analytic supervisor needs to re-locate the problem from within the general practitioner to the network of relationships within the group matrix, against a background of society and history.

At the *workgroup* level it makes little sense to retain the doctor-patient focus in supervision. Being a mature GP currently requires the replacement of an exclusive and over-idealised medical role with a role set which includes patient care, staff management and political liaison. To accomplish the implicit adaptation in professional identity, the needs of the doctor in supervision must be put alongside the demands of the patients and the NHS system. In a recent project based in London a group of doctors were encouraged to explore their mal-adapted professional identity in 30 weekly group analytic sessions. The project was a learning laboratory to test the usefulness of the group analytic approach in the supervision context and it was assumed that the group could be run like a

clinical – cum – experiential – learning group. (Wilke, G. 2001) The word cum in this context denotes the opening of the boundary between a clinical and applied approach to group analysis.

The *Bolingbroke Project* dealt with three separate cohorts of 15 GPs. In the group sessions issues and problems which really unsettled the group members were shared, reflected on and understood at the task and emotional level. The Balint focus on the patient interaction with the doctor was one among several other reflective fields: home and work, partners and colleagues, the social unconscious as well as the process of the group in the here and now as a mirror of what could not yet be put into words. In the event, difficult patients figured largely in the joint sense making work but hardly ever in isolation from the way that their care was intertwined with reforms, audit, quality control, private struggles and the developmental history of the doctor.

Year Group 1: The shock of the new

What united the first year group of GPs was the fact that they were all old enough to have practised in the days before the 1990 primary care reform. The group had a great deal of *mourning work* to do as the loss of the good old days and the transition into the bad new days dominated the year. The demands to reform were so emotionally draining that the developmental

needs of each doctor became buried under a wish-list designed to satisfy patients or appease the modernisers. Pleasing the system had a defensive function and was a symptom of the primitive fear of being swallowed up by the reforms or, in trying to meet them, falling apart as a professional. The reaction to this existential fear varied: some GPs were hiding from the changes through denial; others were anxious to identify with the change-leaders in the role of the aggressor; yet others were in open rebellion against the system and sabotaged attempts to audit what went on in their consulting rooms. A fourth sub-group of GPs were confused by the conflicting expectations put upon them by the system and society. This group was in danger of dropping out of the profession and had little sense of their damaged, professional self-object; they were like survivors faced by a social system that appeared to them to be persecutory and unsafe.

The overall effect of the 1990 reform on GPs had been severe role-strain, generating a need to redefine the function and use of the family doctor. In phase one of the group this meant looking at a shared wish to fit their professional role into the rest of their lives. In the second phase of the group the GPs were able to let go of their predominantly resentful attitude towards the NHS when they recovered their capacity for co-operative relationships in the here and now. Subsequently, they internalised these

new forms of inter-relatedness and transferred them as coping skills into their own primary care teams.

The group offered a *transitional space* which helped each doctor regain credibility with their peers and shifted the use of the self in relationships from a defensive stance towards authentic exchange and *true - self representation*. To consolidate this shift it was necessary to open the psychological boundary between the worlds of the doctor, the patient, the health manager and the politician. As a supervisor I felt the need to work with the matrix and the foundation matrix to explore how these worlds inter-related and how tensions between these fields of activity were defended against by splitting the good matrix of the PHCT and the bad foundation matrix of the NHS. The *taken - for - granted relationship* between doctor and patient, and manager and doctor rested on the unconscious assumption that patients embody death, illness and misfortune. Doctors, in contrast, stood for health and immortality. If they were not immune to illness, they, as doctors, had only themselves to blame. This perversely omnipotent self-blame was a defensive reaction to the doctors' perception that the politicians devalued them by seeing the managers as the grown up representatives of society and the doctors as the childish embodiment of an old fashioned elite whose time had run out. The psychic pain caused by this perceived infantilisation was often

unbearable and was dealt with through encapsulation and re-enactment. By letting these primitive defences surface and by working them through in the group these doctors recovered a sense of professional pride.

Anton Obholzer (1994) pointed out that if the family, the team and the organisation are to thrive, create and survive, such groups can't ignore underlying psychic conflicts which block the system. He says that the unconscious does not have a concept of health; instead it has a deep sense of death. The first year group showed that GPs are located in the space between this external pretence and internal reality. From the point of view of these GPs patients, politicians and managers defend against a constant anxiety about mortality by perverting the health service into a *keep-death-at-bay* service. From their own point of view, these doctors provided a *continuation of life service* and felt that the health reform ignored this reality as it did not count as a legitimate outcome within the evidence based framework of quality control.

The attempt by the patients to use the doctor as a protection against the certainty of death and the doctors' wish to use the patients to fulfil their own unacknowledged neediness emerged in phase three of this group. Some of the GPs got to know their *helper syndrome* which manifested itself through an inability to satisfy their own need to be looked after.

(Schmidbauer, 1993) Instead, they displaced this desire by always caring for others, by always expressing their own unconscious neediness by being the advocate for patients. Through these explorations, group members discovered the art of boundary setting and realised that they could not escape the unconscious wish of society to shield its members from misfortune and the secret wish of the staff to be dependant on a *good parent or pair* at the helm of the primary care team. By the end of the year most group members were less needy and more at ease with themselves and their role.

Year 2: Recovering from a traumatising medical training

The second cohort revealed how the traumatic training experience of young GPs catches up with them during the transition from early-to-mid-career and profoundly influences their ability to deal with reforms. The group re-enacted some of the re-socialisation traumas associated with becoming a doctor. One trauma was the *missing adolescence* due to the pressure of taking exams and meeting parental expectations; the other was the sado-masochistic training suffered at the hands of their professional elders.

As year two was predominantly a homogeneous age group of GPs in their early to middle thirties it took on the feel of an adolescent peer group.

The group worked with splitting, shifting alliances, pairing and oedipal issues and it was hard to foster the development of a sufficiently cohesive matrix. One sub-group formed around young and middle aged women who were unsure about having babies; a second sub-group was made up of young mothers; a third sub-group consisted of young men who had become partners and were struggling to become authority figures. Last but not least, there was a split between the pair of senior lectures from the University, their peers and the group analyst who embodied the outsider who could be helpful at one moment and was cast in the role of the spy at other times. In the presence of such divergent agendas, there was a lot of jostling for power, status and acceptance between men and women, between lecturers and non-lecturers and actual and potential parent figures.

One of the most unconscious members of the group spend a lot of time testing the boundaries and the integrity of the authority figures. As in an adolescent peer group the unconscious leader of the group tried to assuage the guilt associated with wanting to kill off the parents by splitting the authority figures into one good one and one bad one. The senior lecturer from the medical school became the good mother outside the group, the group analyst the hated father in the group and the male senior lecturer got ignored or treated as one of the younger siblings. Both

the loved and hated parental object is required by the adolescent to define an adult personality - the one to identify with, the other to separate from. The process works best if the parents cotton on to the splitting process re-unite and form a holding alliance in which the feelings associated with moving from dependence into independence and interdependence can be owned, shared and discussed.

What the group members had in common was their ambivalence about being finally and really grown up. Their ambivalence about being a full partner in a group-practice and an authority figure to other staff and the next generation of students were frequently acted out in the group. For instance, one group member shared important information only with the senior lecturer from the medical school outsides the group and swore this person to secrecy. The secret was eventually revealed through a hunch by the group analyst who said that the group was blocked by a secret. He asked the group to own up or join him in a search for the taboo subject.

This intervention had two quite powerful effects. The senior lecturer owned up to having carried secrets and was unburdened. She thereby felt enabled to function as an adult member of the group again, but the group member, who had drawn her into this secret alliance, lost all trust in the group and the senior lecturer. Having discovered that mother was not

perfect, that regression into a maternal symbiosis was no longer an option when faced with the adult demands of middle age, she used a change in the senior partner position within his Primary Health Care Team (PHCT) to leave the group.

The loss of this member made me feel the ambivalence of most group members towards being an inter-dependent team member and embodying authority as a doctor. It was a great strain for these younger doctors to be both equal and unequal. The reaction to the person leaving the group was split. Some simply located the problem in the personal ambivalence of this GP towards all groups. Others blamed the group analyst for failing to hold and contain this person. Both these aspects have a bearing on the story but there is also a group dimension to be considered. The ambivalence of this GP embodied a deeper psychic conflict in each GP between the idealised team approach to general medicine and the denigrated single-handed family doctor method.

Inside each GP there is a single-hander waiting to come out and it is clear from my work in the group that sole practitioners have a lot of strengths which need to be integrated in a team approach. Equally, it became clear that partnerships do not just offer benefits but also add considerable stress to the lives of GPs. In the reformed primary care world it is at present not

really possible to integrate being primus inter-pares and one among many in a team. The group showed how painful it is to construct a balance between cohesion and coherence, communality and individual difference within a group, and how rewarding it can be when the self and group ideal can be integrated.

The outcomes of year two were significant for the group members – but, only after the monopolising and splitting group member had been lost. Her loss turned into the group's gain. Several group members restructured their careers in line with their own abilities and one took over the senior partner role. Five GPs decided to have a baby during the year and moved on from being stuck with a false choice between work and family to finding a way of combining the two. The group developed the ability to stay with the emotional part of an interaction in the here and now and in the doctor - patient and staff - doctor relationship. When the group felt more secure its members re-discovered how their ego-development had been a product of the quality of their relationship with mother, father, siblings, teachers and medical trainers. This allowed the group to recover and reflect on their individual *false* and *true* professional self. The group realised that it had reached the boundary of an *age transition* (Hildebrand, 1995) which involved a mourning - liberation process. The parts of the self that were once idealised and others that

were once hoped for had to be relinquished, mourned and internalised. This was accomplished by separating from the member who refused to belong, forming a secret alliance with mummy. By doing that this person had enacted an adolescent position from which the others were, in the end, glad to separate. When this separation from an unattainable self-ideal of eternal youth and total professional independence occurred, reality could be accepted in a new way and internal resources were freed up to become *pregnant* with creativity and new potency. As this group was, in a post-traumatic sense, very literal minded, it expressed itself in giving birth to a new generation of five babies, by separating from the assigned group role of rebellious adolescent through the act of leaving the *as if family* of the support group and by moving into more senior and authoritative positions.

Year 3: Trauma of an adjusted professional identity

The Balints argued that medical schools in the fifties taught *one person medicine* with the doctor being the subject in charge and the patient being the object of the treatment. Their work helped to establish a *two person medicine* as standard practice in medical schools and helped us see the doctor-patient relationship as an interactive process. The third year of the project was facing up to a group matrix model of medicine and supervision. New Labour took multi-disciplinary teams to their logical

conclusion and forced GPs into Primary Care Trusts with indecent haste. Doctors needed to develop the ability to perceive themselves as interdependent figures in a matrix of relationships: doctor - patient, doctor - staff, doctor - primary care trust, doctor - secondary and tertiary sector. The practice of primary care medicine is dependent on the acquisition of group skills. The Labour reforms killed off any idea of returning to pure medicine and an undisturbed doctor - patient relationship. This emerged as the central theme as the group faced up to developing a professional self-ideal based on medicine, management and politics. This process was very painful as it involved the re-negotiation of the boundary between sacred medicine and profane politics, the dirty politician had to be taken in by the clean medic and these inner object representations had to acknowledge their inter-dependence. It is my contention that a strict Balint approach would have struggled with supporting this very significant change. The open group analytic approach to supervision, without a case presentation, simply relying on free association, created a space where this transition could be accomplished and, most importantly, where GPs could be bad enough in order to become good enough for themselves and their patients.

Conclusion

If doctors are to cope with the medical, managerial, political and personal demands in the current situation they must be able to think beyond the patient. The Balint focus on the doctor - patient relationship as the key to solving primary care problems was appropriate in good times when doctors felt looked after by the NHS. In the current context, no GP will be able to manage the job without leadership skills, business know-how and an understanding of his/her need to work through the traumatising loss of professional independence. In a climate of permanent reform doctors need to accept that self-care comes is the foundation for providing better patient care.

The future of support work in primary care lies in recognising that doctors practices primarily under audit and evidence based conditions. This has altered the context of the encounter between doctor and patient. Previously, this encounter was a private matter based on trust, now it is subject to fear of re-accreditation and litigation. The basic situation between doctor and patient is one of distrust. The patient is now a potential complainant, not an object of care which can satisfy the GPs emotional needs by letting him/her be a mother substitute. The doctor's sense of safety no longer lies in the patient –doctor relationship but in the

holding capacity of the partners, the primary care team and the primary care trusts. Support for GPs must now focus on a plurality of key strategic relationships within a team matrix and a systemic foundation matrix. A group analytic group is ideally suited to meet these demands. It offers a space in which GPs can acquire group survival skills through a process of trusting the group with a problem, finding a practical way of experimenting with a new way of doing and being, bringing the learning from that experiment back into the group and internalising the attendant emotional and intellectual experiences of affirmation.

References

E.Balint et al. (1993) the doctor, the patient and the group. Balint Revisited. London and New York: Routledge

Cohen, A.P., (1995) The Symbolic Construction of Community. London: Routledge

Giddens, A., (1997) Modernity and Self-Identity. Cambridge:

Polity Press

Hildebrand, P., (1995) Beyond Mid-Life Crisis. A psychodynamic approach to ageing. London: Sheldon

Hopper, E., (1997) Traumatic experience in the unconscious life of groups : A Fourth Basic Assumption, Group Analysis 30(4): 439 – 470.

Obholzer, A. et al. (1994) The unconscious at Work. Individual and Organisational Stress in the Human Services. London: Routledge

Schmidbauer, W. (1993) Hilflose Helfer. Über die seelische Problematik der helfenden Berufe. Hamburg: Rowohlt

Turquet,P. (1975) 'The Large Group, Dynamics & Therapy', in L. Kreeger (ed.) The Large Group. Dynamics and Therapy, p. 87 – 144. London: Constable

Wilke, G. (2001) How to be a Good Enough GP, Oxford: Radcliff Medical Press

Winnicott, D.W., (1965) The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development. London: Hogarth Press

Winnicott, D.W. (1975) 'Hate in the countertransference', in D.W. Winnicott (1975) Through Paediatrics to Psychoanalysis, p. 194-203. London: Hogarth Press