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Pitfalls and threats in the doctor - patient relation*

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Balint group meetings focus on discussions about the doctor-patient relation, especially with regard to situations difficult for the caregiver - often a so called „difficult case” or a „difficult patient”. This notion covers various pictures: from patients with diseases difficult to diagnose, including those with psychosomatic disorders, to patients who consciously manipulate the physician to obtain a sick leave under false pretences or to receive a prescription for drugs, to which they are addicted, or whose aggression at the whole world is directed against the doctor. The way of handling „difficult patients” is important. Sometimes it may be a method apparently effective in the short-term, which nonetheless leaves an emotional sediment in the doctor’s psyche. It further builds up and accumulates as a result of other similar situations, gradually leading to professional burnout. A discomfort related to burdening and unresolved emotions stimulates the participants of the Balint group sessions to think about their emotions and discuss them together in group

meetings. This publication will present the most often reported types of „difficult patients” and „difficult situations”, based on the author’s own experience as a Balint group leader and the experience of Australian leaders, compiled and summarised by a psychotherapist, dr Marion Lustig (2006), as well as British leaders (Salinsky, Sackin, 2000), German (Luban-Plozza, Knaak, Dickhaut, 1990; Luban-Plozza, 1995) and American ones (Johnson et al., 2004).

Difficulties in accepting the patient

A direct confrontation with the suffering, death, experience of hurt and brutality is an overpowering challenge for many beginning healthcare practitioners. Pushed into the profession by their parents and their environment, young people, thrown at the deep end as general practitioners, experience difficulties functioning in a new reality.

The encountered patients and the substance of their lives raise fear and represent a reality, which they had never accepted and

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which they still refuse to accept. It threatens the vision of the world, on which they had built their existence.

For centuries, the students of medical sciences were taught humility and sacrifice representing an attitude, considered at present by many people as adequate only in religious orders with strict rules. The sick are supposed to be clean, rich and healthy. They are supposed to express themselves in a cultural way and with due respect. Declining a complete physical examination is a practical manifestation of doctor's internal conflicts. It is often discovered that a patient has not been entirely examined by any doctor during many years of treatment. The contact with a sick person who smells, suffers and is unaesthetic is delegated to the nurses, who further leave it to the family. It is very difficult for a doctor to admit that he/she finds a patient disgusting, is afraid of getting infected, does not accept patient's behaviour, language or lifestyle. Often a GP masks his/her own attitude by provoking the patient to behave in a way which would give him/her reasons for rejecting the patient, thus solving his psychological dilemma. Patients may be rejected or discriminated because they remind doctor's past traumatic experiences. The patient is completely unable to understand this conflict and may find doctor's behaviour very traumatizing.

In order to discuss such sensitive topics one needs understanding and openness, which are achieved in the course of a longer work in a closed or semi-closed Balint group. Therefore it is recommended to schedule at least half-year cycles of Balint group sessions. At the beginning some superficial problems are analysed. Gradually they are discussed in more detail and with more precision.

As the analytical skills improve and the sense of security settles, positive effects of the group work are seen in the professional work and comfort of the participants.

Conflict of roles assumed by the doctor

Colliding roles assumed by the doctor and related moral dilemmas are another problem discovered in Balint groups sessions. The vast majority of physicians play a role of a lower level public servant executing the task of healthcare as a constitutional duty of the state. In this role they are accountable to the patients who perceive them as distributors of the health care services, to which they are entitled. On one hand physician is supposed to be a guard of a limited access to limited services and, for example persuade elderly people, that they have the right to less services than children or professionally active persons, and on the other hand, be the patients advocate and provide them with a comprehensive treatment, according to the latest development of the medical knowledge. As the patient's trustee, the GP is obliged to keep secret all information related to their profession and at the same time, as a citizen and an employee, in many cases he or she is obliged to disclose important information about the patient. The GP is entangled in colliding relationships involving friends and family - related interdependencies, formal and informal group and organisational dependencies and those involving finances or a sense of loyalty. When making a decision which is unfavourable to a patient, the GP experiences shame and guilt and is afraid of further contacts with this person, sometimes is also surprised by their own reactions when they happen.

Pitfall of apostolic function

Involvement in a Balint group teaches humility indispensable in the profession of physician associated with an illusory ability to turn somebody's fate and an inclination to believe, that one possesses a part of divine competences (the complex of god described by psychotherapists, according to L. Grzesiuk, H. Suszek, 2010). Earlier, Michael Balint mentioned an „apostolic pitfall”. It occurs when patients buy doctor's favours with flattery and fill their own empty lives with the disease and an idealized figure of their doctor. This situation creates for some of the GPs an opportunity to flee from their real life, in which they fail to „an archipelago of healthcare”, in which they can reign. Such a GP experiences a full accomplishment at work and becomes psychologically addicted to it. He/she functions in a closed circle of patients and co-workers, made dependant on him/her. Every person who leaves the apostolic court, i.e. a patient who dies or another specialist who utters a critical remark, disturbs the idealized virtual world of the archipelago. The GP is then confronted with a feeling of growing professional and personal isolation. The collapse of this illusory vision may provoke a crisis of faith and values and make a psychological breakdown more likely. Devoting attention to this problem in a Balint group prevents it.

One of the main psychological paths creating the mechanism of the apostolic pitfall is a pattern of professional development described by Maedera as wounded healer (Maedera, 1989). It is based on mythological picture of a healer found in many cultures. It implies that acquiring healing powers is preceded by an experience of suffering and pain.

Analogically, a future therapist goes through a series of experiences of his/her own weakness, suffering and internal conflicts (Suszek H., 2010). Failures and criticism reinforce the decision to continue the apostolic mission, drifting away from the real life.

Sin of omission

To many doctors it is a morally consuming issue to be aware of omission of actions, which might reverse a negative development in patient's health and personal problems. This applies not only to actions resulting from one's medical competences, but sometimes also to personal and family-related matters, in which the doctor's action (as that of a trusted person) could prevent serious negative consequences in the patient's life.

The role of a technical physician who handles the patients by operating medical equipment is still limited to hospitals and represents a marginal part of the system which is based on GPs deeply embedded in local societies, considered important persons, to whom patients address not only health issues but also personal ones, for example mediation in a divorce-threatened family, advice about the choice of profession or decision about the migration. Patients also entrust physicians with some confidential information, vital to the fate and life of their relatives. The responsibility generated by the role of a personal advisor, the burden of the secrets they hear and consuming doubts regarding the omission of certain actions add up to the GP's psychological burden. In the times of crisis this issue has become more important as patients share with their doctors moral dilemmas and confusion (Fridman T.L., 2010). In the period of crisis the health care system becomes source

of support for individuals who are maladjusted and confused. GPs receive patients who suffer from the main ailments of contemporary civilization – loneliness and alienation.

In the period of economical, moral and social crisis, the health care institutions and the role of GP assume new tasks, to which GPs are little adapted.

We replace our sense of responsibility and the compromised traditional systems of social support (family, friends, professional circle, religious community, regional and social organisations) with the „welfare state”, which is supposed to ensure our survival, provide treatment and care and take over the responsibility. The notion of disease becomes a key which transforms any family and personal relations into a one-sided dependency. The process of becoming dependent on the system – on a biological as well as psychological and social levels – makes it a tool for boosting the demand for services and goods of the medical, pharmaceutical and related industries.

Chronic condition of being a „full-time patient” is a way of an internal migration from a dynamic and aggressive 21st century world to a world of a passive kolhoz hand-to-mouth existence, set back by half a century, and reflected in psychological characteristics of the health care „customers”. The health care system generates an uncontrollable growth in demand for products and services related to its functions, and at the same time, it transforms the society into a collectivity of patients and pensioners. As a side effect it creates a „full-time patient profession” as a form of personal identification for considerable groups of population. An alienated patient, frightened by the physicians with consequences of diseases and possible complications of surgical

procedures, seeks support from a doctor and gets involved in a symbiotic relationship with him/her. The physician feeds back the patient by reinforcing the myth of the sickness as a source of the patient’s existence and identity. The disease is in demand as the basis of the symbiotic relation. It develops due to psychosomatic mechanisms, affecting more organs and systems.

Through this mechanism, nature adapts the situation to the demand. An authentically sick person consumes dozens of more or less useful drugs and undergoes medical procedures, which fill most of his/her time. The patient, overwhelmed with fear, stimulated with drug leaflets, self-protecting medical specialists, and medical and insurance companies, gets enclosed in a world of the archipelago and leads a passive and minimalistic existence on the sidelines of the 21st century enclaves. The physician – one of the main elements of the archipelago – is an integral part of the social system, in which he/she acts not only as an executor of certain professional tasks, but also as an individual subject to the same social conditions and frustrations as all other citizens. These frustrations add to the potential of frustration mechanisms specific to medical professional, affecting both GPs and – indirectly – the patients (Gertner H., 2002).

Functioning in the period of civilization breakthrough causes archipelago loose its hermeticity and its separation from the enclaves of the life support industry, accessible only to the chosen ones. The patients of the enclaves from their conception, are subject to medical assistance and they need constant use of complex life supporting procedures, because they loose their ability to maintain their health on their own.

The same doctor attending on his/her own a crowd of archipelago dwellers in the morning, spends the other half of the day in the life support factory providing services together with a crowd of people to a few individuals. The schizophrenic situation of double identification is partially soothed by a logic of a better payment or learning opportunities. Nevertheless it still is a source of psychological and moral conflicts. Because of them, doctors, despite the access to a better treatment, have worse somatic and mental health parameters than average. In their early careers, many doctors have a vision close to a priestly calling (Hajduk, 2005) sanctified by serving the sick and disadvantaged, which leads them to a painful confrontation with the reality of functioning in the archipelago and the life support factories.

Difficulties in decision-making and guilt

The problem of hidden or expressed guilt is one of the most common topics reported in the Balint group trainings.

Medical studies overloaded with encyclopaedic knowledge fail to ensure necessary practical knowledge. It is acquired in the course of professional activity when a physician accumulates positive and negative experience from results of therapies he/she ordered. Every therapeutic failure ended in a disability or death affects the doctor, although the official charges are not always pressed. Even after many years one remembers the look of patient's trustful face, his/her hope, the family's faith in the physician's magic power. The doctor cannot find peace knowing, that if he/she had administered a different treatment, the patient could have been saved. High toxicity of such situation, deposited deep in one's

psyche and hidden from others and often from oneself, is destructive.

When an unwritten rule obeyed by the physicians (that neither one's own failures nor the colleagues' ones are to be discussed) breaks in Balint groups sessions, the participants often share painful memories still unhealed, despite the months or years passed. Many participants of the training regain peace, sense of being understood and supported by others only as a consequence of such situations.

Pitfalls related to sexual aspects of medical practice

Sexual aspects are an important problem in the medical practice. Nudity, covered in every-day situations by the veil of intimacy and mystery, is fully exposed in the doctor's office. It is a difficult situation for both, the patient and the physician. It requires maturity of the doctor, because he/she should fully control his/her sexual reactions and have a stable personal life. More often doctors experience consequences of functioning in hospitals like in barracks, which leads to sexual contacts driven more by a favourable situation and ineffective moral restrictions than authentic feelings. Sexual satisfaction associated with a stable family situation of physician is often an insufficient restraint. Statistically, a family of medical professionals is more unstable than an average Polish family. Many physicians have difficulties maintaining durable relationships, do not start up a family or start it very late. Contacts with patients can become a substitute source of sexual satisfaction for a physician or psychotherapist.

Michael Sussman (1992) noticed that therapists gain indirect sexual gratification from

voyeuristic interest in patients' sex life. On the other hand, they sometimes yield to sadistic and aggressive impulses by focusing the therapy on the patient's weakness and undermining his/her self confidence (Suszek H., 2010).

The situation is often far from a model pattern of behaviour and due to poor effectiveness of supervision it depends on individual limitations a doctor has and on his/her moral choices. In a confrontation with such challenges physician can rely only on him/herself, because in the course education nobody had prepared him/her to deal with sexual aspects of the contact with the patient. From the patient's perspective the barrier of shame is an important problem, often making a necessary physical examination impossible. Some basic encyclopaedic knowledge of sexology is provided without workshop training related to self-awareness and enacting reactions and behaviour in situations related to sexual aspects of the medical practice. Since the situation is also embarrassing for the physician, full medical examination requiring complete nudity is rare at present, to the detriment of the patient and the medical art. Physical examination involving inspection of the entire body is currently unusual because it raises patient's and the family's doubts as to the doctor's motivation. Especially, that the studies analyzing time dedicated to each patient in the family doctors' practice show that doctors devote much more time to young and pretty patients than to the elder and ailing ones (Deveugele et al., 2002).

The issue of patients seducing doctors is a separate problem. Seduction, considered as a way of gaining kindness and interest, most often is not openly sexually provoking.

Sometimes, however it is openly provoking, especially, if the patient sees doctor's arousal. Physician's struggle to restrain his/her sexual reactions is exiting to some patients, as they fulfil their narcissistic needs. Such patients often surprise doctors when they undertake formal legal action although they provoked physician's sexual behaviour by themselves.

Physician's paedophile tendencies or other sexual deviations are a difficult problem, often masked by a choice of specialisation. The issue has gained a special significance due to the atomization of medicine, narrowing scope of team work and formation of separate professional islands with one ruling physician, which is conducive to various pathologies, which traumatise the patients.

A Balint group may be a useful tool for discussing problems resulting from sexual aspects of medical practice. It requires however an experienced leader, who knows how to provide support and to address such sensitive matters, selecting the themes and protecting the members of the group from excessive interference in somebody's intimate matters. It must be mentioned that late professor Stefan Leder had these skills. He was able to accurately and confidently lead Balint groups dedicated to sexual aspects of the doctor-patient contact.

Using Balint group trainings is a standard recommended by the WHO since 1975 in the training of health care professionals dealing with sexological issues (WHO report, 1975). A working group of the Swedish Medical Society, presided by a gynaecologist, Lotti Helström and a sexologist, Meri Liljegren issued an analogical recommendation. High effectiveness of the Balint groups in the training related to sexological aspects was em-

phased by the Association of Psychosexual Nursing.

Jules S. Black (2005) describes the Balint training organised in small groups as a particularly useful in sexological training. According to him, Balint group training is the best way to practically integrate the teaching of medical and psychological aspects in sexological therapy. The author emphasises therefore that The World Association for Sexology has recommended the use of this method in sexological training since 1985. A similar opinion was expressed by psychotherapists and coaches Arthita Das (2003) and Elke Muehlleitner (2009) and their co-workers. They positively assess the Balint groups in the training of house physicians specialized in psychiatry, especially in teaching issues related to sexuality. Effective and secure discussion about the sexual problems in the doctor-patient contact requires the group members to get to know each other well and the whole group to develop tools of psychotherapeutic group work. Hence at the beginning, the role of the leader consists in familiarising the participants with the topic by making brief remarks or comments to signal it and to choose the right moment to discuss the reported cases in more detail. Participants' reflections show their own problems and help to undertake actions aimed at eliminating these problems.

Difficulties in diagnosing and treating coexisting psychic and psychosomatic disorders

The cases of psychic and psychosomatic disorders cause serious difficulty to GPs working in the primary healthcare. They differ from internal diseases treated in a standard way, require knowledge refreshment, more

concentration and attention as well as taking a detailed patient's history with additional and completing information. It also requires time and often additional consultations, which generates higher costs, being a burden to the profitability of the practice. Typical ordinary ways of handling the situation fail and the patient becomes an unwanted „boomerang patient” completing the picture of the waiting room near the doctor's office. When the attempts to discourage the patient with some troublesome examinations and consultations fail, when the change of doctor's attitude to a defensive one is ineffective, when the attempts to place him/her under a specialist care are unsuccessful and when the patient consumes already a dozen medications per day, prescribed for subsequently reported complaints, there is one solution left – presenting the case in a Balint group session.

Cases reported in the group sessions show sometimes a gradual evolution of an originally neutral contact with the patient into a fierce struggle in which the doctor tries only not to lose his/her mental balance and the patient fights with him/her as a substitute enemy to get even for all the failures and harm he/she experienced from the state, which was supposed to care for him and which the GP represents.

Patient with addiction issues

Difficulties in managing patients addicted to alcohol or drugs constitute another problem reported in Balint meetings. Such patients present a considerable problem to the managing doctor in the primary and specialist health care.

Most often the addiction is diagnosed no sooner than in its advanced phase. Preventive

measures undertaken by physicians are still exceptions. Using the tactics of rapid customer service, the GP prescribes medicines for every complaint. Emotional disorders are reported in most addicted patients, hence the prescription of sedatives and consequently, the number of patients addicted to them. A similar tendency is observed with analgesics, soporifics and anti-constipation drugs.

Addiction to alcohol is a separate problem, reluctantly diagnosed by physicians who provide a long-term patient care. The patient and his/her family often considers the diagnosis offensive, despite obvious facts which confirm it. The diagnosis of drug addiction is sometimes embarrassing to both sides. Alcohol presents a similar problem and is sometimes abused by the physician him/herself. Many doctors advise consumption of alcohol as a means to reduce stress and improve blood circulation.

The strategies of playing the waiting game or turning blind eye to the problem result in a situation when the symptoms become dramatic both socially and in term of patient's health. The doctor's office is often the scene for situations difficult to the doctor, who faces a patient demanding prescription of particular drugs, his/her family's intervention or incidence of serious medical consequences, of which the doctor blames him/herself.

The problem of one's own addiction is rarely emphasised by physicians who take part in Balint trainings and report the patients' addiction as the main difficulty in the management of these patients. Usually it is noticed during a detailed analysis of a particular case. Overconsumption of alcohol by the doctor or his/her addiction to drugs is not revealed due to professional solidarity, convention of

the Balint group and protective interventions of the leader. The group however transmits clear, yet indirect messages to the reporting doctor, letting him/her notice that the problem, hidden from others – and sometimes from oneself – is visible to colleagues. It happens that in an individual conversation, the group leader suggests the doctor undertaking measures to free him/her from the addiction.

Difficulties in gaining patient's compliance

Noncompliant patients constitute a problem in medical practice. They do not follow doctor's advice, do not take the prescribed medicines. A common practice is to compliment on a doctor in order to gain his/her favours and in parallel to distrustfully check the prescribed drugs or tests in available sources.

Because of shocking information included in the drug leaflets, limited contact with the physician, information spread among the patients about the benefits received by the doctors from pharmaceutical companies for prescribing particular drugs, a part of patients does not take the prescribed drugs at all, take them irregularly or in smaller doses. The World Health Organisation (WHO, 2003) estimates that it applies to approximately 50% of long term therapies. The Philips Index 2010 report about the life quality of the Poles based on a questionnaire conducted 24-27 June 2010 on the sample of 983 adult Polish citizens concludes that over the half of the participants of the survey (58%) avoid medical visits if they can and one in three ignores the diagnosis when it is not in line with their expectations, 47% confirm not taking the drugs in a way recommended by the doctor.

This problem has its economic dimension

since the cost of drugs which end up in the waste bin and the cost of treatment of chronic diseases which had not been previously treated correctly amount to hundreds millions Polish zloty. This phenomenon is caused by the problems in the doctor-patient relation, including the loss of trust towards the doctor and the health care system. Balint trainings are an effective method of reducing the extent of noncompliance, as demonstrated in the study conducted by the researchers of the Uppsala University (Kjeldmand et al., 2005). They demonstrated that the patients treated by doctors who regularly participate in Balint trainings are treated more effectively and better cooperate with their physicians.

Loss of contact with the patient

Loss of a common language with the patient is yet another difficulty reported in Balint sessions and related to patients' noncompliance. An originally good contact gradually deteriorates during subsequent meetings, and finally, the physician and the patient speak different languages. It is often due to a conflict of doctor's and patient's interests, in which the former tries to prevent the latter from plunging in his/her disease, the patient however seeks its development. Source of this pathology is often found in an escapism into disease, triggered by a personal failure, inability to cope with emotional, family or professional problems. It is difficult for the patient to name and realize the actual problem so he/she reduces his/her problems to health issues, which justifies his/her escape from an active life. When the doctor and the patient meet, they both avoid steering from conventional language of the conversation limited to ailments and medical procedures. Due to psychosomatic

mechanisms and side effects of the drugs, gradually the patient does become a disabled person at the mercy of pensions and public support systems. Doctor who is unprepared to understand psychosomatic aspects of the disease, is helpless when it comes to the techniques of handling relations with patients, he/she consents to an unfavourable course of disease, which leads to disability.

One of the driving factors of an unfavourable course of disease is reduction of the patient-doctor contact to the minimum. It is made more difficult by patient's negative attitude resulting from anger and irritation after many hours of waiting for a visit or sometimes after months spent on trying to make an appointment. The patient's negative and aggressive approach meets doctor's defensive attitude and effectively blocks mutual relations.

Serious negligence in medical staff training devoted to psychosocial aspects of disease treatment and prevention has a significant share in activation of a strong capacity of our health care system to foster chronification of civilization diseases and a high rate of rendering patients disabled.

Balint trainings could be an effective way to make up for the shortcomings. A physician trained in a Balint group will more quickly notice the actual problems his/her patients have and will find it easier to avoid conflicts with them (Luban-Plozza, Pöldinger, Kroger, Wasilewski, 1995).

Michael Balint was one of precursors of multidimensional understanding of health and disease, he encouraged the physicians to make a holistic diagnosis, to take into account not only a pathology of the body but also the whole person with their psychological, social and characterological conflicts (Balint, 1957;

1968). A common use of Balint trainings in Germany is largely related to its documented influence on the quality of health care services in the patients' perception and improvement of the health care system functioning. The research conducted in Germany confirmed a high effectiveness of a health care model which takes into account psychosocial aspects of disease in the course of disease, its prevention and in pension prevention (Deter et al., 2011). The basic slogan encouraging the participation in Balint group trainings in Germany is related to the task of maintaining the contact with the patient and gaining his/her active involvement in treatment.

Family doctor – the first and the last link in the process of psychotherapy

In the period of the health care system reform in England and the creation of the public health care service in the late 40's of the 20th century, Michael Balint, got actively involved in its organisation having his own experience as general practitioner. On the basis of his experience he acknowledged an especially responsible and difficult work of the GP as the basis of the health care system. The concept of an optimal activity of a family doctor, as perceived by Balint, required however some changes in the doctors' approach to patients, which had to involve changes in doctors' mentality. Balint implemented an experimental complementary system of professional improvement, offering a long-term participation in meetings of groups, later called Balint groups. Michael Balint is one of the forerunners of the modern understanding of the medical practice. He always emphasised the influence of the quality of the contact with the patient on the effectiveness of the treatment and

the mental comfort of both the patient and the physician. In the education of doctors an impersonal attitude towards patients was recommended and not informing the patients about the details of the therapy. Medicines dispensed in pharmacies were labelled only with the name of the prescribing doctor and an instruction of taking them. Physician's psychological, emotional or communication-related skills affecting his/her relation with the patient were ignored. It became Michael Balint's goal and message to make doctors aware of and sensitive to the importance of the patient-doctor relation. Today, after fifty years from the first publication of Balint's work, still not all professional care-givers realise that a constant improvement of patient relation increases the effectiveness of the therapeutic efforts/actions. The Balint's thesis that the doctor is the best medicine appeared so attractive to the representatives of this profession that it gained many followers interested in Balint's ideas about the general practice (Balint, 1960).

Michael Balint achieved his goal by creating his famous method, which is helpful in professional improvement of family doctors and widening the scope of their skills in doctor-patient relation (Balint, 1957; 1968b). The training of physicians in psychological, emotional, empathic and communication skills improved the quality of treatment, and increased the effectiveness of the medicine which, in Balint's understanding, is the doctor him/herself. At the beginning, only general practitioners received the extended training. The initial concept assumed completing physician's competences with some knowledge of techniques of analytical psychotherapy, so that he/she can use them to make an in-

tervention when need occurs. Mastering the basics of psychotherapy allows the family doctor to:

- notice and modify conflict laden doctor-patient relations;
- talk to the patient not only about the disease but also about the person;
- follow the patient in the course of the conversation (active listening);
- inform about an unfavourable diagnosis in the least traumatising way;
- maintain his/her authority allowing at the same time control by the patient;
- create a psychologically patient-friendly atmosphere in the team coordinated by the doctor;
- make early diagnosis of psychogenic, psychosomatic and psychosocial conflict in patients, understand their negative impact on the course of the disease and limit their scope;
- have an individualized approach and control of one's own attitude towards patients' problems.

A physician trained in a Balint group can sooner perceive true problems of the patients and does not waste his/her time on misleading diagnostic dead ends. He/she is also able to avoid many misunderstandings and colliding models of behaviour in the doctor-patient relation (Luban-Plozza, Pöldinger, Kröger, Wasilewski, 1995).

Abstract

The author discusses the difficulties in the doctor-patient contact and the mechanisms of their formation. Difficulties in accepting the patient are discussed and the conflict of roles assumed by the doctor. This publication

presents the most often reported types of „difficult patients” and „difficult situations”, based on the author's own experience as a Balint group leader. Particular attention is given to the concept of „apostolic pitfall” implemented by Michael Balint. The author also discusses the various types of difficulties in the doctor-patient contact and discuss ways to overcome them.

Keywords: doctor-patient relation, Balint group, group psychotherapy, Michael Balint

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Reference:

1. Balint, M. (1957). *The doctor, his patient and the illness*. London: International Universities Press.
2. Balint, M. (1960). The regressed patient and his analyst. *psychiatry*, 23, 231–239.
3. Balint, M. (1968). *The doctor, the patient and his illness*. London: Pitman Medical Publishing
4. Balint, M. (1968). *The Basic Fault*. London: Tavistock Publications
5. Das, A., Egleston, P., El-Sayeh, H., Middlemost, M., Pal, N., Williamson, L. (2003). Trainees' experiences of a Balint group. *psychiatric Bulletin*, 27, 274–275.
6. Deter, H.Ch., Glaesmer, H., Mertens, R. (2011). The economics of treatment and psychosomatic approach. conference proceedings: *Psychosomatic aspects of therapy and recovery*. Warsaw, 22–23 January.
7. Deveugele, M., Derese, A., Brink-Muinen, A., van den, Bensing, J., Maeseneer, J., de (2002). Consultation length in general practice: cross sectional study in six European countries. *British Medical Journal*, 325, 472.
8. Friedman, T.L. (2010). Superbroke superpower? *international Herald Tribune* (Sept. 6).
9. Gaertner, H. (2002). *Okiem medyka*. W: M. Magdoń, *Współodczuwanie w medycynie*. Kraków: Universitas.
10. Grzesiuk, L., Suszek, H. (red.) (2010). *Psychoterapia. Integracja. Podręcznik akademicki*. Warszawa: ENETEIA.
11. Johnson, A.H., Brock, C.D., Hueston, W.J. (2003). Resident physicians who continue Balint training: A longitudinal study 1982–1999. *Family Medicine*, 35(6), 428–433.
12. Johnson, A.H., Nease, D., Jr, Milberg, L. Addison, R. (2004). Essential Characteristics of Effective Balint Group Leadership. *Family Medicine*, 36(4), 253–259.
13. Luban-Plozza, B., Laederich-Hofman, K., Knaak, L., Dickhaut, H.H. (1996). *der Arzt als Arznei*. Köln: Deutscher Ärzte Verlag.
14. Luban-Plozza, B., Pöldinger, W. (1973). *Der psychosomatisch Kranke in der praxis*. München: J.F. Lehmanns Verlag.
15. Luban-Plozza, B., Pöldinger, W., Kröger, F., Wasilewski, B. (1995). *Zaburzenia psychosomatyczne w praktyce lekarskiej*. Warszawa: PZWL.
16. Lustig, M. (2006). Balint Groups an Australian perspective. *The Australian Family physician*, 35(8), 639–641.
17. Salinsky, J., Otten, H. (eds.) (2003). *The doctor, the patient and Their Well-Being – World Wide Proceedings of the 13th International Balint Congress*, Berlin. The International Balint Federation.
18. Salinsky, J., Sackin, P. (2000). *What are You Feeling Doctor? identifying and Avoiding defensive patterns in the consultation*. Oxford: Radclife Medical Press.
19. Sussman, M.B. (1992). *A curious calling: Unconscious Motivations for Practicing Psychotherapy*. Northvale, NY: Jason Aronson.
20. Suszek, H. (2010). *Motywacja do zawodu psychoterapeuty*. W: L. Grzesiuk, H. Suszek (red.), *Psychoterapia. Integracja. Podręcznik*

- akademicki (s. 365–380). Warszawa: ENETEIA.
21. Wasilewski, B. (1993). Relacje lekarz–pacjent w chorobach psychosomatycznych. Sympozjum “Humanistyczne wartości medycyny u progu XXI wieku. Relacje lekarz–pacjent”. Warszawa, 13–14 maja.
 22. Wasilewski B.W (2005).: Effectiveness of Balint groups in improving doctor-patient-relationship and prevention of Burnout-Syndrome by medical professionals, W: “Development of Behavioural Medicine in Central Eastern Europe”. First Symposium of the Central Eastern European Behavioral Medicine Network Targu-Mures, Romania, 14-16 October, Abstracts
 23. Wasilewski, B.W. (2006). Challenges and limits of European cooperation on education in psychosomatic medicine. *Journal of Psychosomatic Research*, 61.
 24. Wasilewski B. (2007) : European guidelines – the view of Polish psychosomatic medicine. *Psychologische Medizin*, 18, 45.
 25. Wasilewski, B.W. (2007). Contemporary medicine as a tool of health promotion? 17-th European Symposium on Somatotherapy and Psychosomatic Education, Cracow, 25–27 October. Abstracts, 86–87. Wasilewski
 26. Wasilewski, B.W. (2010). Szkolenie psychoterapeutów – Grupy Balinta. W: L. Grzesiuk, H. Suszek (red.), *Psychoterapia. Integracja* (s. 317–338). Warszawa: ENETEIA.
 27. Wasilewski B. (2011): Psychosomatics – how it should be understood nowadays. *Archives of Psychiatry and Psychotherapy*, 3 : 41–48
 28. WHO (1975) Report of a WHO Meeting : Education and treatment in human sexuality: the training of health professionals. WHO Technical Report Series Nr. 572, 1975

