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CUPRINS

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PREZENTAREA ASOCIAȚIEI BALINT DIN ROMÂNIA

Michael BALINT: *Psihanalist englez de origine maghiară*

Data înființării: 25 iulie 1993

Grupul BALINT: Grup specific alcătuit din cei care se ocupă de bolnavi și care se reunesc sub conducerea a unui sau doi lideri, având ca obiect de studiu relația medic-bolnav prin analiza transferului și contra-transferului între subiecți.

Specificul Asociației: apolitică, nereligioasă, inter-universitară, multidisciplinară, de formație polivalentă.
Obiective: Formarea psihologică continuă a participanților. Încercarea de a îmbunătăți prin cuvânt calitatea relației terapeutice medic-pacient și a comunicării dintre membrii diferitelor categorii profesionale. Rol de "punte" între etnii, confesiuni, categorii sociale, regiuni, țări.

Activitatea Asociației:

- grupuri Balint,
- editarea Buletinului,
- formarea și supervizarea liderilor,
- colaborare la scară internațională.

Cotizația se achită până la **31 martie a.c.** Cvantumul ei se hotărăște anual de către Biroul Asociației. În cazul când ambii soți dintr-o familie sunt membrii Asociației, unul din ei poate cere scutirea de la plata abonamentului la Buletinul Asociației, al cărui cost se stabilește anual. Cei care nu achită cotizația până la data de 31 martie a anului în curs nu vor mai primi Buletinul din luna iunie, iar cei care nu vor plăti cotizația nici până la data de 31 martie a anului următor vor fi penalizați cu o majorare de 50%!!! Cei cu o restanță de doi ani vor fi excluși disciplinar din Asociație.
Studenții și pensionarii sunt scutiți de plata cotizației, fiind necesară doar abonarea la Buletinul Asociației. **Cotizația** pentru anul 2009 este de **20 EURO** (la cursul oficial BNR din ziua în care se face plata), în care se include și abonamentul la Buletin. **Taxa** de înscriere în Asociație este de **20 EURO** (nu se face reducere nici unei categorii socio-profesionale).
Abonamentul costă **6 EURO**.

CĂTRE AUTORI

Se primesc articole cu tematică legată de activitatea grupurilor Balint din România și din străinătate, de orice fel de terapie de grup, de psihoterapie, de psihologie aplicată și de alte abordări de ordin psihologic al relației medic - pacient (medicină socială, responsabilitate medicală, bioetică, psihosomatică, tanatologie). Materialele scrise la solicitarea redacției vor fi remunerate. Buletinul este creditat de către CMR ca prestator de EMC, deci orice articol publicat se creditează cu 25 de credite EMC. Abonamentul la Buletin se creditează cu 5 credite. Redactorul șef și / sau lectorul au dreptul de a face cuvenitele corecturi de formă, iar în cazul neconcordanțelor de fond vor retrimite articolele autorilor cu sugestiile pentru corectare.

Deoarece revista se difuzează și în alte țări, articolele care nu se limitează doar la descrierea evenimentelor balintiene, trebuie să aibă un rezumat în limba română și engleză, de maximum 10 rânduri dactilografiate. Lectorul își impune responsabilitatea de a face la nevoie corectura rezumatului

Pentru rigoarea științifică apreciem menționarea bibliografiei cât mai complet și mai corect, conform normelor **Vancouver**, atât pentru articolele din periodice cât și pentru monografii (citarea în text se notează cu cifre în paranteză, iar în bibliografie se înșiră autorii în ordinea citării nu cea alfabetică și doar acei autori care au fost citați în lucrare).

Recenziile cărților trebuie să cuprindă datele de identificare a cărții în cauză - autorii, titlul, toate subtitlurile, anul apariției, editura, orașul, numărul de pagini și ISBN-ul. Se trimite în fișier separat imaginea scanată a copertei. Se primesc doar materiale trimise pe diskete floppy de 3,5", CD room, memory-stick sau prin e-mail ca fișier atașat. Se vor folosi numai caractere românești din fontul Times New Roman, culese la mărimea 12, în WORD 6.0 sau 7.0 din WINDOWS.

Imaginile - fotografii, desene, caricaturi, grafice - vor fi trimise ca fișiere separate, cu specificarea locului unde trebuie inserate în text pentru justa lor lectură. Pentru grafice este important să se specifice programul în care au fost realizate.

Articolele trimise vor fi însoțite de numele autorului, cu precizarea gradului științific, a funcției și a adresei de contact, pentru a li se putea solicita exrase. Autorii vor scana o fotografie tip pașaport sau eseu pe care o vor trimite ca fișier atașat, sau pe o disketă la adresa redacției.

A L'IMPARFAIT DE L'OBJECTIF - François Berton, Paris

À la question de savoir comment se passe ma retraite, la réponse serait que deux cannes, la photographie et le psychodrame, la servent utilement. Transformant l'énigme du Sphinx aux Thébains: l'animal humain retrouve à la fin de sa vie ses quatre pieds initiaux.

Quand Luc Steimer et Monique de Hatjetlache m'ont proposé de mettre l'espace de la clinique et du soin en parallèle avec l'espace photographique, mon acceptation s'est assombrie de la crainte de les emmêler, ces cannes: quoi de commun entre psychodrame et photographie, sinon l'hellénisme de leurs étymologies. Prenons garde de ne pas disserter sur photo-drame et psychographie.

Ce vague et ce flou m'ont justifié le titre de: «A l'imparfait de l'objectif»; j'ai aimé cette parodie de temps de conjugaison; il introduit la subjectivité et l'imperfection créatrices de ces deux disciplines.

Honnêtement, ce titre, je l'ai volé. Je l'ai volé à Robert Doisneau. L'humanisme de ce photographe apprécié et qui a un peu écrit, égale la sûreté de son regard: les photographes écrivent et les écrivains photographient ou s'y intéressent de très près.

Nous en retrouverons aux cotés de Claude Simon, un de nos prix Nobel de littérature, Michel Tournier, Susan Sonntag, Roland Barthes, Hervé Guibert. Lewis Caroll qui photographiait des Alices et racontait ses aventures. Simenon et Zola savaient regarder pour écrire, Gaétan Gatien de Clerambault, aliéniste réputé de la Salpetrière a laissé une œuvre photographique curieuse. Et combien d'autres.

N'oublions pas Gisèle Freund, elle écrivait et photographiait, et nous lui devons d'émouvants portraits d'écrivains, de James Joyce, à Virginia Woolf et Montherlant. Brassaï, ami de Picasso, le photographiait, lui et ses œuvres. Il a laissé un livre, trace de leurs réflexions.

L'imparfait de l'objectif: ces deux termes s'appliquent et à la photographie et à notre travail. L'objectivité du preneur d'image et celle du thérapeute, en relation, laissent institutionnellement à désirer, même si le mot objectif désigne pour le photographe un objet pour lui indispensable, et devenu, lui, minutieusement presque parfait.

Ce troisième œil n'est-il pas comme l'oreille troisième du professionnel de l'écoute?

J'ai volé ce titre à Robert Doisneau: «Le photographe serait-il un prédateur? Certaines cultures le prétendent, craignant que s'envole une couche de leur âme».

Le photographe, pour Baudelaire qui ne les aimait pas, prendrait ce qu'il voit et non ce qu'il rêve; s'il ambitionne une reproduction fidèle du réel il tombe, pense-t-il, dans l'illusion. Le poète visionnaire voit juste: il pourrait y avoir, écrit-il, au travers de la photographie une nouvelle forme d'expression différente de celle qu'on lui attribue. Il devient très violent quand il évoque la vogue du portrait photographique dans les ateliers de Nadar ou de Disderi et il fustige en 1859: «À partir de ce moment, la société immonde se rua comme un seul Narcisse pour contempler sa triviale image... "

Contempler sa triviale image - comment ne pas comparer les rendez-vous en tête-à-tête, forcé à l'immobilité, dans le cabinet du photographe «avec d'autres rencontres actuelles, où l'on se confronte avec une triviale image de nous-mêmes, mentale ou iconographique».

Cette analogie entre espace thérapeutique et espace photographique, nous ne la quitterons pas. Suivons notre poète, pris au piège qu'il dénonçait quand il écrivait à Nadar, par qui il se fera photographier - comme la société immonde: «Quand j'irai chez toi, je te parlerai de mes chagrins qui s'accumulent et je te ferai pitié. Je vois de si terribles choses en rêve que je voudrais parfois ne plus dormir».

Voilà un aspect de la relation photographe / photographié fort ambigu; d'un coté je te parlerai de mes chagrins, de l'autre la triviale image que la société immonde contemple. La photo à la fois fascine et effraye.

Nous mettrons l'accent sur l'acte photographique moins connu de vous que l'acte thérapeutique: que peut receler cette triviale image? Triviale évoquant la rencontre des carrefours, là où s'offrent trois voies avec le banal, le non remarqué, le courant, le commun que l'on ne voit même plus, ce qui précisément nourrit le quotidien du photographe qui sait livrer une image révélatrice, sinon accusatrice de la banalité, et est aussi le pain du thérapeute donnant aux choses discrètes et aux petits signes débusqués un intérêt qui enrichira notre connaissance et notre compréhension du sujet pour le bénéfice de chacun. La triviale, la Traviata, c'est celle, qui, debout aux coins de rue, est à tout le monde: la photo a toujours eu un relent canaille.

Ces modestes éléments inaperçus, que l'art du photographe aura mis en valeur, et le métier du thérapeute relevé, contribueront à éclairer et donner un sens à la scène. Retrouvons une similitude entre la lecture du discours de l'autre et l'écoute de la photographie: nous inversons les termes logiques de ces deux propositions pour mieux mêler les espaces de ces deux domaines; ainsi la photographie ramène sur un seul plan, dans un cadre qui limite et à un instant choisi,

ANUNȚURI IMPORTANTE

Începând de la acest număr cu care demarăm într-un nou an, Veți primi în mână o revistă cu o înfățișare schimbată. Așa, cum se întâmplă deseori cu revistele științifice. Comitetul de redacție are speranța ca noua formă să vă câștige plăcerea și să vă îmbie spre lecturarea articolelor cuprinse în numerele ce vor apare.

le désordre et la complexité du monde.

La prise d'un sujet, l'approche de nos patients, et particulièrement le déroulement et l'observation d'une séance de psychodrame: ces trois situations se ressemblent, provoquant des conséquences recherchées ou imprévues.

Permettez--moi une petite réflexion informative d'optique physique. Nous savons ce qu'est un objectif fixe et un objectif à focale variable, appelé *zoom*. Nous pensons, sans réfléchir, qu'un zoom rapproche optiquement du sujet. Ou en éloigne. Il n'en est rien: il limite ou élargit le champ de vision sans changer les rapports de distance entre le photographe et son sujet. La portion d'une image extraite d'une photo prise à la focale large du zoom et cette même portion isolée par une focale étroite seront rigoureusement semblable, si le photographe n'a pas bougé.

Essayons une image avec une longue focale (appelée aussi téléobjectif), puis une autre image avec une focale moyenne et approchons-nous du sujet pour obtenir à peu près le même cadrage, notre vision du même sujet sera totalement différente: les rapports entre les éléments composant l'image auront changé et son sens différera, comme notre point de vue, tant dans le sens mental de l'expression que dans la position physique du photographe.

Cette *modification de position du photographe par rapport à son sujet* - et non un changement de matériel - entraînera un remaniement entre les éléments de l'image et leur relation avec les bords de l'image. Il élabore des rapports entre lui-même et les éléments qu'il contient, devenant créateur d'ensembles nouveaux, donc de connections nouvelles. Annie Bouillon lui donnait ce matin un rôle de rencontre dans l'espace intrapsychique.

Rappelons cette évidence, d'une importance capitale, qu'une photographie a un cadre, et que le réel n'en possède pas et que c'est une de leurs premières différences. Une image ne sera pas la même selon l'emplacement et les dimensions de son cadre, et qu'un déplacement modifiera cela.

Ne venons-nous pas d'utiliser les notions de *condensation* et de *déplacement* et de *mise en scène* ?

Dans le domaine de la rencontre professionnelle, une variation du regard porté sur nos malades, une proximité améliorée ou une distance prise changera le travail de la relation et en permettra un développement différent lié alors à nous-mêmes et non à la technique utilisée. Un changement de position, nous pointait Bernard Le Flohic, fait parfois naître une nouvelle pensée. C'est, pour paraphraser une formule éprouvée, la conséquence considérable d'une modification limitée. Si la plainte émise ou la pathologie proposée par les patients n'est pas éclaircie, nous redoublons de recherches biologiques ou d'explorations imagières, multiples et performantes, espérant en échange d'une information plus complète une révélation livrant la clef de notre impuissance. «Plus on en sait, meilleur médecin devient-on»; osons nous penser. Cette démarche équivaut en photographie à multiplier le matériel et sa complexité afin d'espérer mieux photographier, ou d'utiliser un zoom pour seulement agrandir une partie de l'image sans la transformer d'aucune sorte - porte son intérêt sur un autre domaine que celui offert par le patient- variation de point de vue - ou les deux ensembles, la situation va se convertir, des interférences et leurs conséquences restées inaperçues ou inexplorées se mettent à jour, pour un profond et fécond remaniement.

Inventons un *éclairage nouveau* en sus *d'une augmentation d'information* - toujours utile.

Voir un photographe effectuer cette étrange danse du scalp autour de son sujet pour varier distance ou angle d'incidence peut rappeler en psychodrame la recherche des scènes, l'invitation aux doublages, aux commentaires et soliloques, pour mieux cerner ce dont il s'agit. N'oublions pas *le flash*, cette incidence inattendue qui éclaire la scène: il possède son équivalent en photo.

Le sujet est-il, en photographie, une personne?

Les résultats différeront si l'opérateur a pu entrer en relation avec elle d'un simple regard, d'un sourire échangé: ils se feront moins peur. Trop souvent en médecine si aucune vraie communication ne passe entre soigné et soignant ce dernier s'étonnera de son efficacité perturbée, bien que le protocole observé ait été correct.

De toute façon, qu'il en ait conscience ou non, il y a relation, et quelque chose se sera modifié; l'observation d'un phénomène, et cela les scientifiques, les biologistes ethnologues et même physiciens le savent, modifie le phénomène observé. Et en retour l'observateur également.

En médecine c'est évident et en photographie aussi; *se sentir la cible change notre comportement* et contempler notre triviale image ne nous laissera pas indifférent. Rapprochons cela du changement de rôles dans notre discipline.

Que le photographe en subisse un coup en retour, c'est là un de nos thèmes. Revenons à la danse du scalp pour y joindre l'attitude du héron, dans cette même collusion espace thérapeutique, espace photographique! Le temps, alors en jeu, se révèle fructueux en médecine comme en photographie: le photographe choisit *un lieu, un environnement, jugé propices au déroulement d'un éventuel événement* - un coin de rue animée, des personnes attablées, des musiciens assemblés; le jalonnement préparé d'une possible mise en scène. Il attend. Quelque chose peut survenir, et les éléments présents soudainement s'organiser d'eux-mêmes. La proximité modeste et discrète de l'opérateur le rend paradoxalement invisible, très réceptif, prêt à saisir, il ne cherche pas à voir. L'attente que les éléments ordonnent leur anarchie d'eux-mêmes laisse surgir immanquablement le moment fécond et très fugitif. Il l'évalue et l'apprécie sans avoir le temps de savoir pourquoi - son expérience des images déjà engrangées dans sa tète le guide. Il prend la photo. Comme le héron planté dans l'eau de la rivière espère, immobile, le passage de son déjeuner pour le happer en un éclair de son long bec.

Il prend la photo. À moins que ce ne soit elle qui le saisisse.

Congresul International Balint 2009

Avec les patients, vus de temps en temps pour des raisons diverses, privilège du généraliste, même phénomène. Le médecin reste en embuscade dans l'enchaînement des consultations, prêt à repérer ou entendre un élément nouveau, une modification à peine provoquée. Les conséquences en deviendront importantes pour la suite de l'écriture de ce roman à quatre mains. Sans que nous ayons à intervenir.

Dans l'exercice du psychodrame, il suffit de planter soigneusement le décor, tant des objets que de l'atmosphère, d'évoquer avec soin et recherche les protagonistes, en une véritable représentation analytique de choses et d'attendre la filiation des scènes pour que le travail du groupe saisisse le poisson: sa mise en lumière rapide prendra valeur d'interprétation, suivie de représentation de mots.

On laisse venir, on appréhende, on pense après.

Le cadrage que nous venons d'évoquer, permets un passage du tridimensionnel à la planéité du bidirectionnel et l'apparition de relations auparavant non-perçues - du moins avant que la photo ne soit prise. Animateur, médecin, photographe repéreront les points importants émergeant du désordre organisé mis en scène pour leur donner un sens.

Le cadre possède une fonction régulatrice, protectrice et créatrice, tant dans la rencontre psychanalytique où son importance n'est plus à dire que dans la plus banale relation professionnelle où sa rupture ou sa négligence entraînent les errements et les déviations étudiés dans les groupes. Ainsi dans le psychodrame: le soin donné aux règles de fonctionnement et le temps passé à reconstruire et installer un cadre ne sont pas temps perdu, ils éclairent une situation désordonnée. *Ce que l'on regarde dans le cadre du jeu a à voir avec le cadre du viseur.*

L'instant de sa prise: autre élément constitutif d'une photo. Pensons seulement aux occurrences fécondes dans nos consultations pointées d'un geste, d'un sourire, d'une note dans le dossier. Le psychodrame, comme la photographie a le pouvoir d'arrêter le temps, pour en modifier même imperceptiblement le cours. Évoquons les «arrêts sur image» les soliloques, devant une situation nouvellement révélée. L'arrêt d'une scène à un instant imprévu traduit un moment photographique, arrêt qui, comme en photo, a souvent valeur d'interprétation.

Cartier-Bresson l'appelle le moment décisif, expression empruntée, les photographes sont de fieffés prédateurs, au cardinal de Retz: Il n'y a rien au monde qui n'ait un moment décisif. Ce moment décisif existerait-il si le photographe ou le médecin n'était là pour le pointer?

Les choses vivent-elles si personne ne les désigne?

La mise au point représente le quatrième élément constitutif de la photo; on focalise sur un plan précis de la scène choisie. Et dans le monde relationnel la focalisation concerne l'intérêt volontairement porté sur un instant fécond ou un point particulier d'une rencontre. Dans les deux cas, on met au point sur un plan du sujet, laissant flous les domaines antérieurs et postérieurs. Le photographe, et c'est là une de ses libertés créatrices décide d'une hiérarchie dans les différents plans qui sont proposés.

Dans la vision du réel, notre œil balaye constamment notre champ de vision; car l'angle utile est très étroit qui correspond a une surface rétinienne efficace très limitée; et notre système optique mets constamment au point sur ces zones toujours changeantes, et dont le choix sélectif traduit nos intérêts ou nos rejets.

L'objectif photo lui, n'est pas sélective: il délivre tout mais pas dans les mêmes valeurs. Je vous regarde et je vois aussi net le premier rang que le jardin par la fenêtre ; sur une photo prise, non. Cela dépendra du plan de mise au point choisi. Ceci permet au photographe de privilégier un domaine et par là même donner un sens a son image. De même que l'intérêt porté a un domaine précis et limité de nos patients aura des conséquences énormes.

Mettre au point c'est adapter l'objectif afin que l'image justement d'un point de l'objet devienne un point sur la photo. Mais nos rétines comme nos optiques demeurent imparfaites et une marge de tolérance permet que l'image d'un point du sujet se traduise par une zone plus grande sur la surface sensible (rétine, pellicule, capteur) et soit perçue comme un point par notre œil. *Cette tolérance se nomme «point de confusion».* Je vous laisse associer en ce qui concerne notre métier sur cette expression.

Les qualités demandées à un thérapeute semblent les mêmes que celles attribuées à un photographe. Henri Cartier-Bresson résume cela quand il compare son état mental à celui du tireur à l'arc zen qui, ayant réussi à souffler le vide en lui, n'envoie pas sa flèche, mais la laisse librement partir. Un ouvrage d'Herrigel *"Le zen dans l'art chevaleresque du tir à l'arc"* concrétise pour lui cette notion perçue confusément, éprouvant la nécessité d'abandonner l'intelligence et la réflexion, qui parasitent la vie sensorielle affective et toute cette zone de nous qui influant nos choix et nos actes constitue un intervalle important entre artiste et œuvre. Quand tout découle de l'oubli total de soi et du fait qu'on s'intègre à l'évènement sans aucune intention propre, il

convient que, sans aucune réflexion, direction ou contrôle, l'accomplissement extérieur de l'acte se déroule de lui-même. Le tireur se laisse surprendre par la flèche qui part d'elle-même; allant jusqu'à prétendre que l'archer se vise lui-même. Prendre une photo ne serait ce pas se photographier soi-même, comme les images de nos rêves ne concernent que nous...

Pour Cartier-Bresson, photographier c'est mettre sur la même ligne de mire la tète, l'œil et le cœur. Il n'est pas certain, ni même obligé que ce soit la cible qui soit atteinte en photographie. Établir un parallèle avec l'attitude du thérapeute dans la périlleuse relation entretenue avec qui s'est exposé à lui, je vous laisse en développer pour et par vous l'évidence.

Mais dans quel ordre manions-nous cœur, œil et tète? Pourquoi choisissons-nous tel sujet à tel instant? Nous ne prenons pas une photo, elle nous prend, avancions-nous à propos du tireur zen. Dire qu'il se vise lui-même revient à évoquer la correspondance entre une image représentative intégrée en soi et celle qui s'offre à l'opérateur: il croit la saisir, or il la possède déjà.

La représentation objective, empruntée au réel va résonner et raisonner avec une évocation subjective, émotionnelle, esthétique pour procurer à l'observateur photographe une image correspondante à sa réalité propre, qu'il possède et, partant s'en trouvera modifiée. Cette opération mentale aboutira au *choix de faire une photo, et à la construction de l'objet-photo qui vivra sa vie dans son créateur, mais indépendamment de lui.*

Bernard Quatelas nous parlait ce matin du symptôme, d'une *vérité qui passe par soi.* Retrouvons ce mot, et la chose. Symptôme vient du grec *tome*: couper en tombant de haut en bas. *Sym* restant le préfixe qui marque la jonction. Transposons en latin: couper en tombant peut devenir *incidere*. *Sym* devient le *cum*. *Cum-incidere* ce qui tombe avec, ce qui arrive, c'est la coïncidence. La photo n'est-elle pas une coïncidence, sinon un symptôme avec ce que nous avons déjà intégré et ce que nous désirons sans le savoir?

Une représentation de chose se réinvestira dans une trace mnésique.

Le corps du photographe est à l'évidence partie prenante dans l'acte photographique, il est là, ses mains font corps avec son appareil, et l'un et l'autre réagissent à *l'émotion ressentie qui influe sur le choix du tir.*

Mon expérience de photographe de musiciens (jazz, blues etc.) m'a appris que pour bien le photographier il faut fermer ses oreilles: une photo induite par la seule émotion musicale intime pourra n'avoir aucune traduction imagière. Le Leica est sourd. C'est peut-être là un exemple d'application de l'art du tir zen et de l'esprit vidé.

Mais l'image prise correspond le plus souvent aux émotions ressenties et aux images déjà engrangées et singulièrement aux fantasmes inavoués ou connus du tireur. Il les photographie. Il se photographie et ce n'est pas sans raison mais avec pudeur que les photographes ne laissent jamais personne explorer leurs archives de travail.

La photographie a progressé parallèlement et conjointement aux sciences humaines, et rappelons que Charcot a photographié ses patientes en crise à la Salpetrière: elles ne demandaient pas mieux. Plus loin encore, Henry William Diamond, premier photographe de la folie avant Charcot a écrit en 1856: «Le photographe, en beaucoup de circonstances, n'a pas besoin de l'aide de la parole, mais préfère de beaucoup écouter, la photographie devant lui, le silence éloquent de la nature...»

Quelle leçon!

Il avait tout compris.

Historiquement, notons que Freud publie sa « Traumdeutung » l'année de la projection de premier film des frères Lumière.

Le cas de l'un devient le cas de tous disait Anne Caïn, à propos des séances de psychodrame. Transposerions-nous sur la photo quand tous la reçoivent, mais différemment? *Nous avons coïncidé l'espace thérapeutique et l'espace photographique comme les tactiques respectives du médecin et du photographe.* Les résultats auront-ils le même sens pour le participant d'un groupe que pour les regardeurs d'une même photo ?

La représentation construite de nos malades se lie à nos réminiscences, associations, interprétations, et projections nées à son contact; l'un des buts du travail du groupe est d'en obtenir la modification au fil des cas. La nôtre aussi. Photographier un sujet (Etre, chose, paysage) c'est aussi en modifier notre représentation. Le réel d'où part l'image, même s'il n'est pas reçu comme tel vient changer et corriger les nôtres. Arnaud Claass, qui a beaucoup photographié, réfléchi et écrit, le traduit ainsi : je photographie une chose pour voir à quoi elle ressemble quand elle est photographiée.

On verra bien ce que cela donnera, murmure le photographe incertain avant d'appuyer! On verra bien ce que cela donnera, pense l'animateur du groupe en proposant une scène. Ce n'est pas par hasard que, dans l'introduction du programme, je parlais de caméra obscure en évoquant le groupe.

La manière d'organiser l'image influera sur son sens manifeste, avec autant de variantes que de lecteurs. *Reprenons la métaphore de l'archer zen* pour préciser qu'il ne lui est pas conseillé de vider sa tête, mais d'en aérer l'intérieur de le rendre disponible pour intégrer et transformer l'image photographique proposée. Nous rejoignons là les études actuelles sur la plasticité créatrice de la mémoire. Pouvoir photographier c'est, et je cite Jean-Pierre Bachmann dans sa communication lors de notre congrès sur la mémoire du corps c'est pouvoir enregistrer l'action dans le système moteur de l'observateur, comme si c'était son propre mouvement. *L'activation du système miroir* est ainsi essentielle pour donner à l'observateur une compréhension réelle et expérientielle de l'action qu'il voit. Il peut donc être conçu

comme celui qui donne a notre expérience visuelle une certaine épaisseur, une profondeur dans laquelle l'action que je vois n'est pas seulement transcrite en moi comme une représentation visuelle, mais inscrire en moi comme un vécu.

Sans que nous le sachions, la photo, avant sa prise, a saisi ce qui correspond à une image interne pour en créer de nouvelles, qui seront utilisées de la même manière. A la fois une trouvaille et une création, ce qu'Anne Caïn disait du psychodrame et que Guy Bruère-Dawson nomme le trouver-créer.

Comme à la brocante d'où chacun repart avec ce qu'il ne cherchait pas.

Prendre une photo, observer une séance de psychodrame c'est se mettre à la fois derrière le viseur et devant l'objectif, on se photographie soi-même, on se projette dans le cas présenté et sujets et objets s'en trouvent l'un et l'autre révélés. *Une chose photographiée n'est plus la chose en elle-même.*

Denis Roche dit *qu'une photo n'est pas l'écriture d'une histoire; ni le décalque ou le substitut de rien; elle est son propre sujet; qui, caché, se révèle différent à chacun.*

Matisse disait à Brassaï que chaque fois qu'il désirait se libérer de sa propre vision, celle des sentiments, il s'obligeait à copier des photographies. Nous retrouvons l'archer zen.

Ma petite fille feuilletait quelques-unes de mes photos, trop rapidement à mon goût. À ma remarque, elle répond: j'attends qu'une me parle. Si tu ne les écoutes pas, elles ne te diront rien. Lui ai-je renvoyé. L'oreille voit, l'œil écoute.

Ou plutôt devrait écouter.

Roland Barthes fait remarquer que le cinéma nous délivre vingt-quatre images par secondes. Si seulement nous consacrions vingt-quatre secondes par images photographiques...

Avant de terminer, je rappelle ma préférence pour le noir et blanc qui ramène à la profondeur du réel alors que la couleur nous laisse à la superficialité de la réalité. Pour Wim Wenders, le cinéaste des Ailes du Désir qui alterne dans ce film séquence couleur et séquences noir et blanc, *la couleur c'est la réalité; le noir et blanc, la vérité.*

Arrêtons-nous. Ne pillons pas trop. Ne diluons pas non plus; ces domaines effleurés mériteraient amples développements. Puissé-je vous avoir donné le goût de lire une photo avec autant de soin que nous décodons nos patients.

La médecine deviendrait une merveilleuse propédeutique à la photographie.

J'avais avoué voler mon titre à Doisneau. Mon remords s'est éteint quand j'ai vu, qu'en exergue de son livre, il avait posé ces mots de Prévert, écrits pour lui-même, Doisneau :

...il dispose son miroir aux alouettes,
Sa piègerie de braconnier
Et c'est toujours à l'imparfait de l'objectif
Qu'il conjugue le verbe photographier ...

CHRONIC CONSTIPATION AND THE FLASH TECHNIQUE

- Mark BUDOW - University of Tel Aviv, Dept. of Family Medicine, Tel Aviv, Israel.

Abstract:
In her book, Six minutes for the Patient, Enid Balint dedicates a chapter to "The Flash Technique" referring to when doctors become aware of their feelings in the consultation and on occasions interpret those feelings back in a way that can give insight into the presenting problems.
In this presentation I shall present how such a "flash" in a conventional Balint group affected both my interpersonal relationship with a now favourite patient of mine and my personal interfamily relationships.
Key words: flash technique, interpersonal relationship, interfamily relationship

The patient I presented at one of our Balint weekend retreats is a now 87 year old retired physician and most of our early consultations were held in his apartment**.** Despite a myriad of medical conditions such as Congestive Heart failure, Diabetes and Mild Chronic Renal Failure, most of our meetings would almost inevitably revolve around his obsession about his constipation. In between consultations he would regularly phone and ask advice on how best to procure his next bowel motion. This was acceptable to me at first but later he called too often. For me things one day came to a head when I could no longer take it anymore and I simply slammed down the phone in an act of anger and frustration. I was shocked by my reaction, especially as we shared the same profession and so brought it up at out Balint meeting**.**

The Balint group took its normal path of presentation, informative questions, and then reflective discussion with me as the presenter excluded. It was when one of the group leaders introduced the "non present third person" into the discussion that I began to understand. The natural candidates for the role were his recently deceased wife and his daughter. But then unexpectedly one of the group members suddenly introduced **my** father. I was surprised and overcome with emotion. I was struck by a FLASH of insight, realising that my anger and frustration was indeed a symptom of my

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anxiety for the welfare of my aging father who lives in South Africa and with whom I communicate regularly by phone.

During the reflection session at the end of the meeting I informed all present of my intention to go and visit my parents more regularly than previously. The following day I called my travel agent and booked a flight to Cape Town from where I now, some three years later, write this abstract during my second "home-visit" this year.

As an interesting footnote, my patient now rarely complains about his lack of bowel motions and comes and visits me in my office. Over time I have discovered a highly intelligent, interesting and insightful man whose visits are indeed a pleasure and privilege for me.

May he and Gerald my father be spared many more years of good health!

Dear Friends

At the last Balint congress in Lisbon two years ago, I had the pleasure of taking lunch with Michael Courtenay and his wife. He had just given his plenary talk in which he recalled working in a very early group led by Michael and Enid Balint and invited us to consider how we might have treated Marcel Proust and his psychosomatic asthma. I mentioned that this was my first congress and that attending had been a dream of mine for many years, my father also a family physician, having been to Oxford in 1982. At some point in the conversation he asked me whether I had ever experienced a FLASH. He was of course referring to where in her book, Six minutes for the Patient, Enid Balint dedicates a chapter to "The Flash Technique" referring to when doctors become aware of their feelings in the consultation and on occasions interpret those feelings back in a way that can give insight into the presenting problems. The Webster on line dictionary has eight different meanings for the word "flash" including **:** to appear suddenly, to give off light suddenly or in transient bursts, to have sudden insight and finally to expose one's breasts or genitals usually suddenly and briefly in public(which I assume is not what Mike or Enid had in mind). In my family, flash has connotations to the Flash Flood in which my father's father was swept away from him when he was 11 years old, leaving him and his three younger siblings to be raised by their grieving 30 year old mother.

It is my pleasure to now present to you what I then shared with Michael and to add a small twist to my tale.

It was March 2005 and Maccabi Tel Aviv had just reached the finals of the European Basketball competition to be held in Moscow a month hence. I was very busing planning my trip when I attended our local Balint Leader's bi-annual retreat attended by some 30 members. The format as always included 2 fishbowl sessions dedicated principally to refining group leader's skills. I joined the inner circle as a group member. As was my may then, I had difficulty dealing with silence at the start of a group and so immediately offered to present the following case.

My patient is an 82 year old retired physician who had joined my practice with his ailing wife some two years earlier. They had moved to a new apartment in my area to be close to their daughter (who is not a patient of mine). As his wife was severely disabled, my meetings with them were always at their home. Some of the early meetings were devoted entirely to her but he would often also ask to be examined. He had a fairly long list of medical problems which included Hypertension, Diabetes Mellitus, and Benign Prostate Hyperplasia and claimed to suffer from Peripheral neuropathy of his legs which caused pain and weakness even though I had found no evidence of such in his medical chart. Despite his age, he is, unlike the majority of my patients his age, exceptionally sharp witted and intelligent. So many consultations became intellectual challenges for me as he is always curious for scientific explanations for all my diagnoses. He often subtly reminded me that he was a doctor by speaking medically like "Do you think the spasms are in my gastrocnemius? " or "Do you think I may have Basedow's syndrome?".

After about six months his wife passed away unexpectedly and as far as I recall the cause of death was undetermined. What I do recall is that on visiting him during the seven day period of mourning traditional to our Jewish culture and again on various occasions thereafter, he showed no signs of sadness or remorse. He merely continued with his life remaining fairly self involved. He employed a male caregiver to move in with him and they live together till this day. At this point I must add that he treats Lohn with the utmost respect and gratitude, something I have always admired.

It was at about the time of his wife's death, that he started to become obsessed with his bowel motions. He felt it essential to have a daily motion and would go into elaborate details of all the techniques he used to procure such an event. Of course he would also look for medical explanations for this dreaded disease and convinced himself that he had developed a Diabetic Autonomic Neuropathy . So off he went to

several gastroenterologists, some privately (not on our NHS) until he even had rectal sphincter manometery performed which showed nothing out of the ordinary. I began to dread our visits as I knew that somewhere in the consultation I would be challenged to find a cure for his constipation. I was not even convinced that he had a physical problem that needed my attention. He would call me during consulting hours and would ask questions like " I've had two glasses of prune juice today-do you think it OK if I have another as I've only passed two tiny stools?". Matters came to a head one day when as soon as I heard his voice on the phone I slammed the phone down in an act of anger and frustration and did not answer the phone again for several hours.

A few days later I presented to the group. I felt very guilty about my feelings toward him, a fellow physician, albeit much older than myself and retired. I am generally very reserved in my behavior and this act of aggression was very out of character for me with any patient. So I asked the group to see if they could decipher what had caused my behavior and hopefully I could thereby understand my feelings.

I remember the initial discussion focused on me and my behavior. One of the group members found it amusing that I thought that putting down the phone was aggressive. A short discussion followed on the difference between native born Israelis and me, South African born. I felt that this discussion was irrelevant to me and my request as they were merely pointing out differences in character without looking for reasons for my actions

The turning point in the group came when one of the group leaders introduced the "non present third person" in the consultation. The initial candidates were his late wife and daughter. But then another member mentioned that I had spoken about my father in present meetings. She was unaware of his physical condition and wondered whether he possibly exhibited similar symptoms and how I as a son related to these complaints of his.

It was like being hit by a FLASH of incisive lightning! How had I not seen the connection? My father, as I mentioned earlier, is also a physician and is a couple of years younger than my patient. Like my patient he too is still in full control of his mental capacities. But unlike my patient he does not live a 2 minute drive from my office but a 12 hour air flight away. And the only way I communicate with him is by phone, the same instrument I had vented my anger with. I would go and visit once him every two or three years and he would pay annual visits to Israel. The FLASH for me was my insight that my frustration and anger at Mordechai was actually an expression of my anxiety for my father's future wellbeing and my lack of control over it. I was flash flooded with emotion and I felt a burning need to be with my parents. It was as if I had been constipated emotionally and the group opened me up to my true needs. And so the next day I called my travel agent and booked a ticket to Cape Town where I have visited every year since- even twice last year. Maccabi Tel Aviv won the European Basketball Cup in Moscow in 2005 and I was not there. But on mornings when I lie in bed between my 82 year old dad and 78 year mom, my cup runneth over and for that I thank Mordechai, the group and the constipation.

And the twist. For reasons beyond my comprehension Mordechai now visits me in my office. He hardly ever mentions his constipation. I have discovered a wonderful, intelligent. humoristic colleague and it has become a pleasure and privilege to be his personal physician.

Several months ago he visited when I had two 1st year American students in my office. "What advice would you give these young students", I asked him. "Always listen to your patients' stories and treat them with respect. Remember you are dealing with people and not with diseases." It could have been my father speaking.

XVI-a Conferinţă Naţională Balint

DEPRESIA POSTPARTUM – O REALITATE ȘI O PROVOCARE PENTRU MEDICUL DE FAMILIE.*

- Dr. Daciana Toma, medic primar medicină de familie, București.

Sumar: *DPP este o tulburare foarte frecventă (10 -15% dintre femeile care au născut dezvoltă DPP), care afectează toate aspectele existenței femeii (statusul psiho-somatic al femeii și al copilului, relațiile de cuplu, statusul socio-economic al femeii). Medicul de familie poate preveni si diagnostica precoce această afecțiune prin informarea și urmărirea activă a populației țintă.*

Abstract: *Postnatal depression is a very common disorder (10 -15% of women in postnatal state developed depression), which affects all aspects of women's existence (psycho-somatic status of women and children, couple relationships, socio-economic status of women). The GP can prevent and early diagnosis this disease by providing information and active pursuit of the target population.*

Depresia postpartum (DPP este o tulburare severă de sănătate mintală care apare în perioada postnatală. Afecțiunea este foarte frecventă, apare la 1 din 9 femei (10- 15%) care au născut.

Se descriu 3 afecțiuni caracteristice perioadei postpartum:

1. "maternal sau baby blues" – definită ca tristețea apărută după naștere (în primele 3 zile), dar care dispare după primele 10 zile de la naștere și nu necesită tratament medical.
2. depresia postpartum – debut până la un an de la naștere, cu durată de săptămâni – luni, necesită tratament specializat
3. psihoza postpartum - afecțiune rară, cu debut în primele două săptămâni de la naștere, reprezintă o urgență psihiatrică.

De ce e importantă recunoașterea DPP?

Apariția DPP este urmată de modificări importante în calitatea vieții femeii, în sensul scăderii ei.

Sunt afectate: starea de sănătate fizică și psihică a femeii, relația cu copilul și starea de sănătate a acestuia, relațiile în cuplu și cele sociale (în general) și scad performanțele profesionale.

Care sunt simptomele DPP?

Simptome ale mamei:

- scăderea interesului pentru activitățile obișnuite
- anxietate, frică, învinovățire, îngrijorare, plâns facil – fără motive întemeiate
- scăderea interesului față de copil și față de îngrijirea acestuia
- scăderea interesului față de aspectul personal
- tulburări ale apetitului, în sensul scăderii acestuia (urmat de scădere în greutate).
- tulburări de somn (insomnie)
- idei legate de suicid
- retragerea față de partener, familie, prieteni
- scăderea performanțelor la locul de muncă
- scăderea capacității de concentrare
- oboseală marcată și lipsă de energie.

Simptome ale copilului:

- devine retras, iritabil, neliniștit
- are probleme emoționale și de comportament,
- prezintă retard (sau chiar regres) în achizițiile psihomotorii specifice vârstei
- întârziere în creștere și dezvoltare
- rezistență scăzută la infecții

Cum putem preveni DPP?

- solicită ajutorul celor din jur în îngrijirea copilului, astfel încât să ai timp să te odihnești, să faci mișcare în aer liber, să mănânci sănătos, să te îngrijești. Este firesc să faci în continuare toate aceste lucruri!
- este firesc să nu știi totul despre îngrijirea copilului – nu ezita să ceri sfatul profesioniștilor în domeniu
- încearcă să recunoști primele semne ale DPP și adresează-te rapid medicului de familie

Mituri despre DPP:

- "DPP este o formă ușoară de depresie" – de fapt este o formă severă de depresie, cu consecințe grave în dezvoltarea psihică și fizică a copilului
- "DPP trece de la sine" – este obligatoriu tratamentul specializat
- "DPP este un semn de lipsă de iubire față de copil" – este o afecțiune care trebuie tratată specific.

Tratamentul DPP:

- consiliere psihologică
- tratament medicamentos

Echipa care se ocupă de îngrijirea pacientei cu DPP este formată din: medicul de familie, psihiatru, psiholog, asistent social, nursă.
Sunt importante respectarea tratamentului recomandat de medic şi prezentarea la vizitele de control.
Este importantă implicarea familiei în susţinerea pacientei cu DPP.

Scala de depresie postnatală din Edinburgh a fost construită pentru a ajuta medicii să determine dacă mama suferă de o depresie postpartum.

Instrucţiuni:

Cum te simţi? Alege răspunsul care este cel mai apropiat de cum te-ai simţit în ultimele 7 zile - nu numai cum te simţi astăzi.

1. *Am putut să râd şi să văd partea distractivă a lucrurilor.*
   a. Da, tot timpul
   b. Da, în cea mai mare parte a timpului
   c. Nu prea des
   d. Deloc
2. *Am putut să privesc viitorul cu bucurie.*
   a. La fel de mult ca întotdeauna
   b. Mai degrabă mai puţină decât de obicei
   c. Cu siguranţă mai puţină decât eram obişnuită
   d. Deloc
3. ** Mi-am făcut reproşuri în plus când lucrurile au mers prost.*
   a. Da, majoritatea timpului
   b. Da, uneori
   c. Nu prea des
   d. Nu, niciodată
4. *Am fost îngrijorată sau am fost neliniştită fără motive întemeiate.*
   a. Nu, deloc
   b. Rar, câteodată
   c. Da, câteodată
   d. Da, foarte des
5. ** Mi-a fost frică sau am intrat în panică fără motive bine definite.*
   a. Da, destul de mult
   b. Da, câteodată
   c. Nu, nu prea mult
   d. Nu, deloc
6. ** Lucrurile m-au depăşit.*
   a. Da, majoritatea timpului n-am fost capabilă să cooperez deloc
   b. Da, câteodată n-am cooperat ca de obicei
   c. Nu, majoritatea timpului am cooperat binişor
   d. Nu, am cooperat ca întotdeauna
7. ** Am fost aşa de nefericită că am avut dificultăţi de somn.*
   a. Da, majoritatea timpului
   b. Da, câteodată
   c. Nu prea des
   d. Nu, deloc
8. ** Am fost tristă sau m-am simţit mizerabil.*
   a. Da, majoritatea timpului
   b. Da, destul de des
   c. Nu prea des
   d. Nu, deloc
9. ** Am fost aşa de nefericită că am plâns.*
   a. Da, majoritatea timpului
   b. Da, destul de des
   c. Numai ocazional
   d. Nu, niciodată
10. ** Am avut gânduri să-mi fac rău mie.*
    a. Da, destul de des
    b. Câteodată
    c. Cu greu aş putea zice
    d. Niciodată

Punctajul:
Răspunsurile au punctaj de 0, 1, 2 şi 3 în concordanţă cu creşterea severităţii simptomelor. Afirmaţiile marcate cu steluţă (*) sunt punctate în ordine inversă (i.e. 3, 2, 1 şi 0). Punctajul final este calculat prin adunarea fiecărui punctaj de la cele 10 afirmaţii.
Un punctaj $\geq$ 10 indică probabilitatea unei depresii, dar nu şi severitatea ei.

Atenţie la întrebarea 10, care reflectă gândurile suicidale!

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** articolul prezentat a fost publicat la pagina pacientului in "Jurnalul medicului de familie", dorindu-se a fi un material pentru pacient, care se poate da gravidei/lăuzei în cursul consultaţiei, spre documentare. Publicăm articolul cu acordul autoarei datorită conţinutului de larg înteres pe care-l reprezintă şi pentru medicii de familie.*

„WRITING PRESCRIPTIONS IS EASY...": FRANZ KAFKA AND HIS COUNTRY DOCTOR

- John Salinsky, general practitioner, London, UK

ABSTRACT

'Writing prescriptions is easy...' This sub-theme of the Congress derives from a rueful reflection in Franz Kafka's short story A country doctor. In this story, a night call from hell vividly illustrates the not-so-easy part of the doctor's life. But what would happen if Kafka's unfortunate GP presented his 'case' in a Balint group? And is Kafka offering himself as a suitable case for treatment?

During my early days as a family doctor over 30 years ago I kept coming across a quotation from a story by Franz Kafka called *A country doctor*. The quotation was:

To write prescriptions is easy but to come to an understanding with people is hard.

It was originally used as the epigraph to one of the early books written by Michael Balint and his group in London. The book was called *Treatment or Diagnosis: a study of repeat prescriptions in general practice* and it is still worth reading. But the quotation kept cropping up in lectures and articles. This was in the 1970s when general practice was reinvented as a speciality in its own right. Far from being inferior to the hospital specialists, we GPs felt that we could provide a personal service to patients that no other doctor could offer. And Kafka's words seemed to encapsulate everything we stood for. Our mission was - and is - not just to scribble on the pad but to connect with our patients as human beings. To reach out to them with empathy, compassion and continuity. Everyone I spoke to seemed to know the quotation but, strangely, no one had read the story. Years later, when I finally read it myself, I was astonished by its power and its strange dream like quality. Not only was it a wonderful piece of writing, but the author seemed to have such an intimate knowledge of what it felt like to be a doctor. Had he ever studied medicine? I didn't think so. And being by Kafka the story must have all sorts of other meaning as well that I might not have figured out. When I telephoned an old friend who is an English professor, he told me that it wasn't really about doctors at all. But I was not entirely convinced. I became obsessed with the story. I read about it. I wrote about it. I gave seminars to trainee GPs about it. And I tried to learn as much as I could about Franz Kafka. He was born in Prague in 1883 into the minority Jewish community in Prague who were German speaking. Although Kafka was fluent in Czech as well, he wrote only in German. He worked as a lawyer in the state workers' insurance agency in Prague and did his writing at night. He was not very well known in his life time but, since his death, he has become one of the most famous, most written about and most perplexing authors of the twentieth century. He was a very troubled person, full of anxieties and psychosomatic symptoms. His name has become associated in the word Kafkaesque with the idea of a world in which a small insignificant person struggles desperately with an unfeeling bureaucracy. He also had a great sense of humour. Franz Kafka died at the age of 40, having written three unfinished, unpublished novels, together with letters, diaries and lots of short stories some of which were published in his lifetime. One of these was *A Country Doctor* (Ein Landarzt).

At this point, I should tell you something about the story. Or maybe refresh your memories if you already know it.

The story begins in the first person. The country doctor is speaking:

I was in great perplexity; I had to start on an urgent journey; a seriously ill patient was waiting for me in a village ten miles off; a thick blizzard of snow filled all the spaces between him and me. I had a gig, a light open carriage with big wheels, exactly right for our country roads; muffled in furs, my bag of instruments in my hand, I was in the courtyard all ready for the journey; but there was no horse to be had, no horse.

We learn that the doctor's horse has died in the night and he has been unable to borrow one in spite of the efforts of his servant girl Rose. Then the story takes a magical or

dream like turn. Out of an old pigsty emerge two splendid horses and a groom who seems to be in charge of them. Problem solved? Yes and no. The groom turns out to be a demonic character who is intent on raping poor little Rose. The doctor finds himself being carried away in the open carriage by the furiously galloping horses and unable to protect Rose from the groom. As in a dream, the gig arrives at the patient's village almost instantaneously and the doctor has to concentrate on his work, despite the agonies of his private life.

"You're coming with me," I said to the groom, "or I won't go, urgent as my journey is. I'm not thinking of paying for it by handing the girl over to you." "Gee up!" he said; clapped his hands; the gig whirled off like a log in a stream; I could just hear the door of my house splitting and bursting as the groom charged at it and then I was deafened and blinded by a storming rush that steadily buffeted all my senses. But this only for a moment, since, as if my patient's farmyard had opened out just before my courtyard gate, I was already there; the horses had come quietly to a standstill; the blizzard had stopped; moonlight all around; my patient's parents hurried out of the house, his sister behind them; I was almost lifted out of the gig;

The patient is a young man who, at first sight appears to have taken to his bed out of sheer laziness. The doctor is furious that he has been dragged out on a totally unnecessary house call in the middle of the night. He grumbles about the way everyone abuses his professional position and his good nature. *My horse was dead, and not a single person in the village would lend me another. I had to get my team out of the pigsty; if they hadn't chanced to be horses, I would have to travel with swine. That was how it was. And I nodded to the family. They knew nothing about it and had they known, would not have believed it. To write prescriptions is easy but to come to an understanding with people is hard. Well, this should be the end of my visit. I had once again been called out needlessly…*

I think plenty of modern day doctors would relate to that feeling. But the family don't accept his perfunctory diagnosis. The sister waves a blood soaked towel in his face. Even the two horses who have managed to poke their heads through the windows (a wonderful comic visual touch) seem to be urging the doctor to take another look. When he does so he discovers that the boy has a terrible wound in his side in which horrible worms are wriggling. He is surely going to die. *Poor boy, you were past helping; I had discovered your great wound; this blossom in your side was destroying you…* Will you save me? pleads the boy.

But the doctor just goes on grumbling to himself about how people expect him to do the impossible. Suddenly the family and the village elders jump on him, strip all his clothes off and put him in bed naked with the patient while a school choir assembles outside and sings a little folk song. Meanwhile the doctor and patient are talking. The boy is angry and resentful. The doctor agrees he is useless. Must I be content with that excuse? Asks the boy. Then more sadly: *'Oh I suppose I must, I always have to be content. I came into the world with a beautiful wound; that's all I was endowed with.'*

Rather disgracefully, the doctor now tries to reassure the young man that his wound is only trivial so that he can make his escape. Hastily he gathers up his fur coat and equipment and - still naked- leaps through the window onto the back of one of the horses. The journey back is painfully slow and the doctor laments the ruin of his life and his practice – all because of one wrong decision.

So that's the story. It's brilliant, exciting, disturbing, baffling. You must certainly go away and read it. But what is it about? It certainly seems to me to have a message for doctors but there are of course all sorts of other things going on as well. Kafka is a writer whose work has been the subject of all sorts of interpretations: political, religious, biographical and existential to list only a few. But before we get into that I think we should take the story at its face value. What we have is an elderly GP telling a story about an encounter with a patient. Is it a suitable case for a Balint group? You bet it is. So let us imagine that the Doctor is a member of *our* Balint group. He is one of us and he has just presented his case. How will our group receive it? What will we think of him?

First of all, we will have a lot of sympathy over the death of the horse. It's true that not many country doctors do their visits by horse and cart these days, but substitute a flat car battery and the situation is the same. Then there is the question of the young girl, Rose, and the groom. How often have we all had to deal with a medical emergency just at the time when there is a huge crisis in our private life? We urgently need to talk to a wife or husband who is threatening to leave, or a teenage son who seems to be taking drugs. Or there just been a burglary or the roof is leaking. But instead of being able to deal with our own lives we have to rush off and help some patient or other. It may be that Mrs Jones who is always calling us out for nothing. But we have to go - just in case this time it really is a heart attack.

Then we get to the point where the doctor takes his first look at the patient, that frail, thin young man lying in his bed. The boy puts his arms round the doctor's neck and says 'Doctor, let me die'. That is quite disturbing. He is suicidal! What will the doctor do? But the doctor is too pre-occupied with his personal problems to care very much. We are a little shocked at his frankness. At any rate, he allows the young man's family to show him hospitality: the sister helps him off with his coat; the father offers him a glass of rum. They are trying to coax him into a better mood, just as our patients do when they sense that we are preoccupied and grumpy. Then, after a very brief examination, our doctor concludes that there is nothing wrong with the boy. He is 'in good health and best kicked out of bed at once.' Then he starts complaining to the group about how he is abused and how the community take advantage of his good nature. *'Though badly paid I am open handed and always willing to assist the poor'*. No one appreciates him. Writing prescriptions is easy, he observes, communicating with people is hard. We doctors in the group are nodding in agreement. Several of us would like to add our own comments about the terrible ways in which doctors are treated these days by ignorant peasants. But the group leader intervenes and asks us to allow our doctor to finish his presentation. Now he comes to the point where he is persuaded to take another look at the

boy and discovers the terrible, fatal wound in his side. Again we doctors are nodding our heads in sympathy. We have all been there. Dismissed a patient's symptoms as trivial and then discovered that he was fatally ill. The family are now pleased that the doctor has begun to take their son seriously. The house begins to fill up with friends and neighbours. The village elders arrive. The school choir assemble outside the door with their teacher! The horses are still watching through the window. There is a lot of comedy in Kafka. Don't let anyone tell you that his stories are depressing. Now the family and the elders strip off the doctor's clothes and put him naked in bed with the patient! Has this ever happened to you? The doctor might ask us, his friends in the group. At first we shake our heads, then we think: wait a minute. I do know what it's like to feel naked in a consultation. And so close to my patient we are almost the same person. Then he admits to another big mistake. He has lied to the patient. Although he knows the boy is going to die, he gives him false reassurance. All he wants to do is to escape from the situation as soon as possible and get back home to save Rose. And to save his practice.

Now it's time for the group discussion. We all have a lot to say. Our leader has difficulty getting us to speak one at a time, we are so excited. At first we avoid talking about the doctor's mistakes and his unprofessional behaviour. We all agree that doctors are exploited, no one appreciates us, the peasants are all a greedy ignorant mob. The government should provide us with free horses and we shouldn't have to do night calls. We should get more pay. And more respect. The leader lets this go for a while and then tries to bring us back to the doctor patient relationship. Gradually we start to examine our own feelings.

How easy it is to get angry when you feel abused. How easy and how dangerous not listen to the patient and his family properly. How important to do a thorough examination. We avoid harsh criticism of our friend because we have all done similar things. And felt ashamed, and then made the same mistake again. What about the patient? How would it feel to be in his shoes? Or as he has no shoes, to be in his bed with that terrible wound? He seems to know that he is going to die. Is he frightened? He is angry with the old man who can only say that isn't easy for him either. We reflect on the boy's remark that 'I came into the world with a beautiful wound: that's all I was endowed with.' What did he mean by that? The group leader thinks he knows but he is not saying. Certainly we agree that the boy might be expecting some compassion, some understanding and a doctor who will answer his questions, stay a while with him and give him as much comfort as he can. Some of us feel rather critical of the doctor now. But we don't say anything because we are sad for him and we suspect that, underneath the anger and despair, he is feeling guilty. Was his practice really ruined because of that one profoundly disturbing night call? Is he suffering from burnout? Some of these things are a bit personal to talk about with a doctor we don't know very well. We end on a note of uncertainty as often happens in Balint groups. Hopefully the doctor has at least felt better for having told his story, made his confession and not been rejected as a person. Does he really understand that he has behaved rather badly? Or does he only feel self-pity? Hard to say. But the rest of us have all learned something about ourselves.

Now some of you may be thinking: this is all very well and at first I was convinced that the Country Doctor was a real person. But he is really only a fictional character who belongs in the mind of his creator. So shouldn't we have Franz Kafka presenting the case at our Balint group? Well, ladies and gentlemen, he was there, all along. While we were listening to the doctor we were also hearing about the thoughts and feelings and anxieties of Franz Kafka. What do we know about Kafka's life that might help us to understand the more puzzling aspects of the doctor's story? At this point a professor of literature if there is one on the audience might stand up and say: the author's life story is irrelevant. Literary criticism should stick to the text and not try to make guesses based on the life of the author. To this I would say, but we are all doctors and psychotherapists.

A text to us is like the symptoms of an illness. We can't resist the urge to encourage the patient to tell us more about himself. And Kafka's life is so interesting that even the professors make an exception and have written millions of words about the relationship of Kafka's life to his work.

So how did this young man of thirty come to write *A Country Doctor*, in Prague, during the First World War? Was he a physician himself? No, he wasn't. His doctorate was in law. But he did have a favourite uncle, Uncle Siegfried, who was indeed a country doctor and the young Franz spent some happy summer holidays staying with Uncle Siegfried and no doubt hearing stories about his patients. One can imagine the doctor coming home from a visit, throwing his bag on the table and saying, 'well that was a complete waste of time!' In a more reflective mood he might have said to his nephew: 'what do these patients really want from me? Don't they understand that I can't work miracles? Believe me, my boy, writing prescriptions is easy, BUT...

At home in Prague, life was more difficult for the young Franz. He had a very problematic relationship with his father who was large noisy, self-confident man, very different from his shy, thin, nervous son. Kafka's father was a successful businessman who wanted a son who would be like himself. But all Franz wanted to do was to write and that his father could never understand. Knowing all this, we come back to the Country Doctor story and what do we see? We see a doctor and a patient. But we also see a frail young man, rather like Franz, and an overbearing older man, perhaps like Franz's father. Clearly they are having difficulty in understanding one another. And what about that terrible wound in the boy's side? Kafka died from tuberculosis which first

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revealed itself when he coughed up some blood. That was not till 1917, after the story had been written, but when it happened Kafka wrote to a friend: 'I predicted that I would cough up blood in *A country doctor*'. But that wound has other meanings. Many critics have seized on its sexual symbolism: it has been likened to a vagina and its colour is described as rose-red, which reminds us of the girl Rose back at the doctor's house. We know that Kafka's relationships with women were difficult and complicated. He wrote hundreds of love letters but shied away from marriage because he felt that living with another person would prevent him from being able to write. Although deeply attached to his fiancée Felice, he seemed to be happier writing to her than being with her. He also had brief affairs with other women some of which made him feel good. After casual encounters he would come away feeling disgusted with himself. Only at the end of his life did he find an all too short happiness with a young woman called Dora. But even if that rose red wound is a symbol of sexuality it doesn't really explain why the young man says that the wound he was born with was the only thing of value that he brought into the world. Perhaps, as some critics have suggested, the wound also represents his gift as a writer: a source of joy but also of pain and ultimately perhaps of his premature death. And what of that famous sentence about prescriptions being easier than understanding? What does he mean by coming to an understanding with people? At the time he wrote the story, in the winter of 1916-17, he was agonising about understanding his relationship with Felice. Their engagement had been broken off but they were writing to each other again and even planning to meet. Kafka's haemoptysis in September 1917, 'the fatal wound' provided a good excuse for him to abandon any ideas of marriage because of his poor health.

Once you start thinking about Kafka's writing all sorts of levels of meaning start to reveal themselves. Some of them may contradict one another but that doesn't really matter. When I read this story I have the strange feeling that I have learned something important although I can't explain what it is or what it means. It's a bit like reading a mysteriously beautiful poem. The same thing can happen in a Balint group discussion. All sorts of different opinions are expressed. We often feel we have learned a lot but uncertainty remains In reading and thinking about *A country doctor* we learn about a doctor and a patient and their relationship with each other as they exist in the mind of the author. We learn something about ourselves and about the human condition. Just like in a Balint group.

AN EXCEPTIONAL POSSIBILITY OR A MISSION IMPOSSIBLE

Obligatory reflection groups during the first clinical year of a brand-new undergraduate curriculum.

- Anders Häggmark, GP, Karolinska Institutet, Center for Family and Community Medicine, - Anita Häggmark, Psychoanalyst in Private Practice, Stockholm, Sweden

For two years we have both – in different ways – been involved in the education of medical students in Stockholm. We have often discussed the similarities of our experiences in reflection groups (Student-Balintgroups) and primary care training. Among other things our thoughts about the students´ capacity for empathy, that we discussed in a paper at the IBF Congress in Lisbon 2007, have been brought up again.

We will start by describing our different starting points: The undergraduate medical education at the Karolinska Institutet Stockholm has got a new curriculum, which has been introduced gradually since the autumn 2007.

Some of the changes are:

- A reduced core curriculum and instead an increased volume of optional courses
- One term for an obligatory scientific project
- Primary care for 4-7 days each term.
- Professional development running throughout the programme.

The total length of the undergraduate course is unchanged, 11 terms. Therefore much stress is laid upon learning "essential facts" during this reduced core.

The Primary Care training

Anders´ role – at the Center for Family and Community Medicine – has been:

- To recruit Health Centres and supervisors for undergraduate placements. From spring 2009 we have about 170 Health Centres in Stockholm joining the programme, giving supervision to 1400 students.
- To be one of the organisers of primary care teaching during clinical medicine, the 6th and 7th terms.

During that year primary care is meant to be an "arena" for the students, where they can meet many patients with varying symptoms. There is a focus upon the whole consultation including planning of investigations and treatment. The students´ role progresses from being a listener to that of a team member (own consultations with supervision), and it is planned that the students will do their own consultations sooner rather than later.

Professional development and the reflection groups

In the undergraduate curriculum at the Karolinska Institutet in Stockholm the professional development module consists of 10 weeks scattered over 10 terms.

It is during the year of clinical medicine that the reflection groups take place as a part of professional development. From the beginning the aims of the groups were rather diffusely defined, so there was an opportunity to suggest student- Balintgroups as an option.

Anita's task has been to organise these groups, above all to find interested and capable leaders. One problem was, that there was almost no flexibility with the time-table.

There are four hospitals for the students´ training during the year of clinical medicine, four groups at each hospital with separate directors, course administrators and time-tables. The time for the groups was – and still is – limited: four to six sessions of 90 minutes each year, two of the hospitals giving more time than the others.

There are 8-10 students in each group, and the participation is obligatory. This was discussed before starting the groups and the student representatives were the most eager in pleading for obligatory reflection groups. Anita's first thought was that such groups should be voluntary, but now she is not sure. The students join the group sessions with very different degrees of motivation, but there are few that in the end think that such groups are totally useless. There are also students, who have asked for the groups to be continued , thus introducing the possibility of some voluntary groups later.

The groups are called "reflection groups" as the concept of Balintgroups was quite unknown among most of the course leaders at the hospitals.

When we started the first groups, we had no clearly formulated aims, but as we found that there are obvious differences – but also similarities – with the work in an ordinary

Balint-group, we made a <u>tentative list of aims:</u>

- Increased knowledge of the student's own reactions and their significance in relation to the patient.
- Increased knowledge of the patient's psychological reactions.
- Getting the courage to examine routines of care.
- Increased knowledge of how to keep one ´s own mental health and thereby the capacity of empathy.

Some examples of themes for the group work:

- The significance of frames for the consultation.
- The ability to bear not knowing everything.
- The student's own reactions (and defences) when meeting a patient.
- Thinking about ethical dilemmas
- What is "a good doctor"?
- The student´s role such as responsibility in the student-patient relationship, the relationship with the supervisor and so on .

When Anita presented the list to one of her groups, their reactions were: "Should we manage to accomplish all these things?" And: "To bear not knowing everything –that ´s valid for graduate doctors- not for us?" Soon after that comment the group was worried because they had forgotten everything during the summer and it was painful to start the new term!

One of the students said: "It would be enough with one item from the list – THE STUDENT ´S ROLE".

That reminds us of what Heather Suckling pointed out in her paper at the International Balint Congress in Lisbon 2007. Several of the themes that she discussed are well recognised in our groups. Heather ´s groups met during the first clinical year – about the same terms as our groups. But there are differences: the English groups are voluntary and run for one hour a week over 12 weeks. This continuity will obviously help with the formation a good working group. On

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the other hand our students have expressed how they appreciate that the groups run throughout the year.

Anita´s groups take place at one of the hospitals and we are happy at least to have six sessions a year, even though they are on Friday afternoons.

We have to use the time we have got as well as possible hoping that the course directors will give the groups higher priority in the future.

A year when the student´s capacity for empathy is in danger?

We will focus upon this first clinical year – the terms of clinical medicine – and discuss how the student might use the reflection groups as well as their training in primary care.

From the, in some ways, rather protected life during the pre-clinical stage it can be something of a shock to enter clinical reality. The illusion of knowing quite a lot is suddenly lost and sometimes it is replaced by a painful feeling of knowing nothing at all. Students often feel that they are hovering between these two extremes.

The student seldom stays for more than one week on a particular ward. As a student in one of the reflection groups said: " You have just learned to find where the ward toilet is, when it is time to leave". A common theme in the reflection groups is how confusing it can be to meet the different cultures of so many wards.

One reason for this schedule is that the wards are much more specialised today than they used to be, so it is a way of meeting patients with different diseases.

In a way it seems like a good idea, but it might not enhance the student-patient relationship and the development of empathic capacity.

Primary care gives the students the possibility of seeing many patients and that is something they are eager to do. They are attached to the same health centre during the two terms, which gives a continuity. Nevertheless there have been unexpected difficulties. One criticism from the students has been that there is too much focus on history-taking . They think that this is too similar to the pre-clinical stage " And we do know how to take a history !"It is as though history taking could always be accomplished in the same way-"one should just follow the model for questioning as learned in the hospital!" The student might vacillate between: "I know this already, just taking a history is boring" and "What´s the use of meeting a patient , when you don´t know his diagnosis?– I have no idea how to handle it."

Patients in primary care often have no clear diagnosis and present with diffuse symptoms. They might not fit well with the model for focused history taking. There is a need for attentive and empathic listening. This seems to be natural and even thrilling for some students but confusing and irritating for others.

One conclusion is that in this first clinical year the students feel that it is so urgent to learn medical facts – and there seems to be such a short time for it – that all the time must be useful in a strict medical way. It might seem disturbing – and threatening - to focus on the doctor/student –patient relationship at the same time, allowing free space of thoughts and feelings, where empathy can grow.

The reflection group gives the students an opportunity to talk about their own experiences of meeting patients, even when they feel confused and worried. For many of them this will be a relief but for some students it might rather threaten their self-esteem.

In the groups they are sometimes preoccupied with discussing organisational problems – important of course, but the patients could be forgotten. As a leader you have to be open-minded and listen out both for the problems of being a student in the organisation and for the sometimes hidden reactions connected with the student-patient relationship.

Hunting good role models

The students are really hunting good role models and in the reflection groups they often express their disappointment with bad ones. Unfortunately there are bad models - as for instance the student, who got advice on how to do quick consultations –"Don´t look at the patient!"

What about a good role model for a doctor? A doctor with no deficiencies in medical knowledge? A doctor whose patients never get disappointed ? No, that doctor is a fiction , but it must be possible for the student to discuss, for example why the doctor at the health centre does not order investigations in the way the student just has learned at the hospital. The students very much appreciate those doctors, who are willing to discuss such things without fear of losing their prestige, the doctors who show the students as well as the patients respect and empathy. In the reflection groups bad models usually involve relationships: supervisor-student and supervisor-patient and especially when the three meet together.

There is often no possibility to talk about the feelings in such a situation when it happens – they are usually expressed in later written evaluations. These situations are challenges to the student´s role: on one hand to be the good pupil accepting everything from the supervisor and on the other hand – if criticizing - to feel the danger of appearing as superior, risking offending the supervisor.

One example from a reflection group: The supervisor has difficulties with the Swedish language, the patient is a depressed woman with diffuse pains and a complicated social situation. The student discovers several misunderstandings between the doctor and the patient, feels very uneasy but remains silent.The other group members understand the dilemma very well, they give other similar examples and we discuss the conflict – to be empathic with the patient or try to save the supervisor´s self-esteem without knowing if he/she really is so vulnerable.

Not easy to be a student

Is the first clinical year a period of increased vulnerability? We think this question is connected with our earlier one: is this a year when the student´ s capacity for empathy is in danger? Our hypothesis in our 2007 paper was that empathy might seem to disappear, but in fact gets concealed because of the student´ s defences that intensify in vulnerable situations.

We think that our actual experiences seem to be in agreement with that hypothesis. Clinging to medical facts, denying all other aspects, can happen for some students. For them obligatory reflection groups might be a good idea.

This year is really in many ways challenging for the students, and we think it is very important to have the reflection groups to give space for all the different aspects of being a student, meeting patients in a complicated training situation.

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ROLURI - SENTIMENTE ŞI IMPRESII ASUPRA CURSULUI DE FORMARE A LIDERILOR DE GRUP, IZVORUL MUREŞULUI - Vajda-Hegyi Csilla, Tg. Mureş

Sunt în tren şi scriu pe laptop. Ce experienţă nouă pentru mine! Eu am crezut, că aşa ceva există numai în filmele din străinătate. Nu contează că s-a descărcat bateria, descoper că există priză! Am crescut în şi pe maşină, din oraşul nostru având doar un trenuleţ, „acceleratul secuiesc" cum îl poreclă lumea, care avea ruta fixă de 3 ori până în Sighişoara şi de 3 ori înapoi. Nu te ajuta prea mult. Părinţii mei au avut maşină de dinainte să mă nasc, deci am călătorit foarte puţin cu trenul.

Mă liniştește oarecum zgomotul monoton şi comoditatea trenului intercity. Ca să ajung în timp în staţie, eram nevoită să părăsesc grupul înainte de a-şi spune toţi sentimentele şi impresiile în grup. Implicit trebuia să mă duc pe jos şi de una singură la gară. Nu s-a cuvenit să mai scot pe cineva din grup să mă ducă la gară. S-a făcut zăpadă ce-mi depăşea gleznele, bagajul imediat s-a făcut şi mai greu, drumul mai lung decât părea la început.

Ajung totuşi în timp util, dar mă lovesc de „amabilitatea" agenţilor de la gară şi incerc să mă abţin până mă serveşte cu biletul. Număr secundele, minutele. Încă puţin şi sunt pe tren. Dar vine spre mine unul din agenţi, văd că se îndreaptă cu paşi siguri către mine, cu siguranţă vrea ceva. Într-adevăr: îmi comunică, că trenul va avea o întârziere de 30 de minute. Încep să plâng. Socotesc timpul, dar consider că nu mai are rost să mă întorc şi să vin iarăşi în staţie. Berci îmi confirmă prin telefon acest lucru. Îşi dă seama că nu sunt bine şi face tot posibilul să mă liniştească. Nu mai era nici un alt călător care să aştepte trenul. Mă simt singură şi la propriu şi la figurat. Şi deodată îmi amintesc de idea de bază a întâlnirii. Rolurile! Ne alegem, ne asumăm, ni se impune. Stau să mă gândesc.

Rolul meu de balintian, de lider, de secretar mi l-am asumat, mi-lam ales singură şi-mi place. Alegerile şi renunţările pentru altceva în favoarea balintului şi până acum, le-am făcut cu drag. Reevaluez situaţia. A trebuit sa fac compromisuri din cauza schimbării datei întâlnirii. Nu toate prea benefice, dar eu am ales să vin, pentru că-mi era important. Corectez, este şi va fi important. Eu am ales să vin cu trenul şi nu cu maşina. M-am informat că s-a stricat rău drumul, s-a anunţat şi cod galben, mi s-a părut ocazie bună de a experimenta trenul. Conştientizez cât de greu îmi este să mă conformez în reguli impuse, în cazul de faţă în cadrul de timp. Nonconformista din mine! Eu mi-am ales să nu particip pe toată durata weekendului.

Rolul de soţie şi familistă este primordial. Mă aşteaptă un alt program pentru duminică, totodată după o săptămână încărcată de serviciu, am nevoie şi de odihnă înainte să înceapă săptămâna următoare. Dar regret că nu pot să fiu în două locuri deodată. Ce păcat. O parte din mine rămâne între ei. Dar mă simt mult mai bine.

Mă gândesc la tot ce s-a petrecut în acest timp în grupuri. Grupuri clasice şi mai puţin clasice pe care le-am avut. Îmi revine idea principală: roluri. Câte şi câte le avem, le-am avut şi le vom avea. Sunt îmbibate cu sentimente, sarcini, definite prin timp şi loc. În grupurile Balint deasemenea avem de-a face cu roluri. Imediat la început se împart rolurile vizibile:

rol de lider, colider, observator extern sau intern, membru de grup, protagonistul grupului. Sub aparenţe sunt rolurile pe care le trăim şi le retrăim prin punerea în situaţia celuilalt, clasic, nu? „eu în locul lui X, eu dacă mă pun în locul lui Y", şirul poate continua.

Eu în locul meu, sau în locul protagonistului mă pun în rolul acestuia dar implicit retrăiesc şi rolurile pe care le-am avut în viaţă, eu ca personajul din cazul balint, dar şi tot ce înseamnă acest personaj în viaţa mea, rolurile se suprapun sau se distanţează, dar la urma urmei acesta este rolul balintului. Mă uit la ceas şi mă mir cum a trecut timpul. Ar fi bine să mă pregătesc de coborâre. Acum sunt în rol de călător şi trebuie să fiu atentă când să apăs butonul pentru a se deschide uşa. Ce noutate! Nu trebuie să împing din greu cum să se deschidă!

Deci roluri,... avem şi vom avea multe!

Ungerea noilor membrii

SOME REMARKS ON THEORY AND PRACTICE OF BALINT GROUP WORK IN GERMANY

- Steffen Häfner, Heide Otten and Ernst Richard Petzold, German

ABSTRACT: *Background and aims: In this study, the characteristics of Balint groups in Germany today are analysed. Methods: A questionnaire was sent to 503 German Balint group leaders. 333 (66.2 %) returned the questionnaire (59 % men, 41 % women, mean age 57.2 years).*

Results: *Despite the original intention of Michael Balint, the idea of weekly Balint groups is not realised in practice. Neither is Balint-group leadership by psychoanalysts very common. The duration of each session is according to the ideas of Michael Balint.*
So is the number of participants registered per group, but not if we consider only the number of actually participating members. Astonishingly, 17.4 % of Balint group leaders were more than 65 years old. As for the composition of different professions (physicians with different specialities, psychologists, teachers etc.) in Balint groups there is a desirable heterogeneity.

Conclusions: *This shows that Balint group work in Germany is not only integrated in general practice or in the field of psychotherapy, but is also of interest for many specialists of other disciplines as a good way of continuing education. The ideas of Michael Balint are very much alive, but – because of the changed realities in the medical field – no longer in their original way, but in settings adapted to the new situations in medicine.*

There can be no doubt that it is beneficial to lead Balint groups. In the year 1984, the Swiss Balint group leader Hans-Konrad Knoepfel gave this remarkable opinion. Why is this so? In order to learn more about the beneficial effects of leading Balint groups and in continuation of previous studies on Balint group work in Germany (Häfner et al., 2005; Foitzig, 2007; Petzold 2008) this survey analyses the practice of Balint groups in Germany today compared with Michael Balint's original idea:

„Eight to 10 physicians meet regularly every week with one or two psychoanalysts for the duration of 2-3 years. In every session a participant reports about his experiences with a patient. At the beginning of each session, follow-up reports are discussed. Every report is spontaneous and leads to a discussion in the group in which the contributions of the psychoanalyst are the starting point of a learning process for the group members by identification with the function of the psychoanalyst.

Training and research are combined in this way" (Argelander, 1979).

Research Questions

The main research question in this study was to investigate the practice of Michael Balint's ideas in Germany today, especially the questions 'who leads Balint groups?', 'what are the characteristics of Balint group leaders and their sociodemographic features?' and 'what are the characteristics of Balint group leadership nowadays?'.

Method

We devised a questionnaire that was sent to all Balint group leaders of the German Balint Society at the beginning of the year 2004. All Balint group leaders have completed the same curriculum to be registered as Balint group leaders by the German Balint Society. At the time of the study in 2004, the German Balint Society had 992 members, 584 men (58.9 %) and 408 women (41.1 %).

Statistics

Descriptive data analysis and group comparisons with the chi-square test were performed with the statistical programme SPSS 15.0.1. Results are presented as mean values + standard deviations with the range in brackets.

Results

Participants

After the first letter in January 2004 and one reminder in March 2004 to 503 Balint group leaders, 333 questionnaires were returned, so the response rate was 66.2 %. The participants (59 % men, 41 % women) had a mean age of 57.2+9.4 years (39-90), 58 participants (17.4 %) were over 65 years old (64 % men, 36 % women). The sample is representative of the members of the German Balint Society in the year 2004.

The Balint group leaders had the certificate of the German Balint Society for 10.0+6.2 years (0-34) and the diploma of the Board of Physicians for 11.4+7.2 years (0-37). Each Balint group leader is responsible on average for 1.34+1.1 (0-9) Balint groups.

39 (11.7 %) Balint group leaders were not leading a Balint group at the time of the investigation. Their mean age was 56.6+11.1 years (40-87), 22 men (56.4 %) and 17 women (43.6 %). They had had their certification for 7.6+5.5 years (1-25) and their diploma from the Board of Physicians for 10.3+8.4 years (1-36). There were no significant differences with „active" Balint group leaders according to sociodemographic features.

Number of participants in Balint Groups

According to the reports of the Balint group leaders, the average number of participants inscribed per Balint groups (members of the group) is 10.7 +3.8 (5-48) though those actively participating in the group average 8.6+2.4 (4-23) **(Fig. 1)**.

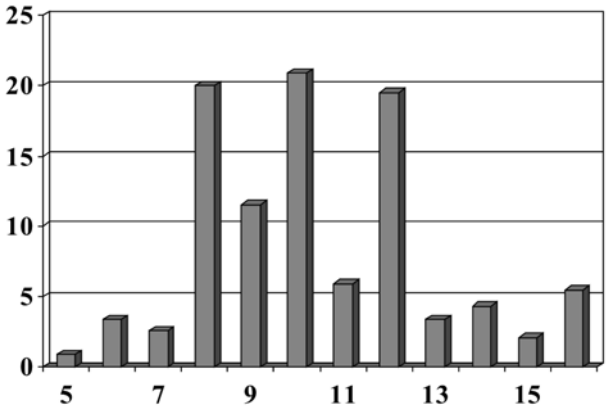


Fig. 1: *Distribution of the number of Balint group members that are inscribed in the group (not necessarily actively participating).*

Duration of Balint group sessions

85.0 % of the Balint group leaders make group sessions of 90 minutes duration, 4.4 % of 180 minutes, 3.3 % of 120 minutes, 1.8 % of 45 minutes and 1.5 % of 60 minutes **(Fig. 2).**

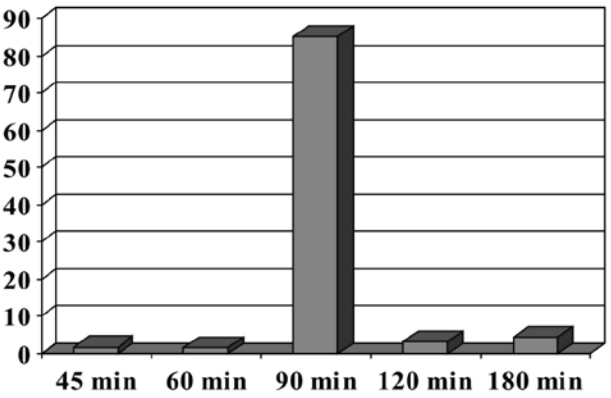


Fig. 2: *Duration of Balint group sessions.*

Specialties of Balint group leaders

It was possible to give more than one response to the question about the physician's specialties. 30.6 % specialised in psychosomatic medicine and psychotherapy, 17.1 % in psychiatry and psychotherapy, 12.3 % were general practitioners and surgical disciplines were represented by a very few Balint group leaders who were ophthalmologists or urologists though there were no general surgeons **(Fig. 3)**. 5.4 % of leaders had a degree as a psychological psychotherapist.

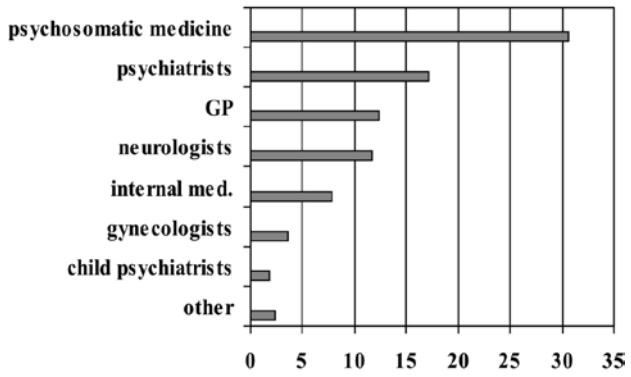
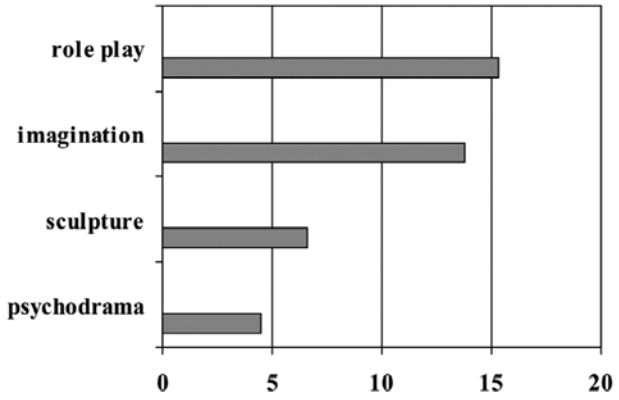


Fig. 3: *Specialties of the Balint group leaders (Doctors).*

Inclusion of other methods in classic Balint Work

The most common methods incorporated into Balint groups are role play (15.3 %), imagination (13.8 %), sculpture (6.6 %) (Otten, 2005) and psychodrama (4.5 %) **(Fig. 4).**



Other methods that are integrated into.

Fig. 4: *Other methods integrated in classic Balint group work.*

Classic Balint group work are focusing, family therapy, group analysis, painting, music, body psychotherapy, systemic elements, behavioural techniques, problem solving, live talks with patients, reflecting team and supervision. These were not very commonly included but they show the heterogeneity of the techniques applied.

Conclusions

Despite the original intention of Michael Balint, the idea of weekly Balint groups is not generally realised in Germany today. Usually sessions are every two weeks. Neither is Balint-group leadership by psychoanalysts very common. The duration of each session is according to the idea of Michael Balint as well as the number of participants registered per group, but the number of actively participating members is significantly fewer.

As for the composition of different professions in Balint groups there is a desirable heterogeneity. Integration of different other methods in Balint group work is very common. This shows that Balint group work in Germany is of great interest for many specialists of various disciplines, not only general practice (Häfner and Petzold, 2007) or psychotherapy. It is also a good method of continuing medical education. The ideas of Michael Balint are very much alive if no longer in their original way, but in many settings adapted to the new situations in medicine – according to changing realities in the medical field.

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THE PHYSICIAN ASSISTANT – PATIENT RELATIONSHIP DESCRIBED BY A CERTIFIED PA

RELAȚIA DINTRE ASISTENTUL MEDICULUI ȘI PACIENT DESCRISĂ DE UN "ASISTENT DE MEDIC"

- Matthew Uhde – Student doctor, College of Osteopathic Medicine, Nova Southeastern University *(Introducere explicativă și rezumat în românește de Almoș Bela Trif)*

Almoș Bela Trif

*Termenul de **„physician assistant (PA)"** se poate traduce în românește cel mai simplu ca **„asistent de medic"**, pentru a evita o dublă confuzie.*

În primul rând e vorba de confuzia cu profesiunea de „asistent medical", care în România este asimilată cu profesiunea de „registered nurse (RN)" din lumea anglo-saxonă.

În al doilea rând, termenul de „medical assistant" în SUA și Australia desemnează o altă meserie -mult mai puțin specializată decât cea de „asistent medical" sau „soră medicală" din România, similară cu cea de „registrator medical", profesie care la rândul ei se deosebește de profesia de „medical registraar" din Anglia și Australia.

Am simțit nevoia unei asemenea introduceri explicative deoarece există numeroși „false friends", ce te induc în eroare în terminologia folosită curent pentru a denumi profesiunile reunite sub numele generic de „health care providers", care s-ar putea traduce cu românescul „lucrători în domeniul sănătății", sau chiar cu mai învechitul termen de „muncitorii sanitari". Veșnica pomenire a celebrei gazete românești - de o înaltă ținută științifică, morală și educativă – „Muncitorul sanitar"!

*Studiind de mai mulți ani bioetica, etica practicii medicale, burnout-ul medicului, relația medic–pacient și grupul Balint ca o metodă de îmbunătățire a „relației medic, soră medicală, psiholog-pacient", am început câteva linii de cercetare cu studenții din Universitatea în care lucrez. Bineînțeles că pe lângă studenții de la stomatologie, optometrie, medicina osteopatică și farmacie, am întâlnit studenții care urmau cursurile de „nursing" și de „physician assitant". Treptat am înțeles curriculum pe care îl urmează aceste linii de studiu, dar eram încă nelămurit, ce face în viața de toate zilele un **„physician assistant"**, adică un **PA** așa cum se spune pe aici, în SUA.*

Matt, unul dintre studenții cam cu zece ani mai în vârstă decât studenții abia ieșiți din colegii, mi-a mărturisit că a lucrat ca PA timp de 8 ani de zile, așa că l-am rugat să scrie ceva despre viața lui ca „asistent de medic" și despre relația sa cu pacienții, ca să îmi pot face o opinie informată asupra relației „asistent de medic - pacient".

El a compus un material original, plin de o savuroasă onestitate, pe care l-am considerat util a fi publicat în revista noastră, ca un model de „modus operandi" al unei profesii mai puțin cunoscute în România.

În rândurile care urmează el explică mai întâi ce este un PA, unde a studiat el însuși și cum s-a angajat prima dată. Mai apoi, el descrie caracteristicele muncii de zi cu zi și rolul unui asistent de medic în activitatea unui serviciu. Cu o notă umoristică el menționează că activitatatea unui PA poate fi diferită în funcție de dorința de afirmare personală a acestuia, de bunăvoința sa și de caracteristicile serviciului care l-a angajat.

Pasajele unde Matt descrie relația sa directă cu pacienții sunt cele mai plăcute de citit, el având grijă să scoată în evidență faptul că, spre deosebire de medicul specialist sau de cel ultra-specializat, asistentul de medic își poate dedica mai mult timp discuției cu pacientul. E nevoie să ne amintim că aceasta era chiar sugestia lui Michael Balint însuși, când se adresa medicilor de medicină generală din Londra la vremea sa.

Pe de alta parte, Matt afirmă cu modestie că asistentul de medic nu e nicidecum primadona unui serviciu chirurgical. El arată cu claritate, cum PA pot fi însărcinați cu proceduri mici de rutină, de așa manieră încât chirurgii vor avea mai mult timp să se dedice procedurilor complicate.

Un paragraf întreg este dedicat avantajelor profesiunii de asistent de medic, principalul dintre ele fiind posibilitatea de a face cunoștință cu mai multe domenii ale practicii medicale, ceea ce stimulează creativitatea. Totodata el menționează limitele unor asemenea treceri de la o disciplină la alta.

Experiența sa în departamentul de urgențe spitalicești îi prilejuiește lui Matt o interesantă descriere a sistemului de funcționare a unui atare serviciu în USA, în care timpul

de contact al medicului cu pacientul este extrem de limitat. Aici, de asemenea el menţionează posibilitatea de a învăţa anumite proceduri, dar şi importanţa pentru actul medical în sine de a petrece mai mult timp cu pacientul. El descrie un caz al unui copil care nu era nici pe departe o adevărată urgenţă, deşi fusese raportat ca atare.

Cu aceeaşi modestie, Matt vorbeşte despre posibilitatea de a fi mai aproape de pacienţi, petrecând mai mult timp cu aceştia, accentuând noţiunea de „calitate a îngrijirii", opozabilă noţiunii mult prea mult folosită de Casa de Asigurări şi Asistenţă de Sănătate, cea de „ numărul de bolnavi trataţi".

Într-un paragraf întreg se vorbeste despre burnout şi despre circumstanţele care duc la acest sindrom în serviciile de urgenţe, atât pentru medici, cât şi pentru asistenţii de medici. Matt mai descrie – foarte folositor pentru cititorul român - diferenţa dintre ER „ emergency room" şi centrele de tratament ale urgenţelor, unde la anumite ore nu lucrează decât asistenţi de medici.

Este scos în evidenţă rolul constructiv al asistentului de medic în domeniul medicinii rurale, unde el poate suplini pe medicul de medicină generală la nevoie.

Ca încheiere se menţionează aspectul economic al folosirii muncii asistenţilor de medici în sistemul sanitar al SUA, concluzionând că pacienţii beneficiază cel mai mult de pe urma relaţiei cu asistenţii de medic.

Matthew Uhde

A Physician Assistant (PA) is a licensed healthcare provider who works under the supervision of a licensed physician.

This translates into a practitioner who provides a broad range of health care services that is dependent on the supervising physician's practice. The PA is licensed to do just about everything their supervising physician does. A PA wouldn't excise a mole if they work with an orthopedic surgeon just as they wouldn't place a cast on someone who came to the dermatologist office. The autonomy exercised is also dependent on this physician. The duties performed are based on what the physician desires the PA to do. In general the PA can perform the following: conduct physical exams, order and interpret tests, diagnose, treat, write prescriptions and educate their patients.

I graduated with my PA Masters degree in clinical medical sciences from Barry University in 2002 and have practiced since. Originally I was drawn to the field to increase my fund of knowledge and responsibilities as a healthcare provider. I had been an emergency room technician and nurse. I sought for an expansion and improvement of my medical role. I was first employed as a PA in the surgical field. There are several types of opportunities for PAs in this setting. A physician assistant could be hired by a physician(s) to be their first assistant in surgery, round on hospital patients, see patients in the clinic setting, or a combination of the three. Another option is to be hired by a hospital to work with their surgical department. This may entail first assisting in the operating room and/or taking care of the admitted patients in the ICU, floor and/or rehabilitation ward. In my situation I was hired to work in the latter format with surgeons associated with the hospital's residency program. We were assigned to scrub into the cases and take care of the patients admitted to the hospital with the surgeons who were involved with the residency program. Patients were separated based on their ailments into several groups which consisted of orthopedic, urologic, vascular or general cases. The five PAs and half a dozen residents were divided into teams and assigned one of these groups. The residents would rotate each month while the PAs would rotate every three months. For one set of allotted months, I would see mostly vascular graft patients while the next period I would take care of hip and knee replacements with the orthopedic team.

Our day to day business started with the team rounding on the patients who were on our service. We were scheduled to scrub into various cases throughout the day. Inside the OR we were generally first assist or second assist if the resident was doing the operation. Towards the end of the case the surgeon would break scrub and let us close up the patient and complete the case. Between cases patient assessments and plans were updated with the other team members and attending physicians. Other duties included dictating charts, operating reports and discharge summaries. We were also on call to attend to new surgical consults on other admitted patients or new ones being seen in the hospital emergency department.

One of our important duties was to optimize care during the monthly resident swap. Since these patients were known to us, better care was taken for them during these monthly transitions. In general, having a physician assistant can provide excellent continuity of care to patients. This resulted in decreased errors, better communication and overall care for the patient. It was good for them to see a familiar face each day. It made them more comfortable dealing with the same provider especially if they were transferred throughout the hospital's services by going from the ICU to the floor and finally to the rehabilitation unit. When the PAs switched services it would be mid month to maintain this flow and continuity of care.

The job provided me ample opportunity to have extra free time. Depending on the personality of the individual this

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could be used positively or negatively. It should be stated the lazy practitioner could take advantage of the situation by glossing over the basic necessities of the patient and sit back and surf the Internet for most of the day. The explicit point is that there was ample time to take care of the patient's medical, social and psychological needs. This came into play multitude of times.

One instance we had a diabetic male in his mid 50's who was suffering from severe arterial vascular disease to his right lower extremity. It was so severe the patient required a bypass graft to save his limb. He was in danger of losing some of his toes. Earlier the physician and the resident had tried to consent him for the necessary operation for which he refused. They were going to be in the OR for the remainder of the afternoon and the duty of obtaining consent was placed upon me. The job turned out to not be such a tumultuous task. I took the time to discuss the patient's concerns. It was revealed after five minutes that his fears of the operation stemmed from his own father's death on an operating table. Once this was established and addressed, the signed consent followed. The patient simply needed the extra time, caring and knowledge a PA can offer. I wonder what would have happened to this patient's leg and toes had there been no PA on the service to attend to this patient while the physicians were in surgery.

Another occasion entailed a "frequent flier" of the vascular surgeon. He had bypass grafts performed twice on one leg and once on the other. On this particular occasion he was once again admitted for cellulitic ulcerations to his lower extremities. His smoking habit was the culprit. He diminished the graft viability with each cigarette. I can remember the physician yelling at him over and over again on previous occasions that his vices would cause him to become an amputee if didn't give up on them. Yet he continued to smoke and be admitted for exacerbations. When I rounded on him on this particular day, his wife was there with him. I sat with him and asked if he wanted to quit and he said he did. I looked at his wife and asked if she wanted to do the same. She did but was confused at the attention upon her. Normally the conversation always revolved around the husband's habit. I pointed out that this venture needed to be a family one. If the two of them were going to quit, they would need to rely on each other's support.

The PAs were by no means the hero of the surgical team. Our roles did give us the opportunity to get to the root of some problems and truly help our patients. We maintained quality by making the services work more efficiently.

One of the advantages of being a PA is the ability to switch between a broad range of fields easily. It is still possible as a physician, but there are limitations. The PA doesn't need to be double board certified to leave family medicine to enter cardiology. They are free to move between various medical branches and fields. They have the ability to practice almost all disciplines. The only hindrance could be lack of knowledge or experience in the particular new field one entered if the new supervising physician wants only to hire a PA with experience in that field. There is a lot of latitude to be able to experience a variety of fields in their career. If the PA feels staled in their chosen field, they have the ability to move on to something else. Granted, one of the difficulties is leaving the comfort zone and experiencing a whole new set of demands. The PA has to reeducate themselves in the new chosen field. Of course moving from family medicine to internal medicine may not be much of a stretch but going from cardiothoracic surgery to endocrinology would be. Even though many stay in a particular field, there are opportunities to move if one desires.

I left the surgical field to expand my medical horizon. My frustrations with surgery were not only the prima donna attitudes of the surgeons but that I felt limited in the medicine I practiced. After leaving the field of surgery I began full time in the emergency room.

A PA in the ER can work in a variety of settings again dependent upon whom you work for. One can seek employment with a private group that is contracted through the hospital or work for the hospital itself. Some of my employers only wanted me to work in an "express care" environment. The patient contact was limited to minor care complaints. We would see sore throats, ankle sprains and other non emergent matters. Some institutions required I work directly with an attending physician while others left me by myself or with another midlevel provider. In a different work environment I only worked in the main emergency department, where I would always work with at least one attending physician. Here the physician and I would take turns picking up new patient charts. There was not a patient that I wasn't allowed to see. We were permitted to function like the emergency physician by running codes, intubating, placing central lines, etc. These advanced duties were naturally delegated when the attending physician/group felt you had experience to do so. This all led to blurring the differences between a PA and a physician. Ultimately, the physician was still in charge and responsible for all the patients. They

had the final say for all tests ordered, treatments provided and every aspect of patient care.

For all intents and purposes, the ER ran more smoothly on a busy night when the doctor took care of the very sick and the flow was maintained by the PA taking the less critical. On the other less demanding shifts the critical patients were not delegated. A well trained PA is capable of taking care of any type of patient, but for billing purposes the physician would see and lay hands on all the patients. We can only bill at 85% the Medicare/Medicaid rate with most insurances falling under the same guidelines. Thus on a busier night the physicians time is best served by taking the highly billable critical patients. Otherwise they will be doing double work by overseeing those patients. The attending can go oversee less critical patients with the PA much faster than emergent ones.

Another way to create greater time efficiency for the attending is to utilize PAs to perform clinical procedures. Most patients who had an abscess to be drained or a laceration to be sewn were done by us. By doing clinical procedures like placing central lines and performing lumbar punctures on most of the patients in the ED, it allowed the attending to be more efficient and see a higher number of patients. This was illustrated by the demands of one of the groups I worked for. There was a minimum amount of patients that needed to be seen per hour. It was 1.2 in the main ED and 2.0 in the fast track area. The ER physician had to see more at 2.0 and 3.0 respectively. The extra time allotted for us allowed us to do some of the mentioned procedures. It also gave me extra time with my patients.

On a particular busy shift a 7 month old presented after falling from a bed onto the floor. Originally the attending was told by the charge nurse that the child had passed out. He ordered a head CT after talking to the parents briefly. He asked if I could examine the patient and write up the chart while he attended to some other urgent matters. The patient was smiling and playing with his mother as I walked into the room. He was without any signs of trauma. After further questioning I determined the child didn't need the unnecessary test for he never actually passed out. A miscommunication was misinterpreted by the nurse and everyone else. I am very careful when it comes to children and CT scans. The risk of radiation must be weighed with great caution at the necessity of doing the test especially at such a young age. By having the PA be available to spend time to question the parents further resulted in negating the potential harmful exposure.

This is not to say we are the unsung hero of the ER as well. Our presence gives everyone the advantage of spending more time with their patients. This in turn allows overall better care for them. More emphasis is placed on quality versus quantity of care.

One downfall of the emergency physician PA is the hours it demands. They are scheduled to work when the ER is the busiest. This usually falls upon the evening hours. Our ability to augment the rest of the staff is ideal during this time. One pitfall of these high volume shifts is that it is high volume most of the time. You are always working from the moment you arrive. We are never scheduled to work the slower periods for obvious economic reasons. We are never afforded to recharge over some lighter/slower shifts. The long term effects are not easily measureable yet they undeniably have some effect on our patient relationship. "Burnout" is a major issue with emergency medicine physicians and as illustrated the physician assistant is not immune to this disease. The high level of stress mixed with the grossly litigious aspect make the profession difficult. I admit I have difficulties from time to time succumbing to it. A periodic mental debriefing is vital to keep myself at a high standard the patients deserve.

If one finds the ER lifestyle to not be there cup of tea, they can avoid this stress by getting a position in an urgent care center. In general the hours are much better and the patients are not critical. I worked for one of these in a small town. During my weekend shift I would be the only provider on duty. The clinic had a secretary and a medical assistant. Sometimes I would get lucky and have a nurse. The attending physician was available by phone if I had any issues. An ER was located nearby in case any patients required a higher level of care than could be provided at the clinic. Those complaining of chest pain or who needed a CT were quickly referred. We operated like a normal walk in clinic and functioned in every way as if a physician rather than a PA were on duty.

This brings up another positive effect of the PA on healthcare. An experienced PA plays a vital role in rural medicine. The physician extension is now literal. The PA can take care of a population far from the physical presence of the attending. As the physician shortage increases, the PA can meet the demand by filling the role of the country doctor.

The effects of PAs involvement in the health care system are widespread. One of the biggest gains is the impact on improvement of the provider patient relationship. We are allowed more time with the physician's patients. This gives the chance to get to the root of their issues. It provides more checks and balances for patient safety. This in turn decreases medical errors and malpractice claims. The PA is also of economic benefit. The supervising physician can hire 2 PAs for the price of 1 physician. The arithmetic simply equates to more patients seen. Not only is the quantity increased but the quality in return. Due to cuts in reimbursement, the physician has to see more patients to keep income steady. By hiring PAs the physician can keep up this volume and maintain quality control. Instead of cutting down patient contact time, they are afforded the luxury of having more than when they first started to practice. Proper PA utilization creates better outcomes for the patients the attending serves.

PROBLEME ACTUALE DE MEDICINĂ BIOPSIHOSOCIALĂ

- Dan L. Dumitrașcu

Termenul de medicină biopsihosocială este relativ necunoscut, atât în practica medicinii românești, cât și în cea din străinătate. Aplicarea unui model psihosocial în ceea ce privește diagnosticul, tratamentul și monitorizarea pacientului, definește cel mai bine acest termen, iar lucrarea : "Probleme actuale de medicină biopsihosocială", sub redacția Profesorului Doctor Dan Dumitrașcu prezintă diverse aspecte ale acestei ramuri și conturează noi tipuri de cercetări în cunoașterea și substratul unei suferințe.

Scopul acestei lucrări este de a evidenția importanța abordării holistice a fiecărui pacient, de a elimina "bariera" dintre elementele clinice, factorii sociali și factorii psihici, a interacțiunilor dintre corp-psihic-mediul social. Un individ cu o anumită suferință trebuie privit și tratat atât din punct de vedere somatic, cât și implicațiile psihologice ale acestuia asupra suferinței. Deci, având în centrul atenției, omul bolnav, cartea pe lângă medicina tradițională, înglobează cunoștiițe solide din domeniul psihologiei și sociologiei pentru îmbunătățirea actului medical.

Cu un titlu sugestiv, lucrarea reprezintă o antologie de referate de foarte mare actualitate, care se bazează pe cercetări originale, elaborate de specialiști din diverse ramuri, atât din domeniul medicinei cât și din domeniul psihologiei.

Pentru a atinge diferite aspecte ale acestei complexități umane/individuale, autorul și-a propus ca acest grup de cercetători-colaboratori să fie cât mai divers și aparținând mai multor generații.

În prima parte a lucrării sunt prezentate scurte referate despre interacțiunea evenimentelor stresante cu funcționarea fiziologică și patologică.

În a doua parte a cărții este descrisă calitatea vieții, pornind de la definiția OMS 1998 a acesteia (un parametru biopsihosocial dat de percepțiile indivizilor asupra situaților lor sociale în contextul sistemelor de valori culturale în care trăiesc și în dependența de propriile trebuințe standarde și aspirații) și de la o a doua definiție dată de Engquist-1979 (care definea calitatea vieții ca fiind o măsură în care o persoană este capabilă să-și realizeze securitatea vieții proprii, încrederea în forțele proprii și șansa de a-și folosi capacitățiile fizice și intelectuale pentru realizarea scopurilor personale în viață).

Iar, în ultima parte a lucrării sunt câteva texte despre impactul psihologiei în abordarea diferitelor patologii și rolul deosebit de important al felului în care percepem această complexitate individuală.

Putem compara această carte cu un puzzle, în care fiecare piesă (din antologia de texte), vine în completarea profesionalismului necesar fiecărui medic.

Domnul Profesor Dan Dumitrașcu a reușit prin amabilitatea colaboratorilor săi, performanța de a edita o carte complexă din punct de vedere al conținutului și care aduce un beneficiu substanțial în acest domeniu al biopsihosocialului, care datorită acestor oameni începe să se înrădăcineze tot mai mult în practica medicală și astfel, cartea, își câștigă un loc important în biblioteca fiecărui medic.

Dr. Anamaria Horvat
medic rezident neurolog

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ȘTIRI DIN VIAȚA ASOCIAȚIEI - Albert Veress


Albert Veress

15-17 Ianuarie, 2010: Weekend Naţional Balint de Iarnă cu Postrevelion Balint, Dulcești-Roman. A doua găzduire a balintienilor în zona Romanului de către gazdele noastre, familiile Țubucanu (Nelu și Marlena) și Costin (Lucian și Mirela). Am iniţiat grupul Balint acvatic, care a avut un asemenea succes, încât se preconizează pentru viitor continuarea acestui tip de grup acolo, unde vor exista posibilităţile necesare. Cele 2 prezentări (Adrian Nicolau, Liviu Bujor) au fost urmate de grupuri mari și mici, tradiţionale weekendurilor. La cina prietenească ne-au delectat elevii unui cor vocal din zona Romanului. Cei 44 de participanţi au dus acasă vestea unei primiri ospitaliere, de-ale moldovenilor. Mulţumesc gazdelor pentru organizarea desăvârșită.

22 Ianuarie: grup ordinar la Sânsimion, găzduit de către Iuliu Oltean și primarul comunei, Fábián László.

11-13 Februarie: etapa IV a cursului de perfecţionare al liderilor de grup Balint de la Izvoru Mureș cu 14 participanţi.

1 martie: s-a format oficial al doilea grup Balint „nemedical" la Odorheiu Secuiesc. Grupul condus de Dr. Váradi István pentru 11 psihologi școlari - din care 10 au participat pentru prima data în grup Balint - a avut un succes remarcabil, cei prezenţi luând decizia de a funcţiona ca grup permanent, cu întâlniri regulate lunare.

3 Martie: la Miercurea Ciuc s-a iniţiat pregătirea în metoda Balint a persoanelor implicate în asistenţa la domiciliul bolnavilor din cadrul organizaţiei Caritas. Éva Veress și István Váradi s-au dedicat acestui șir de întâlniri, planificate a se derula pe parcursul mai multor luni.

PLANURI DE VIITOR - Albert Veress

26 Martie, orele 17-19: grup Balint lărgit în cadrul Congresului MF, București, Palatul Copiilor. Sunt aşteptaţi toţi balintienii, în special cei din București sau împrejurimi.

7-9 Mai: Weekend Naţional Balint de Vară, Ocna-Șugatag. Taxa de participare: 35 Euro. Cazarea cu micul dejun: 20 Euro/zi/persoană. Vor participa și invitaţi din partea Asoc. Maghiare Balint. Termen de anunţare a participării și rezervarea cazării: 3 mai, la dr. Árvai Gheorghe (Gyuri), telefon: 0744-591.365, e-mail: arvaizsogi@gmail.com sau la alveress@clicknet.ro

24-27 iunie 2010: a IV-a Conferinţă Internaţională de Psihiatrie Româno-Maghiară și al VI-lea Simpozion Naţional de Psihiatrie, Miercurea Ciuc. Adresă de site: www.psycongress.com

24-26 septembrie 2010: a XVII-a Conferinţă Naţională Balint, Miercurea Ciuc.

Aşteptăm propunerile voastre pentru organizarea unor weekenduri interjudeţene!!!

Vă doresc o primăvară deosebit de frumoasă, cu lefuri pe aşteptările voastre,