Medicine of the Person
67th International Meeting
19th - 22th August 2015
D - WOLTERSDORF

Conference 1

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20/08/2015

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Biographies in changing times
The illness and the doctor-patient relation

"Medicine of the Person
emphasises a person's coming to awareness in his or her bodily, mental and spiritual entirety, as well as in their social environment."

This is what we read if we consult an Internet search engine.

The text of the invitation to this convention incorporates this as follows :

"Even therapy demands creativity. The appearance of an illness, an injury, or a conflict requires a new solution, so that the human being can pursue his path further. … Often, however, guidelines and the experiences of evidence based medicine are not enough. We have to break out of the pattern. Doctor and patient together search for the way that none has gone before. Scientific analysis, knowledge and the experience of the doctor and other therapists tie in with the situation, the experiences, expectations and hopes of the patient to create a therapy plan for the entire person of the patient."

As keynote speaker, the task was assigned to me to present a paper on this topic, in which we shall deal with the work of the Balint groups.
As the theme of this lecture, we were advised as follows:

Times are changing and we're changing with them.

"Health does not mean being normal; rather it means to be able to adapt, grow, mature and die with time."
So says Viktor von Weizäcker (1933) concerning this.

Hence in my lecture, I intend to follow up the question :

1. What the characteristics of our time are, and to inquire about their implications for society and patients, for the healthcare system and for doctors
2. I want us all to think about what we might mean when we speak of creativity
3. We will seek to outline the method and aims of the Balint group
4. To arrive at some thoughts and conclusions on what has been said

1. The Characteristics of our Time

First of all, we will allow patients from my own practice to speak. In connection with these reports, my aim will be to sort the examples we have heard into an overall context and to deepen our understanding of them:

a) A fifty-eight year old man with an intermediate business training

We are told that he has been working for thirty-four years in a US-American business venture, and that he has shaped its structure in Germany. Over the course of the years, he has performed many different roles in the company. Hence, prior to that, he had already been branch manager on occasions. For some years, he then worked as an internal seminar facilitator in human resources development. His work had brought him great joy and satisfaction, though it involved a lot of travelling and spending nights away from home. In 2010, there had been a change of management in the company. The pressure of all that had to be done was vastly increased. In the follow-up, all previously German-language training materials were replaced with English ones. These had been very poorly put together, with cultural differences being wholly ignored. The pressure of suddenly having to use these materials had led him to severe psychophysical reactions. On one occasion, in a hotel at night, he had suffered a severe case of asphyxiation fear. He had difficulty concentrating any more, and developed marked sleep disturbances. He managed to stabilise himself anew and continued working. About the middle of 2011, he found himself caught up again. At the beginning of 2012, "a new disaster emerged". At last, he had agreed to the suggestion that he should resume the role of branch manager, in which he had experience. He agreed to this, because this role meant no spending nights away from home, and simply being able to drive home after work. In mid August 2012, he was in hospital with acute spinal disc symptoms. Up until the present day, he had a slight paresis of the left dorsal flexor of the foot. However, an operation was not necessary. In 2007, he had already once had spinal disc symptoms in the region of the cervical vertebrae. These had likewise been treated conservatively. At that time, signs of paralysis had appeared in his arm. Meanwhile, his new job role was turning into a nuclear melt-down. His new boss was career obsessed, terrorised him, and expected him to deliver completely unrealistic turnover figures. For months, he struggled on, at last increasingly developing intense anxiety and panic attacks by night. He constantly suffered rapid heartbeat, shortness of breath, extreme diarrhoea, and even when faced with tiny mundane issues he would begin to cry uncontrollably. He could no longer relax or find rest at all. When his anxiety and restlessness, inclusive of his entire bodily symptoms, had become steadily worse, he had at last gone to the doctor, prompted by his wife's urging. The doctor had written him a medical certificate in early 2013.

b) An academic

We are told: he is "a typical manager – I have always managed to lock away emotional subjects inside me." In his socialising, he had never yet learned to appreciate himself and others in emotional terms, to acknowledge his corresponding needs, or to perceive himself in this context. In retrospect, he had developed the ability to work very intensely and continuously. "And I always thought that only women got into states of anxiety !" What he had known since his study days was a tendency towards sporadic attacks of diarrhoea.

Following his business management training, he had worked with several large companies over the course of the years. In this way, his field of work had evolved at the intersection between the spheres of electronic data processing and finance. After very successfully working his way up the career ladder, in 1987 he had been headhunted into the electronic data processing industry, in which he also earned more money. In the course of the years, he had occupied a number of high up positions of management. "You simply keep going up in your job."

Several times over those years he had had to witness large companies being restructured and sold, and parts of the job being translocated abroad. Again and again, he managed seamlessly to re-establish himself in his career. In his last company, he had been director of finances. Five years ago, the company had undergone considerable restructuring, and had made many people, including him, redundant. Of course, with increasing age, it then becomes more difficult each time to find new employment once again. Since this was clear to him, he had set himself up as a freelance consultant – thanks to his numerous good business contacts and his rich business experience, he had seen a good further business perspective in this.

Under the weight of multiple burdens, several of his relationships based on partnerships were broken. He still maintained, as before, those links to his family of origin, which were to him extremely important.

About four years ago, in the context of all the major upheavals that he had witnessed, together with all the associated psychosocial challenges, he had already felt so emotionally unwell that for a while he was no longer able to work. At this time, he had been an in-patient at a psychosomatic

clinic for six weeks. Then he had felt so restored that he was able to work again.

In January 2012, he developed such large kidney and bladder stones that he had to be treated as an in-patient. The whole experience was very burdensome for him, and resulted in him being ill and unable to work for a total of six weeks. Only then was he able to work again.

In March 2012, while driving his car, he suddenly experienced a vague misting up in one eye, and then could see nothing at all. In all, he experienced this seven times, sometimes in one eye, then in the other. Other than while driving, this happened to him twice. It was already known that he had had high blood pressure for some time, which was being treated with medications. In addition, he smoked, and despite all his efforts he had not managed to quit this habit. From this configuration, a vascular incident was initially presumed. But in the comprehensive organ diagnosis, no explanation was forthcoming. For a long time, he had not known what was wrong with him. "At the end of the day, there are always stressful situations that you have to cope with."

A few keywords suffice to briefly define some characteristics of our time, which affect all of us, more or less :

- ☒ We experience a constant shortage of time. Everything has to get quicker and quicker. There is rarely accommodation for gradual development. Instant results are expected, which are then often not very permanent, and sometimes bypass the actual problem and the requirements of its solution.

- ☒ In connection with this, a fast pace is demanded of us, with many swift changes and transitions: By consequence, this means, for example, that people no longer have one employer – and, by extension, a social habitat – throughout their lifespan. They frequently experience restructuring in companies, with endless new colleagues, superiors and different structures. This is combined with increasing insecurity and anonymity in social relationships. My colleague hardly knows me, and moreover he often has little time or energy to take any further interest. We experience a high level of geographical mobility, along with growing instability of partnerships and friendships. Consequently, every individual is far more reliant on himself. This potentially leads to overload and decompensation at the latest in a strenuous situation that inevitably accompanies life. Individualisation and the tearing apart of interpersonal continuities mean increasing social isolation, a decline in trust in interpersonal connections and social structures.

- ☒ In many places, we experience ubiquitous noise, a lack of stillness and reflection, and alongside this we find quick, sensational news, which becomes meaningless in next to no time.

- ☒ No doubt, our world will progress through the primacy of the short-term monetary economisation of management. Often, decisions are made with no consideration for the long-term consequences within one's own field and without the rational weighing up of the immediate ramifications for other areas, both adjacent and further afield, in which ultimately it is evident that higher costs are often incurred.

- ☒ Ultimately, there will emerge a greater plurality of worldviews, socially divergent mileus and sub-groups, religious and pseudo-religious surrogates.

- ☒ Suffering and pain are best avoided, that is to say, should be swiftly eliminated.

- ☒ A decline in relationships and loyalty should be compensated through an increase in supervision with an increase in spending.

<u>What happens as a result to individuals ?</u>

- ☒ We are witnessing a decline in people's ability to tolerate tension and stress, to perceive emotions, to distinguish between them and to control them.

- ☒ People find it harder to connect to others, develop trust and relationships, and likewise to cope with concerns, problems and disappointments.

- ☒ The implicit knowledge of treatment and experience is in decline. Whereas Grandma would once have known what to do for a headache, today the chances are we will consult a doctor. Advice literature for parenting, dealing with disputes or love-sickness is booming just

as much as seminars on how to become successful or how to cope with death and bereavement. And many people are no longer capable of cooking themselves a meal.

What do we see in the field of medicine ?

- There is an increase in chronic illnesses, alongside a relative decline in acute illnesses such as infections. Significantly, lifestyle-induced illnesses such as cardiovascular diseases, diabetes, and obesity, with their orthopaedic and other consequences, play an ever increasing role.

- Additionally, we are witnessing an increasing significance of psychological and somatoform illnesses for unemployability and premature redundancy (in Germany, this has more than doubled since 1994, and more people leave employment because of these illnesses than through malignoma, cardiovascular diseases and muscular-movement diseases combined).

- We are witnessing a medicalisation of individual and social problems. This means that the doctor or the healthcare system has to solve problems that are, in the first instance, not medical problems at all, but rather caused by social structures, personal attitudes and lifestyles, pressures and conflicts in the workplace, and many other things. This brings with it a total overload on the system's resources and on those who work therein with increasing decompensation.

- Mostly, the patient does not have one doctor, but rather many, fragmented, brief, and frequently changing contacts in the medical system. The durations of hospital stays have become extremely short, and treatment occurs under constant pressure of economic optimisation. Many specialists have specialised “job targets” to fulfill each time. In this way, both immediate organ-medical and also psycho-social contexts, symptomatic processes and illnesses often disappear from view. Consequently, medical treatment becomes unsatisfying for the patient and the doctor, and also not infrequently ineffective and expensive. Eventually, it gets to the point in the medical system of that which is criticised in Germany as a complete disarray of inappropriate healthcare.

In this case, the concept of **evidence based medicine** has further reach than that which appears in open discourse and becomes superficially the leading treatment.

The term **evidence based medicine** derives from David Sackett and meant originally that the rationality of clinical decisions should be guided by :

- Scientifically proven evidence from more than one case of the effectiveness of a form of treatment
- Individual clinical expertise of the one carrying out the treatment
- Experiences and values of the one being treated should be taken into consideration.

Shared decision making is usually abbreviated and treated as an information problem. “But in order for the patient to be a 'partner', he or she must be able to enter a relationship, which is what studies in various European countries have shown: in the doctor-patient communication, there arise systematic difficulties and hidden agendas concerning the problem to be dealt with. The task was rarely made clear between the patient and the doctor. Doctors make a virtue of need and give treatment with regard to assumed tasks, though often neglect a verification that would aid a securing of understanding. In particular in the case of patients with chronic illnesses, a preexisting diagnosis on a vague 'et cetera' principle often has a pre-structuring effect.” (Balint Journal 3/2011, P. 78) Besides the doctor and patient, invisible third parties are present (assigning colleagues, relatives of the patient, employers, health insurance funds).

We may ask us: How do we define quality in medicine? And how do we define what a success is?

Let’s take for example the seriously restricted multimorbid patient with pneumonia, residing at home. He takes a turn for the worse, his relatives cannot cope with this, and call the emergency doctor, who advises the patient to go to the hospital. There, maximum therapy is put in place, and the pneumonia retreats. With his health compromised more than ever, the patient becomes stable again. However, as a result, he remains in such a condition that his care can no longer be afforded at home. Hence, the old and seriously ill man has to go into a care home.

In my view, the question remains : does this really represent a desired success, if, following the antibiosis, he wastes away for a few months longer in a care home rather than dying of pneumonia

slightly sooner at home, ideally in familiar surroundings and with familiar people around him ?

We may ask furthermore : Does “success” happen of its own accord when the doctor adheres to so-called quality specifications, that is to say, guidelines ?

Healing cannot be guaranteed and depends on many external factors. The success of a treatment essentially depends on whether it has been possible to motivate the patient to cooperate.

Quality in medicine is not only the quality of action but also the quality of cooperation, the quality of doctors' collaboration amongst themselves with other professions, and the collaboration between doctor and patient.

Giovianni Maio, a professor of medical ethics at the University of Freiburg concerns himself a lot with questions of quality, of success and of economy in medicine :

“Quality in medicine is a quality of decision-making, more than a quality of action. This quality of decision-making cannot be completely formalised, because it always deals with complex and singular problems, which cannot be solved merely through the application of rules, but only by combining formalised professional knowledge with experiential knowledge that cannot be formalised, and, where it is possible, to bring together statistical evidence and the specific condition of the patient." (G.Maio, DNP 2015, 3)

Clinical Case-studies :

- In the case of a thirty-five year old woman with chronic fatigue, a “borreliosis” is diagnosed as the explanation for a medical certificate over many months, even though no corresponding clinical symptoms and laboratory parameter actually exist. The medical certificate reinforces in the patient her conviction that she has a chronic bodily illness. The exclusive private doctor defines himself as a specialist for borreliosis and earns a lot of money thereby. Without any real indication, antibiotics are prescribed over and over, and the patient's social disintegration increases.

- Back-pains lead to spine operations, which are not really indicated and bring no improvement of symptoms. The patient with the back-pains confronts the doctor with a challenge – the doctor therefore feels under pressure in his job without fully realising this himself.

- A patient in her mid sixties received for many years various antidepressants and psychotherapy because of anxiety, depressive adynamia and “fainting seizures”, all in vain. Relatives pressure the medical pyschotherapist to take the patient into therapy because her condition is still so bad. The doctor finds herself feeling extremely pressured and becoming irritable and helpless. To unburden herself, she shoves the patient into the clinic, where, at long last after all these years, the ensuing careful bodily neurological examination reveals an already sizeable extrusively growing meningioma.

- The thirty year old migrant with a German passport is professionally very well integrated and efficient. Then she develops a host of bodily ailments with pains, feelings of faintness, in addition to eventual symptoms of anxiety. Comprehensive somatic examinations reveal no pathological result, the antibiotic treatment of doubtful infections is just as little help as the psychotherapy. The doctor had hesitated over discrepancies in the addresses given by the patient, yet she had always dismissed these as being irrelevant in everyday life. A move towards an improvement of the symptoms ensues, when at last the patient's story of her migration is examined in more detail, and it becomes evident that the patient is currently in the process of dissolving her marriage of convenience to a German man, which allowed her to immigrate to Germany at all. In addition, she has to raise considerable funds for this purpose.

For M. Balint : “The comprehensive diagnosis should give an overview of the bodily and emotional circumstances of the patient and of his relationships with himself and with other people, including the doctor.”

Out of that which has gone before, out of that which exists, to shape something, to set or form this into a new or different relationship, to look upon it from different angles.

2. A few associated thoughts on the subject of creativity

Creativity means to enable development, not to remain static, activity as opposed to passivity, and thereby to awaken hope. But creativity is also coupled with considerable effort and also with lean periods. Painters such as Rembrandt or Dürer have often spent years creating detailed sketches for their great works and preparing preliminary studies. In terms of creative achievement, it has always amazed me how African youths build complex toy cars out of drinks cans, wire and other trash.

Creativity – being creative – therefore means to make possible new paths, to discover alternative and sometimes surprising ways in and out, solutions. But creativity also requires “space” - freedom from fear, room for directionlessness, as opposed to quick short-term efficiency and maximisation pressures. In my eyes, creativity and play go hand in hand. When we are allowed to play, we relax, we keep a productive distance from being pressured, conforming to rules and boundaries. In short: it becomes possible to be creative.

In the context of this conference, therefore, we may examine and reflect a bit in depth on what we find in our world, in the contemporary medical service in the interaction with our patients and how we might better do everyone justice.

3. The Balint-practice

Potentially, the Balint group represents a space that is sufficiently safe to enable a bit more creativity in our work, even under the above mentioned conditions. And although the group can be a place of slowing down, which opens up possibilities in interactions with colleagues, in which what is generally not perceived in ordinary medical practice can be perceived, what is usually only vaguely guessed can be better sensed, and what is otherwise dismissed can be more closely examined and integrated.

A great deficiency that we have identified in our observation of the present is the constant shortage of time, an inability to forge relationships and deeper bonds and connections.

Or, to put it in the words of Martin Buber, to ask for the relationship between one “I” and one “you”.

Michael Balint calls this therefore “object relations theory”.

The fundamental principle of the Balint practice is that professional medical practice is necessarily also always a relationship process. And that we should reflect this relationship to the patient, the relationship that he has with himself, and our own relationship with ourselves, in order to be able as far as possible to work well and more satisfactorily for all concerned, and at the same time as far as possible to remain healthy ourselves.

It is noteworthy in this context that “burn out” is a hot topic for doctors and large-scale studies indicate again and again that among doctors, and most especially among female doctors, the rate of depression is considerably higher than among the population on average.

Quotation (Hess. Ärzteblatt 2/2013): “Resilient doctors know their own goals, limits and biological weaknesses. Dealing sensibly with one's own resources presupposes that one knows one's own motives. What drives me ? In what situation am I easily tempted to overstep my own limits ? What do I not allow myself – although it would be beneficial to me and my work in the long term ?”

It is a proven fact : The doctor in interaction in collegial communication himself remains healthier and more able to work.

Balint groups represent a practice method that has been tried and tested for decades, to be able to better and more deeply understand what happens in the interaction between doctor and patient on various levels. At the same time, in this way, taking the patient in his entirety into consideration, it is often much more clearly possible to realise what has previously not been perceived.

Let us think back once more to the outlined case-studies. Perhaps we might even assist the patient better and more effectively, encourage him to perceive his own relationships for himself, to find a productive way of coping with one's own limits and problems.

Practicing in the Balint group often also represents an opportunity for the doctor to understand more about himself. For example, why do I react in this particular way in the case of this patient? What themes, what experiences or memories does this patient evoke in me? Why do I understand this patient particularly well? Is it possible that I am confusing, that is to say, mixing up, their issues with my own, and losing an essential professional distance? What irritates me especially about this patient, that I become entangled like this? Ultimately, the group represents an opportunity for deepening reflective professional discourse with colleagues, for the broadening of points of view, sometimes for their relativisation and overall for easing the burden of demands on ourselves and exaggerated demands of patients.

The Balint group makes it possible to discuss “difficult cases”. Accompanying this is the fact that I can accept the limits of my professional abilities and acknowledge my own weaknesses and even my failings. Within the group, issues that are embarrassing, painful, worrying and tabooed, concerning the relationship between helpers and those seeking help, can be given voice. In the group, we aim to develop a sense for the psychological dynamic of a relationship. Besides what goes on tangibly in terms of content in a relationship, there is also an indirect exchange of messages and feelings, which remains implicit, and an interplay of modes of behaviour, the intentions of which are not recognised but remain effective.

The learning objective of the group is therefore: to review ordinary personal professional experience of interaction with patients. One's own capacity for perception and empathy for the experiences of others must be practised just as much as the ability to distance oneself sufficiently and to practise thinking in the dimension of relationships.

How does a group of this kind work ? :

Between about seven and twelve participating doctors meet together with a trained group leader. The group issues are the participants' experiences of the relationship between helpers and those seeking help.

Each participant describes an episode of interaction with a patient – the narrator's experience is the key part of this. The basic assumption is that this allows access to an understanding of the patterns of interaction (the methods of coping), that the patient has with himself and with his interaction partners in his surroundings.

The golden rule for the group is therefore confidentiality. Moreover, none is an expert or knows better than others. All ideas and associations contributed by group participants towards the case being presented are allowed and encouraged. For their own part, the group participants contribute whatever their colleagues' reports evoke in the way of fantasies, thoughts and reflections.

There is room for fantasies, random and disturbing issues, previously tabooed things, and things that “don't belong”. The group tolerates the emotions that emerge, ponders and digests them. Ultimately, a deeper understanding of the patient is reached. And the doctor often arrives at new insights and more productive solution approaches towards a patient's problems.

As a young doctor, I once heard it said : “After the Balint group, the patient is changed.” And in my everyday work I have often found that there is much truth in this.

The group-leader's job is therefore to structure the discussion, to help to work out the content, and at the same time to protect the group and to allow the individual to maintain the boundaries of professionality and not to divulge anything more than is actually beneficial for the situation.

The Balint group is therefore at its best an inter-disciplinary work group, among doctors for example, as an instrument for professionalisation and mental hygiene.

4. In conclusion

He who invests in his capacity for relationships invests in his capacity for endurance.
He, so says resilience research, which applies equally for us doctors as for our patients.

Without doubt, we cannot comprehensively answer urgent structural questions about the healthcare system with what is planned. But that was not our task in this case.

Nevertheless, the first beginnings of further reflections on this might emerge.

And we won't fundamentally change the world as it actually is with our insights and our responsible action. However, we might manage to achieve a small productive contribution for our patients, for the people who make up our private milieu, and for ourselves, if we always bear in mind the insight of Martin Buber and also Michael Balint :

- All that is essential in life is connection -
- And the human being recognizes himself and develops by virtue of the “you”, the other –

This means also that for us as human beings we have our set limits : time, space, economic possibilities, the body, the soul, practicality, and what is allowed, without which life would be impossible in any case.